Hawaii QUEST Integration
Quarterly Monitoring Report to CMS

Federal Fiscal Year 2019 4th Quarter

Hawaii QUEST Integration		**Reporting Period:**	**July 2019 – September 2019**
Section 1115 Quarterly Report		Federal Fiscal Quarter:	4th Quarter 2019
Submitted:	November 27, 2019	State Fiscal Quarter:	1st Quarter 2020
	(via secured email)	Calendar Year:	3rd Quarter 2019
		Demonstration Year:	25th Year (1/1/19 – 07/31/19)
			26th Year (8/1/19 – 7/31/20)

[This report includes the last month (July 2019) of the Demonstration Year 25, and the first two months (August and September 2019) of Demonstration Year 26.]

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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.

Harbage came on-site to meet in person and to work with MQD staff last reporting period and provided a final work plan for the implementation of the new QI RFP during this reporting period.

On August 26, 2019, the QI RFP was issued with round 1 questions due by September 13th. MQD responded on September 27th. The second round of questions are due by October 11th and MQD will respond by October 25th. The Final proposal due date is January 17, 2020. Services for this contract are scheduled to begin on July 1, 2020.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality spreadsheet for the quarter ending June 30, 2019 was submitted to CMS by the August 31, 2019 deadline. The Budget Neutrality spreadsheet for the quarter ending September 30, 2019 will be submitted by the November 30, 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 was awarded an extension of the QUEST Integration demonstration on July 31, 2019. MQD received approval for its existing expenditure and waiver authorities with the exception of the waiver of retroactive eligibility rules. MQD had withdrawn its request to continue that policy in June 2019. MQD received additional expenditure authority to expand the set of CIS benefits available to beneficiaries. CMS also included new reporting requirements in the Special Terms and Conditions.

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 finalizing 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 soon. 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, and development of an HSI SPA with technical assistance from CMS.

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. 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

Several PPDO staff attended annual CHIP Director's Meeting as well as the annual NASHP Conference held in Chicago. Topics discussed included Eligibility, Enrollment and Renewals, Overview of Public Charge new rule implications, Improving health through housing, Implicit bias in policy making, new opportunities to support state policy goals, palliative care, and Medicaid date for the future. The opportunity to learn in person from experts, as well as networking with other states, provided a productive and enhanced learning opportunity to help PPDO increase our knowledge and skill base. in In addition to the above, PPDO continues 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. This included a second convening of the technical assistance grant sponsored by the National Governor's Association (NGA) to Foster Cross Collaboration Across sectors. The group involved in this grant have been tasked with development and implementation of a children, youth and family cabinet, with support from the Governor and First Lady.

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 3,303 health plan selections for individuals within the initial choice period. QUEST Integration health plans processed 90 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) (15%), Japanese (23%), Filipino (Ilocano, Tagalog, and Visayan) (12%), Korean (19%), and Spanish (14%).

Beginning FFY 2020, Med-QUEST will increase health plan pre-enrollments with Health Care Outreach Branch specialists and Kōkua Service contractors incorporate plan selection with the application process. This supports the assisting applicants with completing a Medicaid application and include a plan selection for household member that applies for coverage.

Disenrollment Summary

	# of Beneficiaries	**Reason**
Beneficiaries that request plan-to-plan change with cause	4	3 Continuity of Care o 2 behavioral health provider not participating with plan o 1 continuity with former commercial plan. 1 Service coordination o LTC facility not participating
Beneficiaries that request plan-to-plan change without cause	90	
Beneficiaries that changed their health plan after being auto-assigned	2,359	

[See detailed plan enrollment information in section VIII.]

Outreach/Innovative Activities

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

The Health Care Outreach Branch (HCOB) has attended and participated in over 70 community outreach events this quarter to educated the community statewide on how to apply for Medicaid and the Federal Health Insurance Marketplace, assist clients with submitting applications and helping to triage issues they may be having with their health plans or services, etc. HCOB has also on-boarded and conducted training to new Kōkua (Navigators) from our three Kōkua Services contracts along with new staff at Federally

Qualified Health Centers to prepare them for Med-QUEST annual plan change and for the 2020 open enrollment for the Federal Health Insurance Marketplace.

Additionally, we have prepared for our Annual Kōkua Training in October to recertify and retrain on our KOLEA system, cultural competency, MLMS Health Insurance Marketplace certification, etc. Confirmed locations and logistics on each major island of Oahu, Hawaii Island and Maui, sent out save-the-date emails.

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.)

July 2019 – September 2019 Complaints/Grievances
Description :
3 - Follow up calls regarding open grievance 1 - Neglect from a practice and his medication was decreased 1 - Patient wanted an x-ray but was denied by doctor 1 - Received bill asking for reimbursement 3 - Resolution is incorrect/ not satisfied with resolution 3 - Health plan and physician 1 - Transportation 1 - Customer Service and Eligibility 4 - Information regarding a State Grievance 1 - Provider calls 1 - Need a new wheelchair/ not safe 2 - Falsified claims from providers and health facilities 1 - Request for specific medication

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

E. Quality of Care

Work on implementation of the SUPPORT Act was done during the quarter. Health plans were queried on safety edits they had in place to compare to SUPPORT Act requirements to determine how many changes would be required. State requirements in compliance with the SUPPORT Act were issued in September.

The Division continues coordination with the State Department of Health on training for individuals who will be able to provide SBIRT activities. Requirements were issued to health plans to provide guidance to make it clear who can provide the services so that data can be collected.

[See EQRO information in section XI.]

F. Access that is Relevant to the Demonstration

During this reporting period, four (4) new clinics have become FQHC/RHC certified for Medicaid.

1. North Hawaii Community Primary Care Clinic
2. North Hawaii Community Women's Center
3. The Clinic at Kahuku Medical Center
4. Puna Community Medical Center

There has been significant policy and operational work done around standing up the Community Integration Services (CIS) waiver, with the goal of bringing Tenancy Support services to the most needy recipients in Hawaii Medicaid. Multiple meetings were held with agency providers, community advocates, managed care health plans, and other DHS staff, with the goal of designing a CIS program that will have a positive and lasting impact. Being mindful of the need to integrate CIS within the current LTSS structure, discussions have focused around recipient screening, recipient onboarding, recipient assessments, provider training, claim coding, program financing, management reporting, data analytics, and program evaluation.

G. Pertinent Legislative or Litigation Activity

MQD was notified last quarter 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. There has been no substantive MQD activity related to this case during this reporting period.

The legislature was not is session during this report period, however there are a number of ongoing workgroups that were established by the legislature that MQD is participating in including: Earned Income Disregard Program; Intellectual and Developmental Disabilities Medicaid Waiver Administrative Claiming Special Fund which requires MQD and DOH to engage with stakeholders to develop and distribute information about accessing Medicaid services; and a Behavioral Health Care Workgroup.

IV. Adverse Incidents

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

A. Medicaid Certified Nursing Facilities

Total of 16 reported adverse incident reports submitted during the period of July - September 2019.

- 10 unattended/unwitnessed fall
- 2 witnessed fall
- 1 shortness of breath
- 2 self-inflicted unintended injuries

Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities:

Total of 12 reported adverse incident reports submitted during the period of July - September 2019.

- 2 ER visits due to illness
- 9 ER visits due to physical Injury (Hernia)
- 1 L-Ear dx Basal Cell Carcinoma

B. Long Term Services and Supports (LTSS)

Types of Adverse Events	#			
	Month 1	Month 2	Month 3	**TOTAL**
Fall	48	31	38	117
Hospital	25	30	22	77
Death	19	16	11	46
Emergency Room Visit	10	10	17	37
Injury	15	13	15	43
TOTAL	117	100	103	320

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 conducts a monthly encounter validation meeting with all participating MCOs to address major issues in encounter data submission or validation. Ongoing engagement supports a continuous data quality improvement initiative aimed at decreasing the number of encounters that fail system edits. MQD has developed an encounter reconciliation process directly with the MCOs that accounts for financial discrepancies between encounters submitted by the MCOs and accepted by MQD. The protocol for this reconciliation process has undergone iterative improvements, and the reconciliation is conducted at least twice per year. Substantial work has also begun to investigate and address the sources of discrepancies between the MCOs' and MQD's systems. Med-QUEST Division is currently working with its contracted actuary, Milliman, to refine a reconciliation process that will also compare encounters submitted by the MCOs to Milliman for rate development to those submitted and accepted by MQD. This process has been conducted on an ad hoc basis in the past, but will be folded into an ongoing reconciliation process conducted annually. Triangulation of the reconciliation process to identify discrepancies found in the three systems (MCOs, Milliman, and MQD), and reconciliation of those differences, will enable improvements in data quality to support the use of data in the State Medicaid encounter system for future rate setting.

In addition to encounter data reconciliation, MQD has also worked closely with Milliman to effectively increase the financial consequences to MCOs associated with poor data quality in the State Medicaid encounter system; specifically, risk sharing for high cost newborns is exclusively based on encounters found within the State Medicaid encounter system. Beginning in 2019, risk sharing for high cost drugs will also be based on encounters found within the State Medicaid encounter system. Beyond these measures, MQD has also built new provisions into the managed care re-procurement RFP to enhance oversight into encounter data submissions during the next contract cycle.

In 2020, MQD expects procure an encounter data validation contractor to conduct audits of the claims submission and encounter processing protocols in the MCOs' data systems, and to develop a data quality assessment that may be implemented for ongoing data quality monitoring within the State's Medicaid encounter system.

MQD recently conducted an encounter data reconciliation for claims with a service date in calendar year 2018. The findings indicate that the overall financial reports generated from the State Medicaid encounter system and those from the MCOs differ by approximately 8-10%. However, calculated discrepancies continue to vary substantially by plan and categories of claim submissions such as pharmacy, facility, and professional submissions. MQD is working with MCOs to decrease these differences overall and within each category.

VI. 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 long term care eligibility, Medicaid application requirements for special situations, 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**	**7/2019 - 9/2019**	**7/2019 - 9/2019**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	347,569	115,223
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	104,422	34,479
Aged	Aged w/Medicare Aged w/o Medicare	82,574	28,042
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	71,588	24,057
Expansion State Adults	Expansion State Adults	276,605	91,877
Newly Eligible Adults	Newly Eligible Adults	61,054	20,194
Optional State Plan Children	Optional State Plan Children	0	0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,566	531
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)	87,750	28,917
Total		1,033,128	343,320

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	202,332
Title XXI funded State Plan	28,917
Title XIX funded Expansion	112,071
Enrollment current as of	9/30/2019

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 9/30/19
EG 1 – Children	**115,989**	**116,443**	**116,703**	**349,135**
EG 2 – Adults	**37,796**	**34,760**	**34,866**	**104,422**
EG 3 – Aged	**27,334**	**27,627**	**27,613**	**82,574**
EG 4 – Blind/Disabled	**23,768**	**24,087**	**23,733**	**71,588**
EG 5 – VIII-Like Adults	**0**	**0**	**0**	**0**
EG 6 – VIII Group Combined	**112,269**	**111,909**	**113,481**	**337,659**

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 9/30/19
State Plan Children	115,462	115,920	116,187	347,569
State Plan Adults	34,796	34,760	34,866	104,422
Aged	27,334	27,627	27,613	82,574
Blind or Disabled	23,768	24,087	23,733	71,588
Expansion State Adults	91,931	91,665	93,009	276,605
Newly Eligible Adults	20,338	20,244	20,472	61,054
Optional State Plan Children	0	0	0	0
Foster Care Children, 19-20 years old	527	523	516	1,566
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) 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.	**4,277**
Early Intervention Program (EIP/DOH) Infant and toddlers from birth to 3 years old receive services to assist in the following developmental areas: physical (sits, walks); cognitive (pays attention, solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	**870**
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**1,165**

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 11/19/19 9:52 am]

Health Plan	Jul 2019	Aug 2019	Sep 2019
Aloha Care	483	640	692
HMSA	688	698	708
Kaiser	276	292	280
Ohana	3051	2964	2812
United Healthcare	2384	2247	2311
Total	**6882**	**6841**	**6803**

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

July 2019 – September 2019	Number of Members
Individuals who chose a health plan when they became eligible	**901**
Individuals who were auto-assigned when they became eligible	**6,707**
Individuals who changed their health plan after being auto-assigned	**2,358**
Individuals who changed their health plan outside of allowable choice period (i.e., plan-to-plan change)	**90**
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, **901** individuals chose their health plan since they became eligible in the previous quarter, **2,358** changed their health plan after being auto-assigned. Also, **6,707** 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 4th quarter, Health Plans and MQD received and addressed the following number of member complaints/grievances.

Member Complaints/Grievances to Health Plan			
	Jul – Sep 2019	Jul – Sep 2019	Jul – Sep 2019
Submitted	**QI**	**CCS**	**TOTAL**
Total number filed during the reporting period	328	22	350
Total number that received timely acknowledgement from health plan	324	22	346
Total number not receiving timely acknowledgement from health plan	3	0	3
Total number expected to receive timely acknowledgement during next reporting period	4	0	4
Total number that received timely decision from health plan	307	19	326
Total number not receiving timely decision from health plan	17	0	17
Total number expected to receive timely decision during next reporting period	27	3	30
Total number currently unresolved during the reporting period	27	3	30
Total number overturned	0	0	0

Types of Member Complaints/Grievances to Health Plans			
	Jul – Sep 2019	Jul – Sep 2019	Jul – Sep 2019
Medical	**QI**	**CCS**	**TOTAL**
Provider Policy	10	0	10
Health Plan Policy	32	0	32
Provider/Provider Staff Behavior	72	0	72
Health Plan Staff Behavior	38	0	38
Appointment Availability	9	0	9
Network Adequacy/ Availability	5	0	5
Waiting Times (office, transportation)	89	2	91
Condition of Office/ Transportation	4	0	4
Transportation Customer Service	19	2	21
Treatment Plan/Diagnosis	26	0	26
Provider Competency	32	11	43
Interpreter	0	0	0
Fraud and Abuse of Services	2	0	2
Billing/Payments	13	0	13
Health Plan Information	18	1	19
Provider Communication	19	3	22
Member Rights	5	5	10

Member Complaints/Grievances to MQD				
	Jul 2019	Aug 2019	Sep 2019	TOTAL
Submitted	2	0	2	4
Health Plan resolved with Members	1	1	0	2
Dismiss as untimely filing	0	0	0	0
Member withdrew appeals	0	0	0	0
Resolution in Health Plan favor	0	0	2	2
Resolution in Member's favor	0	0	0	0
Still awaiting resolution	0	0	0	2
Care over from previous Quarter				1 *

*This is a carry-over from 5/14/19 working with eligibility to resolve issues related to bills received for services not used by member.

Types of Member Complaints/Grievances to MQD				
	Jul 2019	Aug 2019	Sep 2019	TOTAL
Medical	2	1	1	4
Long Term Services and Support	0	0	0	0
Transportation	0	0	1	0
Applied Behavioral Analysis (ABA)	0	0	0	0
Durable Medical Equipment	0	0	0	0
Reimbursement	0	0	1	2
Medication	0	0	0	0
Miscellaneous	1	0	0	1

Some members had multiple areas that need to be addressed within their one grievance report to MQD.

B. Appeals

Member Appeals to Health Plans	
	TOTAL
Total number filed during the reporting period	322
Total number that received timely acknowledgement from health plan	288
Total number not receiving timely acknowledgement from health plan	32
Total number expected to receive timely acknowledgement during next reporting period	23
Total number that received timely decision from health plan	274

Total number not receiving timely decision from health plan	29
Total number expected to receive timely decision during next reporting period	40
Total number currently unresolved during the reporting period	40
Total number overturned	192

Types of Member Appeals to Health Plans	
	TOTAL
Service denial	47
Service denial due to not a covered benefit	35
Service denial due to not medically necessary	230
Service reduction, suspension or termination	5
Payment denial	9
Timeliness of service	0
Prior authorization timeliness	0
Other	0

Member Appeals to Administrative Appeals Office (AAO)				
	Jul 2019	Aug 2019	Sep 2019	TOTAL
Submitted	2	4	1	7
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	3	0	4
Dismiss as untimely filing	0	0	0	0
Member withdrew hearing request	0	0	0	0
Resolution in DHS' favor	1	0	0	1
Resolution in Member's favor	0	0	0	0
Still awaiting resolution	0	0	2	2

Types of Member Appeals to Administrative Appeals Office (AAO)				
	Jul 2019	Aug 2019	Sep 2019	TOTAL
Medical	0	0	1	1
Long Term Services and Support	1	1	0	2
Van Modification	0	0	0	0
Applied Behavioral Analysis (ABA)	0	0	0	0
Durable Medical Equipment	0	0	0	0
Reimbursement	0	0	0	0
Medication	1	1	0	2
Miscellaneous – Claim Denial	0	2	0	2

The two miscellaneous – claim denials were filed by members in anticipation of receiving a bill. The member did not receive any bills for the denial of payment and the health plans were not asking the member to pay the bills.

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.)

During FFY 2019 4th Quarter, the Health Analytics Office (HAO) was formally created within the Med-QUEST Division to lead health analytics priorities for the program. Staff within the HAO worked on building driver diagrams and logic models to support both HOPE initiative and demonstration goals. With the finalization of the special terms and conditions for the new demonstration period (2019-2024), work in earnest began on the development of the evaluation design with external partners. A work task letter was drafted to be issued under a previously approved Memorandum of Agreement with the University of Hawaii that included specific evaluation requirements. A team at the University of Hawaii was assembled comprising researchers with subject matter expertise in statistics, health services research, program evaluation, and research interests in key priority areas such as homelessness. Preliminary work identified the need for in-depth evaluation in five areas: Community Integration Services, Home and Community Based Services, Social Determinants of Health, advancing primary care, and the evaluation of a quality area that is indicative of needing improvement, as identified during the previous demonstration period (childhood immunization status). Subsequent efforts have focused on orienting the University of Hawaii research team to data available within Med-QUEST, program goals as outlined in the demonstration and in the newly released Managed Care Request for Proposals, as well as current operations and protocols in place to administer existing programs. The team at the University of Hawaii has focused on identifying additional data needs and potential options for obtaining the data, selecting appropriate hypotheses for each of the above topics, and developing methodological options for each of the in-depth evaluations.

XI. Quality Assurance and Monitoring Activity

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

<u>Quality Activities During The Quarter July to September 2019</u>

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)

July:
- Provided PIP technical assistance in preparation for the Module 1 and Module 2 submissions, as requested.

August:
- Received the Module 1 and Module 2 submissions from the health plans for validation.
- Submitted the 2019 draft PIP validation reports to the MQD.
- Received approval of the draft reports from the MQD.
- Provided the final PIP reports to the MQD and health plans.

September:
- Provided the Module 1 and Module 2 validation tools to the health plans and requested the resubmissions by 10/04/19.
- Provided technical assistance to the health plans in preparation for the Module 1 and Module 2 resubmissions.
- Scheduled the Module 3 training webinar for 11/05/19.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

July:
- Finalized NYU performance measure rates for HMSA on 07/30/19.
- Submitted the Final Audit Report to the health plans, MQD, and NCQA
  - AlohaCare and UHC on 07/10/19.
  - HMSA, Kaiser, and Ohana on 07/11/19.

August:
- None at this time.

September:
- None at this time.

3. Compliance Monitoring

July:
- Final compliance review reports and CAP templates sent to Ohana QI, Ohana CCS, and UHC CP on 07/10/19.
- Final compliance review reports for all health plans and CCS posted to SAFE FTP for the MQD on 07/11/19.
- Received completed CAP templates from AlohaCare and KFHP on 07/26/19.
- Granted HMSA's request for an extension on their CAP template until 08/09/19 due to a staffing change.

August:
- Received completed CAP templates from HMSA, Ohana QI, Ohana CCS and KFHP on 08/9/19.
- Sent CAP templates with recommendations to the MQD for review on 08/13/19.
- Received feedback on the CAP templates from the MQD on 08/22/19.
- Provided CAP templates with comments to the health plans on 08/22/19.

September:

- Began drafting documents/tools for 2020 Compliance Reviews
- Confirmed 2020 Compliance onsite reviews with health plans

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

July:

- Performed Star Report survey data analysis on 07/02/19.
- Prepared data files for the MQD on 07/02/19.
- Submitted Star Reports, respondent-level data files and data dictionary for each QI health plan and CHIP to the MQD on 07/09/19.
- Performed comprehensive survey data analysis on 07/31/19.

August:

- Compiled draft reports on 08/13/19.
- Submitted draft reports and cross tabulations to the MQD on 08/23/19.

September:

- Received approval on draft reports from the MQD, including confirmation on the number of printed copies of each report the MQD will require on 09/13/19.
- Submitted final reports electronically and shipped the requested number of hard copies to the MQD on 09/17/19.

5. Provider Survey

No Provider Survey for 2019.

6. Annual Technical Report

July:

- Provided report template sections and instructions for EQR activity team members.

August:

- Began analyzing findings and drafting language for the various report sections.

7. Technical Assistance

July:

- None at this time.

August:

- Provided EQRO on-site training to the MQD on 08/15/19.

September:

- Met with DHS Health Analytics Office to discuss SBIRT and Rebalancing Quality Measures on 09/20/19.

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 planned to begin earnest discussions with Myers & Stauffer on the quality strategy update in the FFY 2019 4th quarter. However, although plans were in place to begin discussion with Myers & Stauffer on the quality strategy updates, during this reporting period MQD re-focused on the new QI RFP procurement. Additional work needed to get done to ensure the timely release of the RFP, as well as, timely and accurate question and answer deliberation. Tentatively, MQD hopes to resume the quality strategy discussion during the 2nd quarter FFY 2020.

XIII. Other

Final Rules

During the reporting period, MQD received approval for QI RFP SC #11. MQD is working on QI RFP SC #12 to include departing Health Plan guidance and some house-keeping items such as definitions.

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 6, 2020, to account for unforeseen complexities in business rules development and software coding and implementation.

In the current period, MQD named the PMSU project, Hawaii's Online Kahu Utility (HOKU). Hoku, in Hawaiian means guiding star. Kahu, in Hawaiian means caretaker or pastor, one who looks after their flock. Med-QUEST providers are caretakers looking after and taking care of members.

MQD staff engaged and completed phase 1 and 2 gap testing in the HOKU system. Phase 3 gap testing, as well as, business case testing, are scheduled for the next reporting period. MQD elected to not hire a vendor for provider training on the HOKU system, but instead will use internal resources familiar with HCBS providers to conduct training in the 2nd quarter FFY 2020.

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 4 (Q4), MQD continued to collaborate with Arizona Health Care Cost Containment System (AHCCCS) towards implementation.

During this quarter, the EVV Project Team continued to focus their attention on tasks related to completing the Business Rules Workbook; which is the cornerstone for the EVV solution as it reflects all the business rules that are needed to support the EVV impacted programs and configure the EVV solution. To assist in that completion, EVV Business Rules meetings with Sandata occurred the week of August 12th in Hawaii, which focused on the Hawaii configuration. Overall, the feedback received from the team related to these meetings was positive and the meetings met the objectives and expectations of the team. At the conclusion of these meetings the EVV team realized that there were a few decisions that still needed to be made prior to the workbook being approved. The team stated that in some cases meetings with the provider community were warranted to assist the states in making informed decisions. The workbooks were completed and submitted on October 11, 2019, which is approximately a two-month delay from the original date. Based on this delay, as well as other project activities and the constraints of resources due to competing Provider Management System Upgrade (PMSU) project, the EVV Team has determined to submit a Good Faith Efforts letter to CMS requesting approval for a delayed implementation of the EVV solution. Currently, the revised go-live date has not been finalized as the project schedule is still being refined. The draft schedule reflects an Implementation date in March 2020, but that date was dependent on completing the Business Rules Workbook in August.

MQD’s future EVV workplans include:

The Business Rules Workbook and Technical Specification final approval is anticipated to occur in mid-November. The team will 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. The team anticipates that the revised, and ultimately baselined, schedule will not be received until November 2019. The team will continue working with the EVV vendor towards an implementation date projected in the summer of 2020.

JULY
Reviewed the proposed HCPCS table for EVV services with the MCOs. EVV vendor held the Outreach and Training Kick-off meeting for MQD and established reoccurring meetings to build the communications plan. Reviewed the EVV vendor device proposal with AHCCCS to ensure deliverable alignment.

AUGUST
EVV vendor held software demo for MCOs to explain the functionality of the EVV solution. The IV&V vendor SLI conducted on-site interviews with the MQD team to capture project status and identify areas for improvement. MQD hosted EVV kick-off meetings for the three provider groups representing the 90 agencies with over 150 participants. Met with the EVV vendor in a three-day working session to define program configuration requirements. Established reoccurring provider self-directed and financial intermediary meetings. Attended the CMS hosted EVV Learning Collaborative meeting.

SEPTEMBER
Reviewed EVV configuration workbook with Sandata to progress toward a final configuration. Continued to work with the EVV project to update the configuration requirements. Attended the CMS hosted EVV Learning Collaborative meeting. Met with Sandata to clarify HCPCS codes and modifier functionality and determine how to implement in the EVV solution. Engaged the provider agencies to discuss the proposed HCPCS codes and modifier use in the EVV solution to ensure alignment and that no undue hardship would be imposed.

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 another set of meetings during the week of July 15th with various staff to finalize their reports.

MQD Workshops and Other Events

Focus:	**A BESSD Program Overview for Your Members**		
For:	**MCO Service Coordinators and Homeless Housing Agencies**		
Trainer	Christine Wong, DHS/BESSD Assistant Administrator	**Location**	Webinar
Length	1 hour	**Dates**	July 10, 2019
Attendees	Approximately 320		
Description	Overview of the DHS/BENEFIT, EMPLOYMENT AND SUPPORT SERVICES DIVISION (BESSD) to include: Supplemental Nutrition Assistance Program (SNAP), General Assistance Program (GA), Assistance for the Aged, Blind and Disabled (AABD), Temporary Assistance to Needy Families (TANF), First To Work Programs (FTW), SNAP Employment and Training (SNAP E&T), Low Income Home Energy Assistance Program (LIHEAP), Child Care Subsidies (CCS), Child Care Licensing (CCL), Homeless Programs (HP)		
Objectives/Outcomes	• Overview of the Social Determinants of Health • BESSD Mission: Services to expand member capacity for self-sufficiency, self-determination, independence, healthy choices, quality of life, and personal dignity • Overview and description of BESSD services and eligibility requirements		

Focus:	Provider Outreach: Provider Management System Upgrade (PMSU)		
For:	Community Home Care Association of Hawaii (CHCAOH) Association		
Speaker	Jon Fujii Jackie Indreginal	**Location**	Waipahu, Oahu
Length	1.0 hours	**Dates**	July 17, 2019
Attendees	Approximately 75		
Description	Provide Medicaid updates and communication for new PMSU system.		

Focus:	Provider Outreach: Provider Management System Upgrade (PMSU)		
For:	United Caregivers of Hawaii Association		
Speaker	Jon Fujii Jackie Indreginal	**Location**	Waipahu, Oahu
Length	1.0 hours	**Dates**	July 20, 2019
Attendees	Approximately 70		
Description	Provide Medicaid updates and communication for new PMSU system.		

Focus:	Provider Outreach: Provider Management System Upgrade (PMSU)		
For:	Adult Foster Home Association (AFHA)		
Speaker	Aileen Manuel	**Location**	Wailuku, Maui
Length	1.0 hours	**Dates**	July 26, 2019
Attendees	Approximately 35		
Description	Provide Medicaid updates and communication for new PMSU system.		

Focus:	Home and Community-Based Services Settings Requirements: Dignity of Risk		
For:	Adult Foster Home Association (AFHA)		
Speaker	Aileen Manuel	**Location**	Wailuku, Maui
Length	2.0 hours	**Dates**	July 26, 2019
Attendees	Approximately 35		
Description	Provide guidance on dignity of risk when delivering home and community-based services.		

Focus:	Provider Outreach: Provider Management System Upgrade (PMSU)		
For:	Adult Residential Care Home Association (ARCA)		
Speaker	Aileen Manuel	**Location**	Waipahu, Oahu
Length	1.0 hours	**Dates**	August 19, 2019
Attendees	Approximately 85		
Description	Provide Medicaid updates and communication for new PMSU system.		

Focus:	Provider Outreach: Provider Management System Upgrade (PMSU)		
For:	Adult Foster Home Association (AFHA)		
Speaker	Aileen Manuel	**Location**	Waipahu, Oahu
Length	1.0 hours	**Dates**	September 14, 2019
Attendees	Approximately 120		
Description	Provide Medicaid updates and communication for new PMSU system.		

Focus:	Home and Community-Based Services Settings Requirements: Dignity of Risk		
For:	Adult Foster Home Association (AFHA)		
Speaker	Aileen Manuel	**Speaker**	Aileen Manuel
Length	2.0 hours	**Length**	2.0 hours
Attendees	Approximately 120		
Description	Provide guidance on dignity of risk when delivering home and community-based services.		

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 July 2019 – September 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 11/19/19 9:52 am]

Attachment B: Up-To-Date Budget Neutrality Worksheet

The Budget Neutrality worksheet for the quarter ending 6/30/2019 is attached. The Budget Neutrality worksheet for the quarter ending 9/30/2019 will be submitted by the 11/30/2019 deadline.

B. MQD Contact(s)

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