CMS Quarterly Report

FFY 2019 1st Quarter

<u>Hawaii QUEST Integration</u>
Section 1115 Quarterly Report
Submitted: February 28, 2019

<u>Reporting Period: October 2018 – December 2018</u>

Federal Fiscal Quarter:	1st Quarter 2019
State Fiscal Quarter:	2nd Quarter 2019
Calendar Year:	4th Quarter for 2018
Demonstration Year:	25th Year (10/1/18 – 9/30/19)

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

Med-QUEST Division used the Indefinite Delivery/Indefinite Quantity (IDIQ) procurement method to select 11 contractors in the pool for future task order proposal submissions. During the reporting period, MQD continued to work with the 5 contractors selected for the following task orders: 1115 Waiver; QI RFP; High-Needs/High-Costs; Primary Care; and Project Support.

Additionally, MQD continued progress on its 1115 Waiver renewal. Following the second comment period, MQD reviewed the submitted comments. Med-QUEST Division began working with the IDIQ contractor, Harbage, on moving the 1115 Waiver renewal forward. On November 28, 2018 a public forum was held at the State Capitol. The goal of this public forum is to achieve the Triple Aim of better health, better care, and sustainable costs for our community.

Hawaii had an Annual Plan Change period from October 1st to October 31st of 2018. During that period, Medicaid beneficiaries could select a new health plan which would start January 1, 2019.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality spreadsheet for the quarter ending September 30, 2018 was submitted by the November 30, 2018 deadline. The Budget Neutrality spreadsheet for the quarter ending December 31, 2018 will be submitted to CMS by the February 28, 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

Community Integration Services (CIS)

On October 31, 2018, CMS approved an amendment to the State's 1115 waiver giving the State the ability to provide Community Integration Services (CIS), which presently include pre-tenancy and tenancy-sustaining services for individuals that are homeless or at-risk of homelessness if they meet certain health needs-based criteria. The State has begun the immediate pre-implementation phase of final planning before the benefit goes live.

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.

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

Med-QUEST Division leadership and staff successfully completed participation in the workgroup formed under Resolution No. 81, REQUESTING THE ESTABLISHMENT OF A WORKING GROUP TO EXAMINE HOW THE DEPARTMENT OF EDUCATION CAN MAXIMIZE MEDICAID REIMBURSEMENT FOR SUPPORT SERVICES OFFERED TO ELIGIBLE STUDENTS DURING SCHOOL HOURS. Med-QUEST continues to partner with DOE and assist their staff with Medicaid billing issues. This includes bi-weekly meetings, emails and written guidance to enable DOE to maximize federal reimbursement for school based medically necessary services.

C. Enrollment and Disenrollment

Med-QUEST Division experienced another slight increase in Medicaid applications completed by phone. During the period, 1,183 applications were processed and clients pre-enrolled in the QUEST Integration health plan of their choice.

The 2018 QUEST Integration Annual Plan Change was October 1 through 31. A total 326,306 clients were eligible to participate this annual plan change period. Of the total population eligible to participate, 5,752 (1.8%) clients elected to enroll in a different health plan for the 2019 benefit year. The new benefit year starts January 1, 2019. The following is a summary of the annual plan change participation by island.

Program	Oahu	Kauai	Hawaii	Maui	Lanai	Molokai
MAGI	2839	213	770	673	60	7
MAGI Excepted	831	36	217	88	17	1
Total	3670	249	987	761	77	8

The top five languages serviced this reporting period using interpreter assistance included Chinese (Mandarin and Cantonese) (17%), Japanese (24%), Filipino (Ilocano, Tagalog, and Visayan) (11%), Vietnamese (3%), and Korean (38%).

Outreach/Innovative Activities

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

During this quarter Health Care Outreach Branch (HCOB) conducted Annual KOLEA and Health Insurance Marketplace certification and training to approximately 92 "Kōkua" in-person assisters from Federally Qualified Health Centers (FQHC's), Med-QUEST Kōkua Services Contractors, Federal Marketplace Navigator organization and other community health centers statewide, in preparation for open enrollment period for the Health Insurance Marketplace. Training curriculum included detailed overview of how to gain access to and successfully submit an online application for Medicaid through our KOLEA Enterprise system and through www.healthcare.gov which included overview and understanding of the Affordable Care Act (ACA), the Health Insurance Marketplace; portal.cms.gov MLMS online learning

management system certification and the subsidies offered by the ACA at healthcare.gov such as Advance Premium Tax Credits (APTC) and Cost Share Reductions (CSR), the need to reconcile APTC's from a 1095-A form with Annual Tax Filing by way of tax form 8962 to the IRS. Cultural Competency was incorporated in all of our trainings.

HCOB Coordinators and Kōkua schedule and participated in over 200 outreach and enrollment events statewide during the Health Insurance Marketplace Open Enrollment from November 1 – December 15, 2018. We focused our efforts to enroll citizens where English is a second language and those who are from COFA Nations; Federated States of Micronesia, The Republic of Marshall Islands and The Republic of Palau. These populations also tend to have critical health needs which often go undiagnosed or untreated until they end up in emergency rooms.

Hawaii's enrollment numbers for the Health Insurance Marketplace held steady with a slight increase for open enrollment 2019 at 20,193.

Continued work, in identifying and assisting hard to reach populations and those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers, justice-involved populations and those who are admitted to and discharged from public institutions.

HCOB continues to work with clients and issuers to review and determine applicants' eligibility for the State of Hawaii's Premium Assistance Program (PAP), the State's innovative approach to helping those who are living in poverty, are deemed ineligible for Medicaid due to their citizenship status, whose households are below 100% of the Federal Poverty Level (FPL) gain access to the benefits of health insurance by paying for the remaining portion of a PAP qualified individual's premium, not covered by the Advanced Premium Tax Credit (APTC) they are eligible for, thus meeting the expectations of the Affordable Care Act (ACA) which require individuals without qualified exemptions be insured.

D. 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.)

Fifteen (15) complaints/grievances were received during this reporting period. See Section IX(A) for monthly count.

October – December 2018 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.
2- Transportation	Transportation services do not come during schedule times, member waited over and hour and a half for her pick up and drop off. Drivers are unprofessional and uncaring to disabled members. Member feels health plan sides with contractors. Pick-ups are not scheduled correctly. Drivers do not follow policies and protocols.
6 – Health Plan	Several complaints regarding health plans incorrectly in taking members complaints. 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 plans sending false resolutions that have not been solved nor addressed. Health plan being uncooperative and denying recommended services.
1 – Services	Member chore services worker damaged his personal belongings. No reimbursement was given for his home appliances that got damaged.
3 – Miscellaneous	Calling wrong business line. Calls regarding appeal and the process. I explain to the members our Appeals process and provider them with any needed information such as contacts and

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

E. 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 worked in partnership with the State Department of Health to issue guidance to Federally Qualified Health Centers (FQHCs) and the managed care plans.

Med-QUEST Division 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.

The Division worked on researching the provision of palliative care in the community setting. There have been a couple health plans that would like to provide palliative care under a similar reimbursement structure as hospice care. It is felt that provision of palliative care, that includes curative care and care management, it 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.

The Division's Annual Plan Change period occurred in October, 2018. The Division worked to ensure transition to a new health plan occurred smoothly by providing losing and gaining health plans with rosters ahead of the change to allow for medical records/prescriptions, services to be transferred, if applicable, to ensure services were available from the first day of new enrollment.

F. Access that is Relevant to the Demonstration

There were no events affecting accessibility of services provided by the health plans during this reporting period.

G. Pertinent Legislative or Litigation Activity

In late December, MQD received notice that DHS was named in litigation against DOE.

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

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

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

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

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

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

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

		Law Enforcement Assisted Diversion; Appropriations		

IV. Adverse Incidents

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

A. Medicaid Certified Nursing Facilities

Total of 12 reported adverse incident reports submitted during the period of October - December 2018.

- 7 unattended/unwitnessed fall
- 4 witnessed fall
- 1 unknown cause of pain/skin discoloration

Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities:

Total of 21 reported adverse incident reports submitted during the period of July – September 2018.

- 18 ER visits due to illness
- 1 ER visit-uncooperative behavior (refusal to walk)
- 1 teeth extraction
- 1 scheduled shunt operation
- 1 ER F/U Admit to monitor

B. Long Term Services and Supports (LTSS)

Adverse event information for the federal fiscal year (FFY) 2019 quarter 1 (Q1) for the LTSS population will be reported in the next quarterly report, federal fiscal year (FFY) 2019 quarter (Q) 2 because the LTSS report which includes adverse incident data for FFY 2019 Q1 is submitted on January 31, 2019. The information for the LTSS population in this report is from the FFY 2018 Q4.

In FFY 2018 Q4, a total of 321adverse events related to the LTSS population were reported. The top five categories in the order of the most frequent occurrences are: Fall, Hospital, Death, Emergency Room Visit, and Injury. Falls, although the most frequently occurring, were noted to be trending down. Hospitalizations were noted to be trending up. Overall, these five categories were consistently in the top five throughout FFY 2018.

The downward trend in falls may be attributable to MQD's increased reinforcement of ensuring that fall precautions are in place for members as well as requiring follow ups for individual fall cases. The upward trend for hospitalization may be attributed to varying category labels related to hospitalization among reporting entities.

Plans are in place to review and possibly revise the LTSS report in order to capture incident occurrences on a more granular level. A couple of updates being considered are to create subcategories or to provide more detailed or different category descriptions. It is anticipated that updating the LTSS reporting tool will improve the overall portrayal of events within each quarter as well as more readily illuminate areas of improvement as well as areas for remediation.

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.

During November, MQD received final approval for QI RFP Supplemental Change #9, which approved the 2018 CAP rate to be paid to the MCOs.

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**	**10/2018 - 12/2018**	**10/2018 - 12/2018**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	351,631	113,940
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	108,416	34,666
Aged	Aged w/Medicare Aged w/o Medicare	80,718	26,901
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	72,797	24,103
Expansion State Adults	Expansion State Adults	281,649	90,720
Newly Eligible Adults	Newly Eligible Adults	64,253	20,605
Optional State Plan Children	Optional State Plan Children		0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,424	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)	87,732	28,108
Total		1,048,620	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	12/31/2018

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 12/31/18**
EG 1 – Children	**118,170**	**117,934**	**116,951**	**353,055**
EG 2 – Adults	**36,332**	**36,238**	**35,846**	**108,416**
EG 3 – Aged	**26,879**	**26,928**	**26,911**	**80,718**
EG 4 – Blind/Disabled	**24,136**	**24,410**	**24,251**	**72,797**
EG 5 – VIII-Like Adults	**0**	**0**	**0**	**0**
EG 6 – VIII Group Combined	**114,694**	**115,384**	**115,824**	**345,902**

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 12/31/18
State Plan Children	117,738	117,432	116,461	351,631
State Plan Adults	36,332	36,238	35,846	108,416
Aged	26,879	26,928	26,911	80,718
Blind or Disabled	24,136	24,410	24,251	72,797
Expansion State Adults	93,553	94,063	94,033	281,649
Newly Eligible Adults	21,141	21,321	21,791	64,253
Optional State Plan Children	0	0	0	0
Foster Care Children, 19-20 years old	432	502	490	1,424
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.	**4,598**
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).	**985**
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.	**1,006**
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.	**147**

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.)

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 (Combined Dashboard as of 2/19/19 2:03 pm)

Health Plan	Oct 2018	Nov 2018	Dec 2018
Aloha Care	449	533	544
HMSA	834	844	722
Kaiser	215	209	217
Ohana	3122	3014	2982
United Healthcare	2195	2221	2159
Total	**6815**	**6821**	**6624**

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 Change Plans After Auto-Assignment

Member Choice of Health Plan Exercised

	#
Individuals who chose a health plan when they became eligible	**608**
Individuals who changed their health plan after being auto-assigned	**2561**
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	**134**
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**14**

During this reporting period, 608 individuals chose their health plan when they became eligible, 2561 changed their health plan after being auto-assigned. Also, 9,929 individuals had an initial enrollment which fell within this reporting period.

In addition, 14 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 1st quarter, MQD received and addressed the following number of members complaints.

Month	# of Member Complaints/Grievances
October 2018	5
November 2018	6
December 2018	4
Total	**15**

B. Appeals

The hearing held in November (reported in 4th Quarter) was decided in DHS' favor.

For the 1st quarter, there were five (5) member appeals. Two (2) of the appeals were withdrawn or dismissed. Two (2) of the hearings were decided in DHS' favor. One (1) is pending a hearing which is scheduled in February.

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

Member Appeals	#			
	Oct 2018	Nov 2018	Dec 2018	TOTAL
Submitted	3	0	2	5
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	1	0	1	2
Dismiss as untimely filing	0	0	0	0
Member withdrew hearing request	0	0	0	0
Resolution in DHS favor	2	0	0	2
Resolution in Member's favor	0	0	0	0
Still awaiting resolution	0	0	1	1

Types of Member Appeals	#			
	Oct 2018	Nov 2018	Dec 2018	TOTAL
Medical	2	0	0	2
LTSS	1	0	1	2
Van modification	0	0	0	0
ABA	0	0	0	0
DME	0	0	1	1
Reimbursement	0	0	0	0

X. Evaluation Activities and Interim Findings

A. Evaluation Activities

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

Final Rules

During the reporting period, MQD received approval of QI RFP Supplemental Changes (SC) #9 regarding 2018 rates and scope from CMS. Supplemental Change #11 for 2019 rate and content were submitted in December 2018.

During this reporting period, MQD also worked with CMS on the new 2018 CCS RFP rate and scope by submitting SC #1, #2 and #3, including completing the initial draft of the behavioral health parity report.

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, a vendor kick-off meeting was conducted at AHCCCS. Work was initiated on gap analysis and design requirements. MQD continued to 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 1 (Q1), MQD continued to collaborate with Arizona Health Care Cost Containment System (AHCCCS) towards implementation. Efforts primarily revolved around activities to procure a statewide EVV vendor and acquiring additional staffing support in anticipation of the EVV rollout, all the while communicating progress to stakeholders via several modes of communication including email, face-to-face meetings, and EVV webpage updates.

MQD's future EVV work plans include selecting and awarding a statewide EVV vendor; working with the IV&V provider to ensure that 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.

OCTOBER

MQD worked with AHCCCS to respond to two hundred eight questions received from prospective EVV vendor offerors. An EVV progress update was given in person and via telephone conference at the monthly Managed Care Organization (MCO) meeting, including a reminder that the request for proposal (RFP) for a statewide EVV vendor was posted to the website on September 28. This update was also emailed to the MCOs, Department of Health-Developmental Disabilities Division, and home and

community based service providers, and all who attended the MQD EVV information sessions in February and March 2018.

NOVEMBER

EVV vendor proposals were received and reviewed by the RFP evaluation team on an individual basis. Work was started in response to the return of our Planning Advanced Planning Document from CMS which was accompanied with a table of questions and guidance for the next update. In anticipation of the need for more staffing support for the upcoming EVV implementation, MQD conducted interviews for a full time MQD EVV Project Manager. MQD also received further EVV guidance from CMS by attending the CMS EVV Open Door Forum on November 7 and also the National Association of States United for Aging and Disabilities all state call on November 28 where the idea of the CMS EVV learning collaborative workgroup was introduced.

DECEMBER

MQD was delighted to receive a CMS invitation to participate in the CMS Learning Collaborative which would convene on January 10, 2019. Unfortunately, the January date conflicted with the ability to present since procurement for the EVV vendor would be in progress. MQD and AHCCCS look forward to future EVV discussions after the projected EVV vendor award date of April 2019. The RFP evaluation team, consisting of AHCCCS and MQD staff, met in person over four days for the sole purpose of evaluating all received EVV vendor proposals. A dedicated full time MQD EVV Project Manager was hired and started working in mid-December.

B. Interim Findings

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

XI. Quality Assurance and Monitoring Activity

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

Quality Activities During The Quarter October to December 2018

The External Quality Review Organization (EQRO) oversees the health plans for the Quest Integration (QI) and Community Care Services (CCS) programs. Health Services Advisory Group (HSAG), the EQRO, performed the following activities this quarter:

1. Validation of Performance Improvement Projects (PIPS) –

October:

- Reviewed Module 4 updates and provided feedback to AlohaCare and Kaiser.
- Scheduled a Module 4 and 5 refresher training for 01/08/19, prior to deadline for submitting the final Modules 4 and 5 for validation on 02/15/19.

November:

- Finished reviewing the Module 4 progress updates and provided feedback.
- Participated in a meeting with the MQD to discuss the next rapid-cycle PIP topics.
- Received from the MQD the topics for the PIPs starting in 2019.

December:

- Provided the 2019 PIP draft timeline to the MQD on 12/19/18.
- Received approval of the draft timeline from the MQD on 12/19/18.
- Sent a reminder email to the health plans on 12/19/18 with the 02/15/19 PIP submission due date, Module 5 form, and PIP reference guide.

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

October:
Continued review of EDUH measure rates

November:

- Continued review of EDUH measure rates and working with the health Plans to obtain correct data
- Sent CAHPS Sample Frame validation related letters to the health plans and emails requests to the MQD.

Reviewed draft list of measures from the State for HEDIS 2019.

December:

- Resolved the NYU and EDUH performance measure rates for all plans except for UHC. We are continuing to work with UHC to obtain final resolution for the EDUH performance measure.
- Received and approved the source code for the Child CAHPS sample frame.
- Work with the State to receive final list of measures to be validated in 2019.

Send out the document request packet to all health plans with the list of measures for validation in 2019.

3. Compliance Monitoring –

October:

- Completed review of revised CAPs for HMSA, KFHP, ‘Ohana QI/CCS, and UHC; submitted to the MQD for review.
- Completed review and prepared revised CAP documentation for KFHP and UHC the MQD feedback; submitted to the MQD for review
- Submitted notification to HMSA and ‘Ohana QI/CCS that 2017 CAPs have been closed.
- Received confirmation from the MQD on the 2019 Compliance Monitoring Review standards, activities, and timeline.

Began coordinating on-site compliance reviews with QI and CCS health plans.

November:

- Received feedback from the MQD on KFHP’s CAP submission; incorporated into CAP document and returned to KFHP for review.
- Completed review and prepared revised CAP documentation for UHC; submitted to the MQD for review.
- Received confirmation from the MQD on the 2019 Compliance Monitoring Review standards, activities, and timeline.

Coordinated on-site compliance reviews with QI and CCS health plans.

December:

- KFHP requested a conference call to review required actions necessary to resolve its CAP; scheduled for 01/09/19.
- Schedule pre-KFHP discussion meeting with the MQD to align objectives and expectations prior to January conference call; scheduled for 01/03/19.
- Submitted updated UHC CP CAP to the MQD to review.
- Received the MQD’s feedback on HSAG’s updated to the UHC CP CAP document; revised and submitted to UHC CP for review and resubmission.
- Received UHC CP’s updated CAP documentation on 12/27/18; HSAG began its review of the updated material.
- Received feedback from the MQD on the 2019 Compliance Monitoring Review (CMR) tools.

Updated 2019 CMR tools based on the MQD’s feedback; submitted for final approval.

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

October:

- Prepared presentation of key findings of 2018 CAHPS results and methodology based on the MQD’s request.
- Attended NCQA HEDIS/CAHPS 2018 survey vendor training on 10/10/18.

November:

- Attended the meeting with the MQD to review the 2019 CAHPS activities on 11/02/18.
- Attended conference call with the MQD to discuss the 2018 CAHPS Methodology and Results on 11/07/18.

- Sent survey notification letter with data submission and administrative requirements, including supplemental questions, as well as the text for cover letters and postcards and sample frame creation instructions to the MQD on 11/09/18.
- Sent and received approval from the MQD on the email language for the 2019 CAHPS sample deduplication request on 11/09/18.
- Sent CAHPS sample deduplication request to the QI health plans on 11/15/18.

December:

- Received final approval on language block text that will be included on English cover letters, as well as the current letterhead from the MQD on 12/03/18.
- Received initial list of supplemental questions to include in the 2019 surveys from the MQD on 12/11/18.
- Notified the MQD of NCQA's denial to include more than 12 supplemental questions in the 2019 CAHPS Child Medicaid Health Plan Survey on 12/20/18.
- Received request for duplicated sample from UHC CP QI and HMSA QI.
- Notified the MQD that HMSA QI will submit their sample frame for deduplication to the MQD in early-February.
- Received final approval on the supplemental questions to include in the 2019 surveys from the MQD on 12/28/18.

5. Provider Survey –

October:

- Mailed second provider surveys and cover letters to all non-respondents on 10/15/18.
- Received confirmation from the MQD on 10/19/18 that Kaiser received the surveys from the first mailing on 10/10/18.

November:

- Notified the MQD that the survey field closed on 11/27/18.

December:

- Received final data files from Subcontractor on 12/07/18.
- Submitted the final disposition report to the MQD on 12/14/18.
- Performed survey data analysis on 12/28/18.

6. Annual Technical Report –

October:

- Began drafting 2018 EQR Technical Report sections where activities have been completed.

November:

- Continued drafting 2018 EQR Technical Report sections where activities have been completed.

December:

- Continued drafting 2018 EQR Technical Report sections where activities have been completed.

7. Technical Assistance

None for this quarter.

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 to work on updating quality strategy to align with the new QI RFP and HOPE Initiatives.

XIII. Demonstration Evaluation

(Discuss the progress of evaluation design and planning.)

As a requirement to complete the 1115 Demonstration Renewal, MQD submitted on June 29, 2018, the interim evaluation of the 5-year 1115 Waiver expiring on December 31, 2018.

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 October 2018 – December 2018

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.

Attachment B: Up-To-Date Budget Neutrality Worksheet

The Budget Neutrality worksheet for the quarter ending 9/30/2018 is attached. The Budget Neutrality worksheet for the quarter ending 12/31/2018 will be submitted by the 2/28/2019 deadline.

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