

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: July 31, 2018

Demonstration/Quarter Reporting Period:

Demonstration Year:	22	(10/01/2015 - 09/30/2016)
Federal Fiscal Quarter:	FFY 2016 1 st Q.	(10/01/2015 - 12/31/2015)
State Fiscal Quarter:	SFY 2016 2 nd Q.	(10/01/2015 - 12/31/2015)
Calendar Year:	CY 2015 4 th Q.	(10/01/2015 - 12/31/2015)

Introduction

Hawaii's QUEST Integration is a Department of Human Services (DHS), Med-QUEST Division (MQD) comprehensive section 1115 (a) demonstration that expands Medicaid coverage to children and adults originally implemented on August 1, 1994. The demonstration creates a public purchasing pool that arranges for health care through capitated-managed care plans. In 1994, the MQD converted approximately 108,000 recipients from three public funded medical assistance programs into the initial demonstration including 70,000 Aid to Families with Dependent Children (AFDC-related) individuals; 19,000 General Assistance program individuals (of which 9,900 were children whom the MQD was already receiving Federal financial participation); and 20,000 former MQD funded SCHIP program individuals.

QUEST Integration is a continuation and expansion of the state's ongoing demonstration that is funded through Title XIX, Title XXI and the State. QUEST Integration uses capitated managed care as a delivery system unless otherwise indicated. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria to beneficiaries eligible under the state plan and to the demonstration populations. During the period between approval and implementation of the QUEST Integration managed care contract the state will continue operations under its QUEST and QUEST Expanded Access (QExA) programs. The current extension period began on October 1, 2013.

The State's goals in the demonstration are to:

- Improve the health care status of the member population;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Align the demonstration with Affordable Care Act;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP);
- Expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS;
- Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations;
- Establish contractual accountability among the contracted health plans and health care providers;
- Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

Enrollment Information

Note: Enrollment counts include both person counts (unduplicated members) and member months. Member months and unduplicated members data for October 2015 to December 2015.

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 10/2015-12/2015	Unduplicated Members 10/2015-12/2015
Mandatory State Plan Groups			
State Plan Children	State Plan Children	371,036	119,451
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	115,162	37,204
Aged	Aged w/Medicare Aged w/o Medicare	74,000	25,046
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	75,417	25,081
Expansion State Adults	Expansion State Adults	226,802	72,850
Newly Eligible Adults	Newly Eligible Adults	102,060	33,472
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,289	
Medically Needy Adults	Medically Needy Adults		
Demonstration Eligible Adults	Demonstration Eligible Adults		
Demonstration Eligible Children	Demonstration Eligible Children		
VIII-Like Group	VIII-Like Group		
Total		965,766	313,104

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	206,782
Title XXI funded State Plan	25,790
Title XIX funded Expansion	106,322
Enrollment current as of	12/31/2015

Outreach/Innovative Activities

The DHS focused on enrolling Medicaid individuals using new Modified Adjusted Gross Income (MAGI) criteria. In addition, MQD fine-tuned its work within its eligibility system called Kauhale (community) On-Line Eligibility Assistance System (KOLEA). DHS focused applicants to apply on-line at its mybenefits.hawaii.gov website.

The Health Care Outreach Branch (HCOB) program focused its outreach and enrollment assistance efforts on those individuals and families who experience significant barriers to health care access due to various social determinants of health such as houselessness, lack of transportation, language/cultural barriers and public institution/justice-involved populations. Due to the multiple challenges faced by these individuals/families, they are traditionally less likely to proactively enroll themselves in health insurance. Having an outreach team in the field that can meet the people where they congregate and offer on-the-spot application assistance has been helpful in serving this high-risk population.

For those in the community who are below the 138% of the Federal Poverty Level, but who were deemed ineligible for Medicaid due to their citizenship status (Immigrants here less than 5-years and non-pregnant, non-blind, non-disabled 19-64 year olds from the Nations under the Compact of Free Association, including the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau) the HCOB team provided assistance with the completion of their Marketplace applications for health insurance. This expanded assistance is vital to meeting the expectations of the ACA that requires individuals without qualified exemptions be insured. During this reporting period, the HCOB team worked closely with MQD's Medical Director to address the growing number of applications received from uninsured individuals seeking assistance with one-time-emergent care coverage. These 500+ uninsured individuals have either been connected with Medicaid coverage, or have been placed on a high-priority outreach list in preparation for the 2017 Marketplace Open Enrollment.

Operational/Policy Developments/Issues

During the first quarter FFY16, the Med-QUEST Division (MQD) continued its monitoring of the QUEST Integration (QI) implementation. QUEST Integration or QI is a melding of both the QUEST and QExA programs. QI is a patient-centered approach with provision of services based upon clinical conditions and medical necessity. QUEST Integration combines QUEST and QUEST Expanded Access (QExA) programs into one and eliminates the QUEST-ACE and QUEST-Net programs. In addition, beneficiaries remain with same health plan upon turning 65 or when changes occur in their health condition. In QUEST Integration, health plans will provide a full-range of comprehensive benefits including long-term services and supports. MQD has lowered its ratios for service coordination.

QUEST Integration has five (5) health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, 'Ohana Health Plan, and UnitedHealthcare Community Plan. The MQD has been assuring readiness of the five (5) QI health plans since February of 2014 (see transition information later in the report).

Submission of HCBS Settings Rule Statewide Transition Plan

The MQD held a Public information session on State Transition Plan for the new Home and Community Based Services (HCBS) Federal Rules on July 30, 2015. MQD held two sessions, from 9:30a to 11:30a and 1:00p to 3:00p, to accommodate the participants receiving HCBS services and HCBS providers and other interested parties. The information session was held at the Hawaii State Laboratory in Pearl City on Oahu. The Hawaii State Laboratory has access to video teleconference (VTC) for streaming information to Kapolei on Oahu and other islands included Kauai, Maui and Hawaii. Updates and new information regarding the State Transition Plan was presented to the attendees. The attendees were also given an opportunity to provide input on the new requirements and the assessment component of the State Transition Plan.

Expenditure Containment Initiatives

No expenditure containment planned.

Financial/Budget Neutrality Development/Issues

The budget neutrality for first quarter of FFY16 was already submitted.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (Oct 2015)	Month 2 (Nov 2015)	Month 3 (Dec 2015)	Total for Quarter Ending 12/2015
EG 1-Children	124,248	124,613	123,464	372,325
EG 2-Adults	38,861	38,545	37,756	115,162
EG 3-Aged	24,202	24,910	24,888	74,000
EG 4-Blind/Disabled	25,026	25,195	25,196	75,417
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	108,061	110,082	110,719	328,862

This member month reporting related to the budget neutrality for first quarter of FFY16 was submitted.

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (Oct 2015)	Month 2 (Nov 2015)	Month 3 (Dec 2015)	Total for Quarter Ending 12/2015
State Plan Children	123,824	124,190	123,022	371,036
State Plan Adults	38,861	38,545	37,756	115,162

With Waiver Eligibility Group	Month 1 (Oct 2015)	Month 2 (Nov 2015)	Month 3 (Dec 2015)	Total for Quarter Ending 12/2015
Aged	24,202	24,910	24,888	74,000
Blind or Disabled	25,026	25,195	25,196	75,417
Expansion State Adults	74,217	76,064	76,521	226,802
Newly Eligible Adults	33,844	34,018	34,198	102,060
Optional State Plan Children				
Foster Care Children, 19-20 years old	424	423	442	1,289
Medically Needy Adults				
Demonstration Eligible Adults	0	0	0	0
Demonstration Eligible Children				
VIII-Like Group	0	0	0	0

This member month reporting related to the budget neutrality for first quarter of FFY16 was submitted.

QUEST Integration Consumer Issues

HCSB Grievance

During the first quarter of FFY16, the HCSB continued to handle incoming calls. As telephone calls come into the MQD Customer Service Branch, if related to client or provider problems with health plans (QUEST Integration or QI), transfer those telephone calls to the HCSB. The clerical staff person(s) takes the basic contact information and assigns the call to one of the social workers. MQD tracks all of the calls and their resolution through an Access database. If the clients' call is an enrollment issue (i.e., request to change health plan), then the CSB will work with the client to resolve their issue. The CSB did not have any calls related to QI this quarter.

	Member	Provider
October 2015	14	85
November 2015	12	66
December 2015	13	57
Total	39	208

During the first quarter of FFY16, the HCSB staff, as well as other MQD staff, processed approximately 39 member and 208 provider telephone calls and e-mails (see table above).

HCSB Appeals

The HCSB received nine (9) member appeals in the first quarter of FFY16. DHS resolved seven of the appeals with the health plans in the member's favor prior to going to hearing. Of the nine (9) appeals filed, the types of appeals were medical (3), and other (6).

Types of Member Appeals	#
Medical	3
LTSS	0
Other: Medications	1
DME	2
Reimbursements	3

Appeals	Member #
Submitted	9
DHS resolved with health plan or DOH-DDD in member's favor prior to going to hearing	7
Member withdrew hearing request	0
Resolution in DHS favor	2
Resolution in Member's favor	0
Still awaiting resolution	0

Provider Interaction

The MQD and the health plans continue to have two regularly scheduled meetings with providers. One of the meetings is a monthly meeting with the Case Management Agencies. MQD focuses the meetings with these agencies around continually improving and modifying processes within the health plans related to HCBS.

In addition, the MQD and health plans meet with the behavioral health provider group that serves the CCS population. This group focuses on health plan systems and addressing needs of this fragile population.

Most of the communication with providers occurs via telephone and e-mail at this time. The MQD will arrange any requested meetings with health plans and provider groups as indicated.

The MQD estimates that provider call volume has decreased due to frequent meetings with the providers throughout the program as well as the health plans addressing provider issues when the provider contacts the health plan first.

Enrollment of individuals

The DHS had an increase of enrollment of approximately 1,158 members during the first quarter of FFY16. Of this group, 217 chose their health plan when they became eligible, 3,531 changed their health plan after being auto-assigned.

In addition, DHS had 326 plan-to-plan changes during the first quarter of FFY16. A plan-to-plan change is a change in enrollment outside of the allowable choice period. Both health plans (the losing and the gaining health plan) agree to the change. Changes are effective the first day of the following month.

In addition, 20 individuals in the aged, blind, and disabled (ABD) program changed their health plan

	#
Individuals who chose a health plan when they became eligible	217
Individuals who changed their health plan after being auto-assigned	3,531
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	326
Individuals in the ABD program that changed their health plan	20

during days 61 to 90 after a confirmation notice was issued.

within days 61 to 90 after confirmation notice was issued	
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Long-Term Services and Supports (LTSS)

HCBS Waiting List

During the first quarter of FFY16, the QI health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

During the first quarter of FFY16, MQD monitored the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) were required. The number of beneficiaries requiring long-term services and supports slightly decreased from the fourth quarter of FFY15 to the first quarter of FFY16. However, since the start of the program, the increase of beneficiaries receiving long-term services and supports in the first quarter of FFY16, is 30.1%. The number of individuals in nursing facilities decreased this quarter from the previous quarter. Nursing facility usage has decreased by approximately 25.6% since program inception.

HCBS usage has more than doubled since the aged, blind, and disabled populations were incorporated into managed care (formerly QUEST Expanded Access (QExA), currently QUEST Integration). The number of beneficiaries receiving HCBS has increased by approximately 105.1% since program inception. At the start of the program, beneficiaries receiving HCBS was 42.6% of all beneficiaries receiving long-term care services. This percentage is at 67.2% in the first quarter of FFY16.

	2/1/09	4th Qtr FFY15, av	1st Qtr FFY16, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 1st Qtr FFY16
HCBS	2,110	4,492	4,328	105.1%↑	42.6%	67.2%
NF	2,840	2,200	2,114	25.6%↓	57.4%	32.8%
Total	4,950	6,692	6,442	30.1%↑		

Behavioral Health Programs Administered by the DOH and DHS

Individuals in Community Care Services (CCS) have a Serious Mental Illness (SMI) diagnosis with functional impairment. The Medicaid beneficiaries who continue to receive services from AMHD are legally encumbered. These individuals are under court order to be cared for by AMHD.

The Early Intervention Program (EIP) under the DOH provides behavioral health services to children from ages zero (0) to three (3). EIP is providing services to approximately 589 children during the first quarter FFY16.

Program	#
Adult Mental Health Division (AMHD/DOH)	206
Early Intervention Program (EIP/DOH)	589
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,161
Community Care Services (CCS/DHS)	5,369

The Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (20). CAMHD is providing services to approximately 1,161 children during the first quarter FFY16.

QUEST Integration Contract Monitoring

The MQD moved all of its QUEST and QExA population into the QUEST Integration (QI) program on January 1, 2015. The transition was seamless with all five-health plans being ready to accept their new members. All five health plans received transition of care files in November and December 2014 that allowed them to maintain services through March 31, 2015 (or until a new health and functional assessment (HFA) was conducted). In addition, several health plans maintained services to June 30, 2015 while they completed their HFAs.

The MQD continued to conduct three additional oversight processes. Information about these programs is included below.

1. Ride along program

MQD nurses and social workers went on home visits with service coordinators to observe their conducting assessments and developing service plans. These ride alongs identified areas for improvement to include pre-filling assessments prior to the visit, talking with member to obtain information instead of reading the questions from the assessment tool, and listening to needs of the member more than paying attention to questions on the assessment tool. MQD shared these observations with health plan leadership in April 2015. This program has been temporarily suspended, and is in the process of being modified and improved for a second wave of future ride alongs.

2. Customer Service Call Listen-In program

MQD staff listened to live health plan QUEST Integration customer service calls to ensure that customer service representatives were meeting MQD contract requirements. Initially, all five health plans had room for improvement. After providing health plans with a summary of the listen-in program, all five health plans are performing at 100%. MQD continues to listen to calls to support our beneficiaries.

Quality Assurance/Monitoring Activity

MQD Quality Strategy

Our goal continues to ensure that our clients receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. We have adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. MQD identified an initial set of ambulatory care measures based on this framework. MQD reviews and updates HEDIS measures annually that the health plans report to us.

MQD continues to update its quality oversight of home and community based services, which will affect mostly our QI health plans, the DDID program, and the Going Home Plus program. MQD uses quality grid based upon the HCSB Quality Framework for monitoring the DDID program. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. We have also been working on behavioral health monitoring and quality improvement.

Our quality approach aspires to 1) have collaborative partnerships among the MQD, health plans, and state departments; 2) advance the patient-centered medical home; 3) increase transparency- including making information (such as quality measures) readily available to the public; 4) being data driven; and 5) use quality-based purchasing- including exploring a framework and process for financial and non-financial incentives.

MQD updated its quality strategy and submitted a draft version to CMS on December 18, 2014. MQD received feedback from CMS on July 16, 2015, and subsequently submitted a revised draft quality strategy on September 30, 2015. MQD received further feedback from CMS on April 5, 2016, and subsequently submitted a revised draft quality strategy on May 6, 2016. MQD is currently awaiting further comments or approval from CMS. The revised quality strategy is consistent with the previously approved 2010 version.

Quality Activities During The Quarter

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

1. Validation of Performance Improvement Projects (PIPS) –

January: HSAG reviewed the health plan’s Module 4 updates and provided feedback as needed.

February:

- Awaiting the health plans’ response to the feedback that was sent to them on 3/1/16.
- Continuing to provide PIP technical assistance as requested by the health plans.

March:

- HSAG provided feedback on Module 4 to health plans and the MQD by 3/1/16.
- Module 4 resubmissions were due to HSAG on 3/31/16.
- HSAG sent an e-mail to the health plans and the MQD explaining the approved changes to the PIP timeline.

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

January:

- Confirmed on-site visit dates with health plans and the MQD.
- Per email from Jon Fujii on 1/14/16, the MQD approved Kaiser’s hybrid waiver request for the following measures: ABA, CIS, IMA, HPV, COL, CCS, FPC, W15, W34, AWC, and CDC.
- Per email from Jon Fujii on 1/14/16, the MQD approved UHC’s proposed sampling method.
- Submitted final health plan audit schedule to the MQD on 1/15/16.
- Conducted kick-off call with AlohaCare on 1/22/16.
- Received completed Roadmaps from health plans on 1/29/16.
- Completed validation of the CAHPS survey sample frames on 1/29/16. Ongoing guidance for Ohana and UHC for the CAHPS survey and any changes that may be needed for the CAHPS sample frame approval.
- Submitted on-site agendas to UHC and Ohana.
- Began medical record review activities with the health plans.
- Provided updated FUP specifications to Ohana.

- Ongoing technical assistance discussions with Ohana on the reporting of the BHA measure.

February:

Discussions regarding data sharing.

- Kick-off calls conducted with ‘Ohana and UHC.
- On-site visits for UHC and Ohana and Ohana CCS March 9-11, 2016.
- Lead auditor’s preliminary IS Grid findings reports submitted to them on 2/17/16.

March:

- Conducted on-site visit with ‘Ohana on 3/10/16–3/11/16 and UHC on 3/9/16.
- Initial post-on-site report sent to ‘Ohana on 3/25/16.
- Initial post-on-site report sent to UHC CP on 3/22/16.
- Submitted lead auditor’s preliminary IS Tracking Grid report to AlohaCare on 3/11/16.
- Conducted kick-off call with HMSA on 3/24/16.
- Completed non-standard supplemental data proof-of-service verification for random samples before 3/31/16.
- Received source code from Kaiser for measures generated in-house.
- Provided input on AlohaCare P&Ps as per MQD request.

3. Compliance Monitoring –

January:

- Analyzed and Compared QI and CCS contracts/amendments to prior versions and initiated changes to compliance review tools.
- Established 2016 Compliance Review schedule.

February:

- Submitted the draft compliance review tools to the MQD for review on 2/17/16 (requested approval/comments by 3/3/16).
- Met with the MQD in Honolulu on 2/2/16 to discuss questions regarding the contracts between the MQD and the health plans and missing federal requirements, as well as compliance review related items.
- Drafted customized on-site review agendas and review tools by 2/24/16 (will be posted to the SFTP site on or before 3/8/16).
- Sent all health plans an email on 2/26/16, describing the desk and on-site review processes and schedule, the agenda, scope of review and date/time for a technical assistance session on 3/31/16.
- Scheduled Compliance Technical Assistance meeting with the health plans – targeting 3/31/16.

March:

- Finalized the Compliance Review tools on 3/7/16.
- Finalized the on-site review agendas on 3/7/16.
- Posted health plan specific Review Tool(s), Desk Review Form (Instructions) and Agenda to the FTP site on 3/8/16.
- Distributed Compliance Review technical assistance presentation and agenda to participants on 3/23/16 as part of the Outlook/Webinar meeting invitation.
- Conducted Technical assistance presentation/webinar with the MQD and Health Plans on 3/31/16.

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

January:

- Received final approval from the MQD on language block text to include on English cover letters on 1/8/16.
- Received completed administrative forms from the MQD (including letterhead, logo, and signature) on 1/8/16.
- Received final approval from the MQD on supplemental questions to include in the 2016 survey questionnaires on 1/8/16.
- Received sample frame files from the MQD on 1/13/16.
- Performed translation of the adult Medicaid language blocks for English cover letters on 1/20/16.
- Submitted CAHPS 2016 survey materials to NCQA for approval prior to volume printing.
- Submitted language block on backside of English cover letters to the MQD for final review and approval on 1/25/16; the MQD approved these items on 1/26/16.
- Submitted revised project timeline to the MQD; the MQD approved revised project timeline.
- HEDIS auditors completed validation of the sample frame files on 1/28/16.
- Received request from HMSA to schedule a call to discuss the potential implications of the Telephone Consumer Protection Act (TCPA) and the telephone follow-up processes for the CAHPS surveys HSAG conducted on behalf of the MQD.

February:

- Sent subcontractor CHIP sample frame file on 1/28/16 and the Adult Medicaid sample frame files on 2/2/16.
- Participated in call with HMSA on 2/4/16 to discuss telephone follow-up processes for the CAHPS surveys administered by HSAG; followed up with HMSA to address items discussed in the call.
- Performed translation of NCQA-approved survey mail materials into predetermined non-English languages on 2/5/16.
- Survey samples were selected on 2/8/16.
- Survey samples ran through the U.S. Postal Service's National Change of Address (NCOA) system on 2/10/16.
- Submitted final mail materials to the MQD on 2/19/16.
- Printed and produced survey packets.
- Mailed first questionnaires and cover letters to members on 2/18/16.
- Mailed first postcard reminders to non-respondents on 2/25/16.
- Health plans completed the Health Organization Questionnaire (HOQ) on NCOA secure site.

March:

- Submitted disposition report to the MQD on 3/11/16, 3/18/16, and 3/25/16.
- Mailed second questionnaires and cover letters to non-respondents on 3/24/16.
- Mailed second postcard reminders to non-respondents on 3/31/16.

5. Provider Survey –

No update at this time. 2016 activities are not scheduled to start until April 2016.

6. Annual Technical Report –
No update at this time.

7. Accreditation Updates (ACU)
January: Updates received from the health plans.

8. Quality Assessment Performance Improvement (QAPI)
No updates at this time.

QUEST Integration Dashboard

The MQD receives dashboard on QUEST Integration program monthly (see Attachment A for months April, May and June 2016). These reports allow MQD to track provider network, claims processing, processing of prior authorization, and call center statistics at a glance.

Demonstration Evaluation

MQD submitted its QUEST Integration Draft Evaluation Design to CMS on December 18, 2014. CMS responded with comments on September 9, 2015. The MQD has reviewed the CMS comments and had concerns about a few items. During a Quarterly 1115 Waiver Monitoring Call on October 21, 2015 the MQD shared that there were a few concerns and requested an extension on the existing deadline of November 9, 2015. CMS agreed on an extended deadline, and that a new deadline will be determined after a pending conference call to discuss these concerns. The list of concerns was sent to CMS on November 12, 2015.

Enclosures/Attachments

Attachment A QUEST Integration Dashboard for October 2015 – December 2015

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