CMS Quarterly Report

Federal Fiscal Year 2019 3rd Quarter

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: August 26, 2019
(via secured email)

Reporting Period: April 2019 – June 2019

Federal Fiscal Quarter:	3rd Quarter 2019
State Fiscal Quarter:	4th Quarter 2019
Calendar Year:	2nd Quarter 2019
Demonstration Year:	26th Year (1/1/19 – 12/31/19)

Table of Contents

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 Indefinite Defined Indefinite Qualified (IDIQ) vendor, Harbage, came on-site to meet in person and to work with MQD staff to set up a plan to implement the new QI RFP requirements.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality spreadsheet for the quarter ending March 31, 2019 was submitted to CMS by the May 31, 2019 deadline. The Budget Neutrality spreadsheet for the quarter ending June 30, 2019 will be submitted by the August 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 continued to work with CMS on approving the 1115 extension in the April 2019 – June 2019 timeframe. MQD answered all of CMS's questions in a timely manner and began the process of outlining its evaluation design with CMS subject matter experts. There continued to be issues in the negotiation that required more detailed follow up even after multiple rounds of CMS and MQD questions and answers, and the negotiation was not completed by the end of June. Recognizing this issue, CMS granted an additional temporary extension in June to run until July 31, 2019.

MQD anticipates that the renewal will be approved at the end of July to begin on August 1, 2019.

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 be 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. The DOE now has a Medicaid office specifically tasked with working with MQD for claiming issues. MQD staff continues to offer guidance, assistance and information when needed. DOE staff has increased efforts statewide to be in compliance with Medicaid requirements to ensure maximum federal reimbursement for school based Medicaid services.

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 to broaden collaborative efforts with other divisions, offices and other both public and private entities.

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, participating in the BES project in various areas, 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 maintains a steady number of Medicaid applications completed by phone, at just under 1,000 each quarter. The phone process encourages the applicant to pre-select a QUEST Integration health plan. Clients that apply by paper or online are auto-assigned a health plan and mailed a choice form. This reporting period, Med-QUEST processed 3,384 health plan selections for individuals within the initial choice period. Med-QUEST is developing a plan to increase pre-enrollments through Health Care Outreach Branch Coordinators and Kōkua Service contractors assisting applicants in the community and at service centers statewide when the public hand-delivers paper applications.

QUEST Integration health plans processed 86 plan change requests from its members. This only occurs if the request for change is not covered by QUEST Integration 2014-005-2013 Section 30.600.

Language assistance is offered to individuals with limited English proficiency upon request, if a preferred language is recorded in a client's profile, and when staff identify it beneficial in serving the clients. This reporting period the top five languages which required interpreter service were Chinese (Mandarin and Cantonese) (13%), Japanese (19%), Filipino (Ilocano, Tagalog, and Visayan) (22%), Korean (22%), and Vietnamese (9%).

Outreach/Innovative Activities

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

The Health Care Outreach Branch (HCOB) has successfully procured Three Kōkua Services contracts for the next two fiscal years 2019 -2020 and 2020- 2021. These organizations will have "Navigators" we call

Kōkua who will conduct outreach, provide 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.

We continue to do provide normal services and outreach to the community, working with homeless shelters and justice involved populations. HCOB continues to look for new ways to connect and collaborate with community partners and provide resources for our clients.

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.)

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

April 2019 – June 2019 Complaints/Grievances	
Number and Type of Complaints:	**Description :**
3 – Transportation	Member was on a trip to California, while being there she was in an incident where she had to be transported by ambulance. The member received a bill for the services because the health plan denied to pay the bill the Health plans response to the denial of payment was "**Medicaid plans are State specific meaning health coverage is only in the State of Hawaii, unless it is an emergency. They also said transportation from one facility to another facility is not a covered benefit."** A Member wants to file a harassment complaint against his health plan for not providing necessary travel arrangements required by Hawaii State Law. Health plans are not providing members with necessary transportation.
8 – Health Plan (HP)	Several complaints regarding health plans incorrectly in taking members complaints. Members' grievance resolutions do not contain correct information or has been addressed inaccurately and they are not satisfied. Member said they did not receive a resolution letter from their health plan. Health plans are denying services even though it's medically necessary. Member received an acknowledgement letter from the Health plan stating he filed a grievance; member said he did not want to file a grievance and he wants to withdraw it. Member is upset because she was denied coverage for custom blacked out drapes from the health plan, she appealed the decision and the State also denied her request for reimbursement. Member didn't agree with the health plans

	resolution so she would like to file this complaint with the higher up. Complaint against the health plan, they are not taking necessary care for their members.
3 – Services / Service coordinators & Case managers	Member is unhappy with a contracted nursing service who promised that they will be able to fill all available hours that the member is requesting; the promised services were not completed but the resolution says different. Multiple complaints against fraud concerns; one member said a chores service worker asked her for cash and is always trying to sell her things. Another member filed for a fraudulent complaint against her chore service worker for asking for cash and charging hours that has not been worked; she also feels her service coordinator doesn't care.
12 – Miscellaneous	Members' current health plan is not doing their part and they are requesting to switch health plans. Calls regarding appeals and its process. I explain 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. A member was approved for Medicare a few months back but he is still waiting for someone to get back to him regarding if they are going to take money out from his social security. Member contacted customer service multiple times to update his current address and it keeps on reverting back to his old address; this is an ongoing issue with the member. Calls from members who are trying to get ahold of customer service regarding a change and updates for PCP. Calls requesting eligibility and customer service forms and printouts; forward members to the correct department. Calls to make changes to their Medicaid benefits. Request of certain documents. Trying to enroll in Medicaid and need assistance. Members need help with denied benefits and or termination of benefits. Member having problems with MQD customer services and eligibility, member was told by multiple workers that they were going to terminate her as a Medicaid member (per members' request) by a certain date and the case was not terminated. Members calling to follow up on their existing grievances.

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

E. Quality of Care

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 submission of the annual report in Q4.

During the 3rd quarter the Clinical Standards Office was able to concentrate on the requests from our Eligibility Branch regarding determination of emergency services for those ineligible for Medicaid. Upon review of requests it was found that there were individuals who repeatedly went to the emergency room who could qualify for Medicaid or had third party insurance. The effort to identify individuals as disabled and therefore qualify for Medicaid will enable those individuals to receive needed medical care through a QUEST Integration health plan, assignment to a primary care provider and care coordination services to reduce unnecessary emergency room

visits. Those covered by a third party insurer were directed back to the insurer which will hopefully allow the individuals to receive care from a covered provider rather than continued use of the emergency room.

SBIRT efforts continue as it has been added as a Pay for Performance measure. The Division has been coordinating with the State Department of Health on establishing training and measures. More discussion on SBIRT activities will be provided in Q4 report.

F. Access that is Relevant to the Demonstration

Kaiser had 3 clinics certified as Rural Health Center (RHC) in Lahaina, Kihei and Kahuku. During this reporting period, MQD confirmed with CMS that these RHCs may service only Kaiser members.

G. Pertinent Legislative or Litigation Activity

MQD was notified of being party to a lawsuit along with the Children and Adolescent Mental Health Division, Dept. of Health for the provision of mental health services for a child/young adult.

The 2019 Legislative session concluded in May 2019. The following summarizes legislation that impacts the Medicaid program: the provider tax programs were continued that allows expanding the quality improvement and performance measurement programs with the hospitals and nursing facilities; several bills create task forces or workgroups with Medicaid representation addressing the continuum of care for behavioral health services and homelessness; eligibility criteria, and I/DD waiver home/community based services for individuals with autism or with fetal alcohol syndrome; and expanding eligibility criteria for employed persons with disabilities.

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 14 reported adverse incident reports submitted during the period of April - June 2019.

- 7 unattended/unwitnessed fall
- 5 witnessed fall
- 2 unknown cause of pain/skin discoloration

Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities:

Total of 16 reported adverse incident reports submitted during the period of April - June 2019.

- 6 ER visits due to illness

- 9 ER visits due to physical Injury (Hernia)
- 1 ER visit-replaced catheter

B. Long Term Services and Supports (LTSS)

The data that the health plans provide are a quarter behind.
The information reported in the 2nd quarter report is the data for January, February and March 2019.
Below is the data for October, November and December 2018 which should have been reported in the 2nd quarter report.

Types of Adverse Events	#			
	Oct 2018	Nov 2018	Dec 2018	**TOTAL**
Fall	28	29	28	85
Hospital	14	29	20	63
Death	13	12	6	31
Emergency Room Visit	22	2	5	29
Injury	8	7	4	19
TOTAL	85	79	63	227

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.

MQD is considering stratifying the encounter pend reasons into 3 buckets. The first bucket are encounters that are pending for reasons that MQD is responsible for. The second bucket are encounters that are pending for reasons that the MCO is responsible for, and the last bucket are encounters that have yet to be assigned.

MQD started to engage conversation with a vendor to conduct an encounter data validation (EDV). This is scheduled to occur sometime in 2020.

VI. Initiatives and Corrective Action Plans for Issues Identified In:

A. Policy

During the reporting period, there were several policy issues that required clarification to MQD staff and certain providers, but no corrective action was needed. The clarifications included treatment of certain assets for determination of eligibility, Administrative appeals for DOH services, Medicaid eligibility for certain institutionalized individuals, and cost share/spenddown related questions.

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**	**4/2019 - 6/2019**	**4/2019 - 6/2019**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	347,123	114,777
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	104,468	34,632
Aged	Aged w/Medicare Aged w/o Medicare	82,685	28,077
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	71,226	24,159
Expansion State Adults	Expansion State Adults	277,242	92,004
Newly Eligible Adults	Newly Eligible Adults	61,425	20,428
Optional State Plan Children	Optional State Plan Children	0	0

Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,532	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)	87,934	29,032
Total		1,033,635	343,613

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	202.149
Title XXI funded State Plan	29,032
Title XIX funded Expansion	112,432
Enrollment current as of	6/30/2019

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 6/30/19
EG 1 – Children	**115,818**	**116,437**	**116,400**	**348,655**
EG 2 – Adults	**34,543**	**35,037**	**34,888**	**104,468**
EG 3 – Aged	**27,556**	**27,514**	**27,615**	**82,685**

EG 4 – Blind/Disabled	**23,848**	**23,588**	**23,790**	**71,226**
EG 5 – VIII-Like Adults	**0**	**0**	**0**	**0**
EG 6 – VIII Group Combined	**112,959**	**112,513**	**113,195**	**338,667**

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 6/30/19
State Plan Children	**115,308**	**115,929**	**115,886**	**347,123**
State Plan Adults	**34,543**	**35,037**	**34,888**	**104,468**
Aged	**27,556**	**27,514**	**27,615**	**82,685**
Blind or Disabled	**23,848**	**23,588**	**23,790**	**71,226**
Expansion State Adults	**92,469**	**92,002**	**92,771**	**277,242**
Newly Eligible Adults	**20,490**	**20,511**	**20,424**	**61,425**
Optional State Plan Children	**0**	**0**	**0**	**0**
Foster Care Children, 19-20 years old	**510**	**508**	**514**	**1,532**
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

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.)

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

Program	# of Individuals
Community Care Services (CCS) [Not administered by DOH] 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.	**4,342**
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).	**865**
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.	**1,149**
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.	**144**

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 8/19/19 9:57 am]

Health Plan	Apr 2019	May 2019	Jun 2019
Aloha Care	514	513	553
HMSA	696	685	686
Kaiser	232	244	259
Ohana	3038	2948	2940
United Healthcare	2335	2402	2381
Total	**6815**	**6792**	**6819**

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

April 2019 – June 2019	Number of Members
Individuals who chose a health plan when they became eligible	**747**
Individuals who were auto-assigned when they became eligible	**6,512**
Individuals who changed their health plan after being auto-assigned	**2,359**
Individuals who changed their health plan outside of allowable choice period (i.e., plan-to-plan change)	**86**

Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**8**

During this reporting period, **747** individuals chose their health plan since they became eligible in the previous quarter, **2,359** changed their health plan after being auto-assigned. Also, **6,512** individuals had an initial enrollment which fell within this reporting period.

In addition, **8** 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 3rd quarter, MQD received and addressed the following number of members complaints.

Month	# of Member Complaints/Grievances
April 2019	7
May 2019	11
June 2019	8
Total	**26**

B. Appeals

The hearing held in May (reported in 2nd quarter) was decided in DHS' favor.
For the 3rd quarter, there were two (2) member appeals and both were dismissed.
The types of appeals were: (1) Medical, and (1) Reimbursement.

Member Appeals	#			
	Apr 2019	May 2019	Jun 2019	TOTAL
Submitted	1	1	0	2
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	1	0	2
Dismiss as untimely filing	0	0	0	0
Member withdrew hearing request	0	0	0	0
Resolution in DHS favor	0	0	0	0
Resolution in Member's favor	0	0	0	0
Still awaiting resolution	0	0	0	0

Types of Member Appeals	#			
	Apr 2019	May 2019	Jun 2019	TOTAL
Medical	0	1	0	1
LTSS	0	0	0	0
Van modification	0	0	0	0
ABA	0	0	0	0
DME	0	0	0	0
Reimbursement	1	0	0	1
Medication	0	0	0	0

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. In the meanwhile, substantial work was completed in establishing both internal and external capacity to support CMS evaluation requirements in the new 1115. First, MQD established and filled three technical positions to support MQD health analytics. Additional positions remain to be filled. The three positions include two epidemiologists and one statistician. These staff will provide guidance and support for evaluation activities. Additionally, MQD made good progress in finalizing the creation of a Health Analytics Office within the division to oversee all data analytics including evaluation. Finally, MQD also progressed in identifying and developing agreements with an external evaluator. In June 2019, MQD finalized and executed a Memorandum of Understanding with the University of Hawaii at Manoa that established the financial and legal mechanisms by which MQD will contract with the University to provide evaluation support. A lead evaluation coordinator has been recruited and ongoing meetings have been held to increase the coordinator's familiarity with the goals and objectives of the Medicaid program in general, and the proposed activities in the 1115 renewal in specific. The UH Evaluation Team stands prepared at this time to engage the appropriate subject matter experts to support the evaluation of demonstration activities in the renewal period once STCs have been finalized. At this time, a planning process to (a) ascertain data needed for appropriate evaluation of demonstration activities, (b) identify data gaps where additional primary data collection is needed, and (c) develop mechanisms to ensure reporting of additional data elements has begun.

XI. Quality Assurance and Monitoring Activity

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

Quality Activities During The Quarter April to June 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)

April:

- Provided the Module 4 and 5 tools to the health plans on 04/02/19.
- Answered PIP resubmission questions for UHC and Kaiser.

May:

- Received the Module 4 and Module 5 resubmissions from the health plans.
- Completed a review of the Module 4 and Module 5 resubmissions.
- Notified the health plans of the new PIP topics and scheduled the Module 1 and Module 2 PIP training for 06/14/19.

June:

- Provided the final Module 4 and Module 5 validation tools to the health plans.
- Provided Module 1 and Module 2 PIP training on 06/14/19.
- Provided PIP technical assistance in preparation for the Module 1 and Module 2 submissions, as requested.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

April:

- Approved source code for non-HEDIS performance measures for AlohaCare and UHC on 04/02/19, and HMSA and Kaiser on 04/10/19.Completed final approval of standard and non-standard supplemental databases for UHC on 04/01/19.
- Completed onsite visits with the plans from 04/09/19-04/16/19.
- Conducted HEDIS 2019 pre-MRRV Webinar on 04/18/19.
- Completed Convenience Sample review and sent Convenience Sample reports to all health plans.
    - Ohana 04/01/19
    - UHC 04/04/19
    - Kaiser 04/04/19
    - AlohaCare 04/12/19
    - HMSA 04/18/19

- Provided MRRV templates (i.e. Attachments 1-4) and submission instructions to all plans via FTP site.

May:

- Completed MRRV.
- Completed Preliminary Rate Review.

June:

- Completed Final Rate Review with all health plans for the HEDIS measures.
- Completed final rate review for the non-HEDIS measures for AlohaCare, Kaiser, UHC and ‘Ohana
- Working with HMSA for correcting the rates for 2018 and 2019 for the NYU measure.

3. Compliance Monitoring

April:
Began drafting compliance review reports.

May:
Completed draft compliance review reports for AlohaCare, HMSA, and KFHP and submitted them to the MQD for review on 05/16/19.

June:
- Received comments from the MQD on the draft compliance review reports for AlohaCare, HMSA, and KFHP and updated the reports.
- Sent draft reports to AlohaCare, HMSA, and KFHP for review on 6/10/19.
- Completed draft compliance review reports for Ohana QI, Ohana CCS, and UHC CP and submitted them to the MQD for review on 6/12/19.
- Received comments on the draft compliance review reports from AlohaCare, HMSA, and KFHP on 6/17/19.
- Received comments from the MQD on the draft compliance review reports for Ohana QI, Ohana CCS, and UHC CP on 6/21/19 and updated the reports.
- Sent draft compliance review reports to Ohana QI, Ohana CCS, and UHC CP for review on 6/24/19.
- Final compliance review reports and CAP templates sent to AlohaCare, HMSA, and KFHP on 6/28/19.

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

April:
- Mailed second postcard reminders to non-respondents on 04/04/19.
- Began CATI for non-respondents on 04/17/19.
- Performed CATI monitoring of survey vendor on 04/25/19.

May:
- Completed CATI for non-respondents and notified the MQD that the survey field has closed on 05/07/19.
- Received data files from subcontractor on 05/22/19.
- Submitted CAHPS Health Plan Database data submission instructions to the MQD on 05/24/19.
- Notified the MQD that NCQA data submission for all QI health plans was completed on 05/30/19.

June:
- MQD re-activated their CAHPS Health Plan Database account and submitted the signed Data Use Agreement (DUA) to the CAHPS Health Plan Database.
- Notified MQD on 06/27/19 that submission of the 2019 data and survey questionnaire to the CAHPS Health Plan Database is complete.

5. Provider Survey

No Provider Survey for 2019.

6. Annual Technical Report

April:

- Finished drafting 2018 EQR Technical Report sections, including follow up on 2017 findings.
- Received feedback from the MQD on Section 5.
- Finalized 2018 EQR Technical Report, ensured 508 compliance, and submitted report to the MQD on 04/26/18.

May:
Mailed hard copies of the 2018 EQR Technical Report to the MQD on 05/02/19. Copies distributed to the health plans.

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, 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 executed contracts of QI RFP Supplemental Changes (SC) #11 from Aloha Care, Kaiser, Ohana and UnitedHealth Care and routed for internal approval. All four executed contracts were then sent to CMS. After receiving the executed contract from HMSA and completed internal approval, MQD will send to CMS for their final approval of QI RFP SC#11.

MQD also received the executed contract for CCS RFP SC#1 from Ohana, completed internal approval and sent to CMS. MQD is awaiting for CMS's final approval of CCS SC#1.

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. The initial go-live date of August 26,

2019 was postponed until March 1, 2020, to account for unforeseen complexities in business rules development and software coding and implementation.

In the current period, MQD utilized our fiscal agent vendor and a second vendor to complete the back-log 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 3 (Q3), MQD continued to collaborate with Arizona Health Care Cost Containment System (AHCCCS) towards implementation. MQD / AHCCCS received CMS approval of EVV vendor Sandata. Primary efforts were focused upon EVV vendor engagement and planning. Additional efforts continued with 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: Business Rules session with Sandata in August; 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. Engage in second communication outreach with Healthcare Association of Hawaiian (HAH) and HHCS agencies to discuss the EVV initiative and its projected timeline.

APRIL

Continued engaging EVV related providers to gather critical information to ensure a smooth integration. MQD representatives met with the IVV vendor, SLI Government Solutions individually providing input for reporting purposes.

MAY

Met with EVV vendor to review implementation strategy and how it will impact MQD. After CMS review, the AHCCCS / MQD EVV vendor selection was approved in mid-May.

Reviewed and aligned on a coordinated Program / Project Management methodology between MQD and AHCCCS. Consolidated MQD and AHCCCS project documentation into one repository. Aligned EVV vendor kick-off agenda between MQD and AHCCCS.

JUNE

R1 documentation was submitted to CMS the week of June 10th, 2019 for review and response.

EVV Update #2 posted to MQDs EVV webpage and emailed to over 180 representatives from MCOs, Providers, Associations, Agencies, and Workers.

Attended consolidated EVV vendor kick-off meeting in Arizona to review the implementation approach. The three-day session was held with Sandata reviewing the solution and its capabilities. It was a very productive meeting aligning MQD requirements with Sandata.

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

In the reporting period, Medicaid Information Technology Architecture (MITA) contractor, Cognosante, held several individual meetings and conference calls with different staff from different offices and branches of MQD to understand their staff and office functions, operational process, goals and future improvement of their work flow.

This project, launched in March 2019, has goals 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

This project highlighted the current state of architecture for MQD, where for a vast majority of the categories MQD was at a level 1 or level 2 rating. MQD is expecting to receive the final MITA report in the following quarter.

MQD Workshops and Other Events

Training Focus:		**My Choice My Way Home and Community Based Final Rule MCMW 201: Review of Participant Rights in a Provider Owned and Controlled Residential Setting**	
For:		**Big Island Adult Foster Home Operators (BIAFHO) Association**	
Trainer	Aileen Manuel	**Location**	Aging and Disability Resource Center, Hilo
Length	2.0 hours	**Dates**	April 16, 2019 Session 1 11:00 AM to 1:00 PM
Attendees	Approximately 63		
Description	This module provides individuals with an overview of the Medicaid HCBS final rule and how it applies specifically in residential provider owned and controlled settings.		
Objectives/Outcomes	Overview of Medicaid HCBS final rule Intent of the final rule Review of HCBS settings requirements specifically for provider owned and controlled residential settings Application and barrier identification		
Training Focus:		**My Choice My Way Home and Community Based Final Rule**	

	MCMW 201: Review of Participant Rights in a Provider Owned and Controlled Residential Setting		
For:		**Big Island Adult Foster Home Operators (BIAFHO) Association**	
Trainer	Aileen Manuel	**Location**	Aging and Disability Resource Center, Hilo
Length	2.0 hours	**Dates**	April 16, 2019 Session 2 4:00 PM to 6:00 PM
Attendees	Approximately 45		
Description	This module provides individuals with an overview of the Medicaid HCBS final rule and how it applies specifically in residential provider owned and controlled settings.		
Objectives/Outcomes	Overview of Medicaid HCBS final rule Intent of the final rule Review of HCBS settings requirements specifically for provider owned and controlled residential settings Application and barrier identification		

Training Focus:		**Nursing Facility Transition: Demystifying the Path To Housing – Pre-Tenancy**	
For:		**MCO Service Coordinators**	
Trainer	Lisa Maetani- MFP, Madi Silverman	**Location**	Video Conference Centers- Oahu, Kauai, Hilo and Maui
Length	4 hours	**Dates**	June 25, 2019
Attendees	Approximately 65		
Description	Pre-Tenancy Housing Coordination for QI Members Transitioning Out of Nursing Homes and Hospitals		
Objectives/Outcomes	• Identification, screening and housing assessments for institutionalized members • Describe the pre-tenancy activities • Learn about types of housing and rental assistance • Resources to identify suitable housing and requirements to initiate housing applications		

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 April 2019 – June 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 8/19/19 9:57 am]

Attachment B: Up-To-Date Budget Neutrality Worksheet

The Budget Neutrality worksheet for the quarter ending 3/31/2019 is attached. The Budget Neutrality worksheet for the quarter ending 6/30/2019 will be submitted by the 8/31/2019 deadline.

B. MQD Contact(s)

Jon D. Fujii
Health Care Services Branch Administrator
601 Kamokila Blvd. Ste. 506A
Kapolei, HI 96707
808 692 8083 (phone), 808 692 8087 (fax)