FFY 2017

Hawaii QUEST Expanded Section 1115 Annual Report

Reporting Period:

October 1, 2016 - September 30, 2017

(Demonstration Year 23)

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Introduction

During this reporting period, Hawaii renewed its demonstration on September 23, 2013 to start a new demonstration called QUEST Integration (QI).

Hawaii's QI 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, 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 for whom 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.

Healthcare Delivery System

The State of Hawaii's 1115(a) demonstration has two programs: QUEST and QUEST Expanded Access (QExA). The QUEST program is for children and adults who are under the age of 65 and do not have a disability. The QExA program is for adults 65 years and older and children or adults with a disability. Table 1 provides a list of enrollment by program.

Both the QUEST and QExA programs are managed care delivery systems. Enrollment into managed care is mandatory.

The QUEST program has five health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, 'Ohana Health Plan, and UnitedHealthcare Community Plan. MQD enacted the commencement of services to members for the current contract of the QUEST program on July 1, 2012. This contract expires on December 31, 2014.

The QExA program has two health plans: 'Ohana Health Plan and UnitedHealthcare Community Plan (formerly Evercare QExA). MQD enacted the commencement of services to members for the current contract of the QExA program on February 1, 2009. This contract expires on June 30, 2011 with three one-year options to extend for the State of Hawaii. DHS has extended this contract for all three one-year extensions until June 30, 2014. DHS obtained an extension of this contract with an expiration of December 31, 2014.

The benefits offered by QUEST and QExA are comprehensive benefit packages. See Table 2 for a list of benefits provided to both QUEST and QExA members. Table 3 contains a list of the carve-out benefits for either QUEST or QExA.

Effective January 1, 2015 QUEST and QExA were combined to become QUEST Integration (QI).

The QI program has five health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, 'Ohana Health Plan, and UnitedHealthcare Community Plan. MQD enacted the commencement of services to members for the current contract of the QI program on January 1, 2015. This contract expires on December 31, 2018 with three optional one-year extensions.

Effective July 1, 2017 to December 31, 2017, Kaiser Permanente had opened up their MCO on Oahu for new enrollee choice. Also, Kaiser Permanente opened up for enrollee choice for both Oahu and Maui during the Annual Plan Change period from October 1, 2017 to October 31, 2017.

The MQD decided to convert the current paper Pre Admission Screening and Resident Review (PASRR) process to an electronic PASRR process. This involved working with a vendor to develop an e-PASSR portal that has the same look and feel as our existing Hawaii Level of Care (HILOC) portal, as both portals will be seeing the same users and providers. The design, development, and provider training was completed in September 2017, with a staged go-live scheduled from October 2017 – February 2018.

Based on the 21st Century Cures Act, MQD began planning and researching Electronic Visit Verification (EVV) systems with the following activities:

- conducting research regarding other states' models of implementation,
- begun collaborative discussions with AHCCCS towards a joint EVV solution,

- listened in on monthly Money Follows the Person webinars where EVV has been discussed.

The MQD continued these planning and research activities into the fall and winter of 2017.

Beginning in October 2016 the MQD strengthened the language in our Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program information to include Autism Spectrum Disorder (ASD) screening as a specific requirement. We also required our MCOs to add this strengthened language in their provider and member communications, both paper and electronic forms, as they mention EPSDT benefits.

Operational & Policy Developments

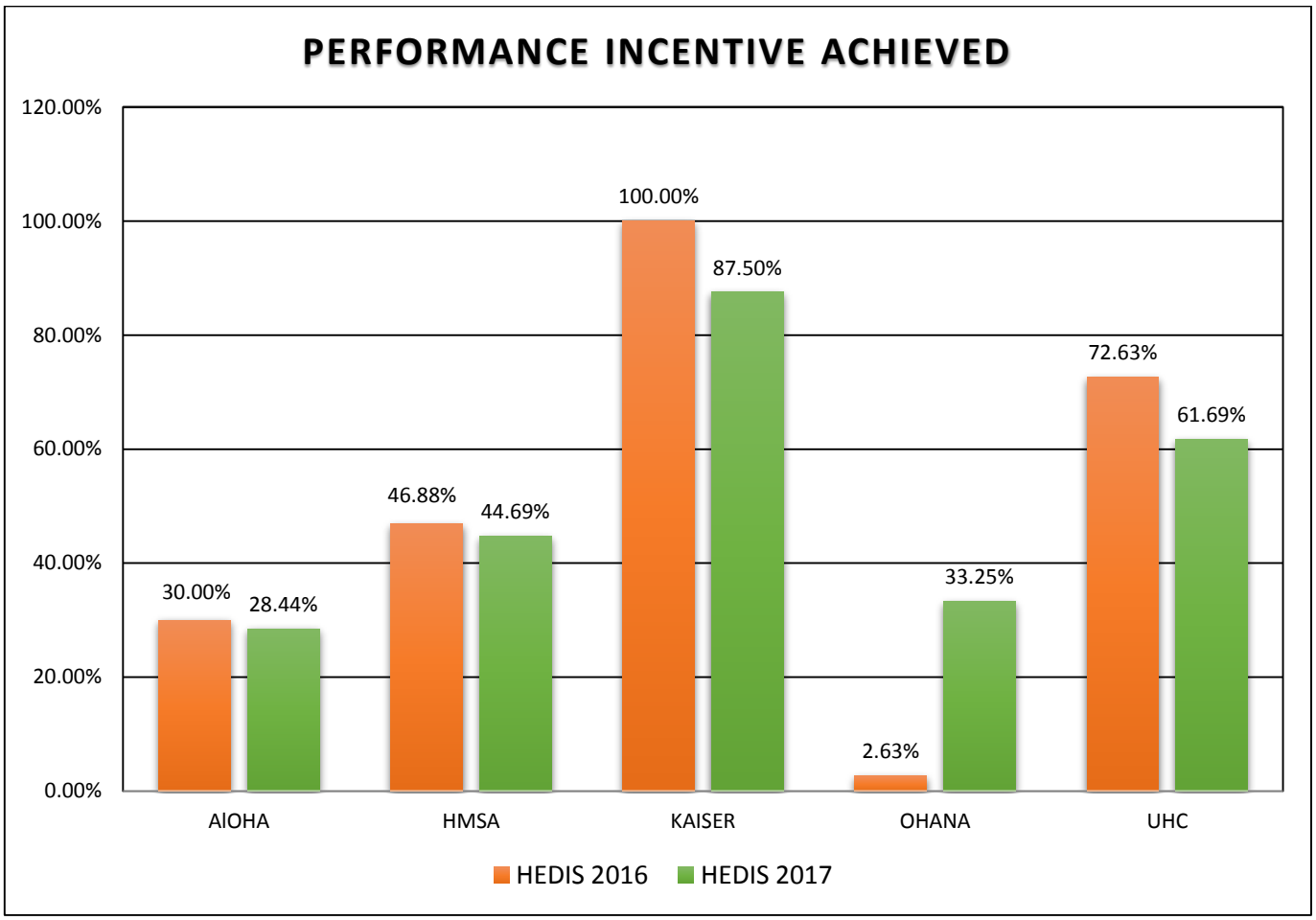
During the reporting period, MQD worked with Managed Care Organizations (MCO) on the implementation of the QI program.

The MQD uses HEDIS results to monitor progress in these areas for the QI health plans. The QI health plans had a withhold of $2.00 PMPM for the non-ABD population and $1.00 PMPM for the ABD population. These entire withhold amounts were available for both the CY 2015 and CY 2016 P4P Program. The MQD improved its Pay for Performance (P4P) in the QI program.

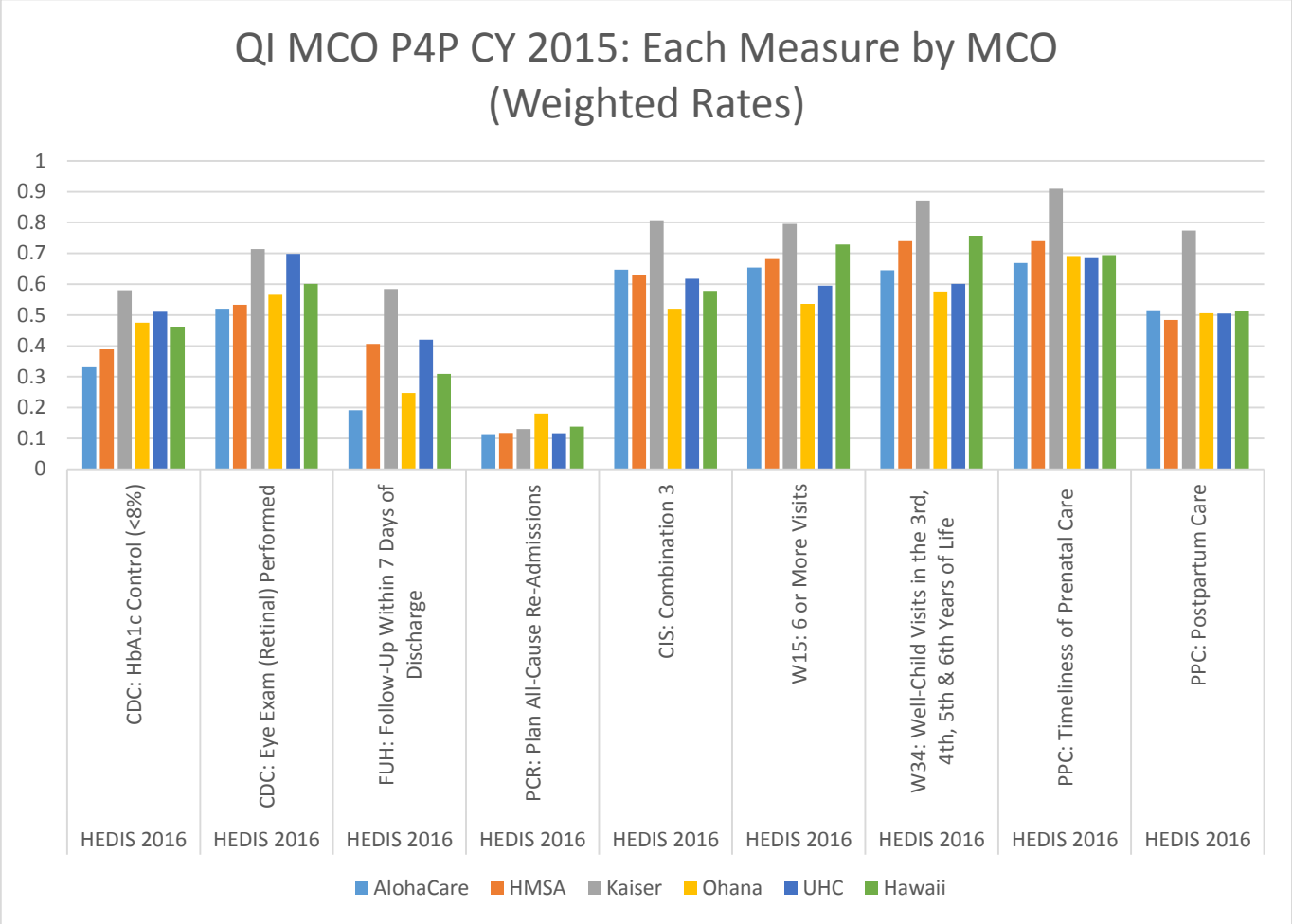
The following were improvements made to the QI P4P Program beginning CY 2015:

- Expanded measure set – increased number of measures from six (6) to nine (9)
- Recognized both improvement and goal achievement of individual measure scores – added incremental achievement targets to the current excellence target, with corresponding additional percentage incentives
- Weighted the measures differently based on the percentage of ABD enrollment each MCO served during the time period

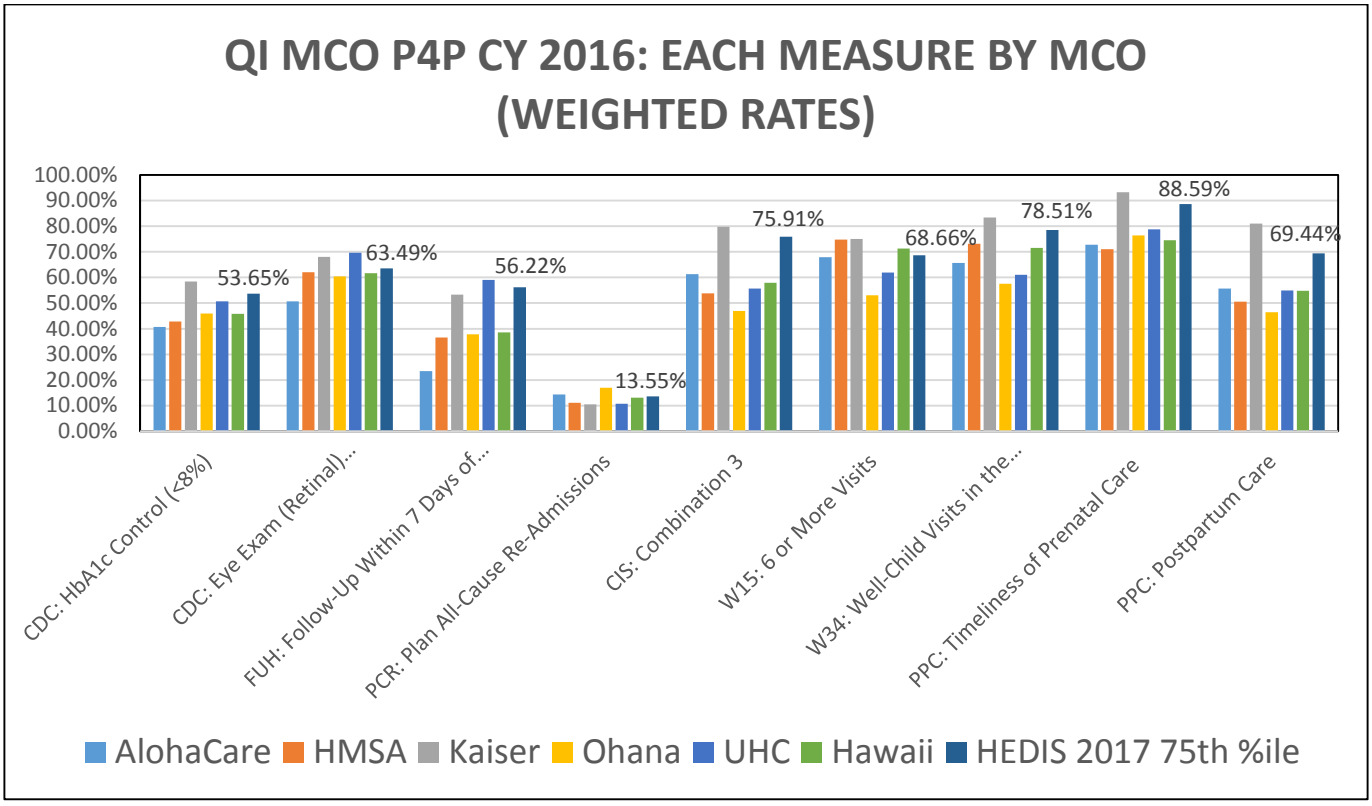
The result of these P4P changes has been broader participation achievement of intermediate goals by a broader spectrum of the QI MCOs. Whereas in past years a maximum of only two QI MCOs in any year achieved any P4P payout, in the first two years of the new P4P each and every QI MCO participated in the P4P payout. This serves to keep each QI MCO engaged in the quality improvement process no matter where they are on the performance spectrum. The following graph shows the amount of the performance incentive each of our five MCOs achieved over the CY 2015 and CY 2016 periods (these CYs correspond to HEDIS 2016 and HEDIS 2017, respectively):



Kaiser's HEDIS scores were consistently the highest among our five MCOs in CY 2015, continuing the trend of past years. HMSA and UHC both scored relatively well in the CY 2015 period as compared to their peers, and also on an absolute basis on select measures. The following graph shows the five MCO's performance for each HEDIS measure in CY 2015, along with a comparison against the Hawaii Medicaid composite:



Although Kaiser continued their dominance in the CY 2016 scoring, HMSA and UHC both exceeded the 75th %ile target for several measures in this period. Ohana also showed overall scoring improvement over the prior year's performance, and AlohaCare also represented well in a few measures. The following graph shows the five MCO's performance for each HEDIS measure in CY 2016, along with a comparison against the Hawaii Medicaid composite and the HEDIS 75th %tile score:



Outreach and Innovation Activities

The DHS started determining eligibility for Medicaid individuals using new Modified Adjusted Gross Income (MAGI) criteria on October 1, 2013. In addition, MQD fine-tuned its work within its eligibility system called Kauhale (community) On-Line Eligibility Assistance System (KOLEA). DHS encouraged applicants to apply on-line at its mybenefits.hawaii.gov website.

The MQD implemented the Affordable Care Act (ACA) requirements in October 1, 2013. This included the FQHCs becoming navigators with the Hawaii Health Connector. Through this process, FQHCs were able to submit applications for Hawaii Medicaid through the KOLEA system and submit applications for the State Based Marketplace through the Hawaii Health Connector portal.

In addition to encouraging applicants to apply through the KOLEA system, DHS-Med-QUEST Division established a new branch in December, 2015. The Health Care Outreach Branch (HCOB) was created in response to a demonstrated community need for additional application assistance for some of the hardest to reach populations. The 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 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.

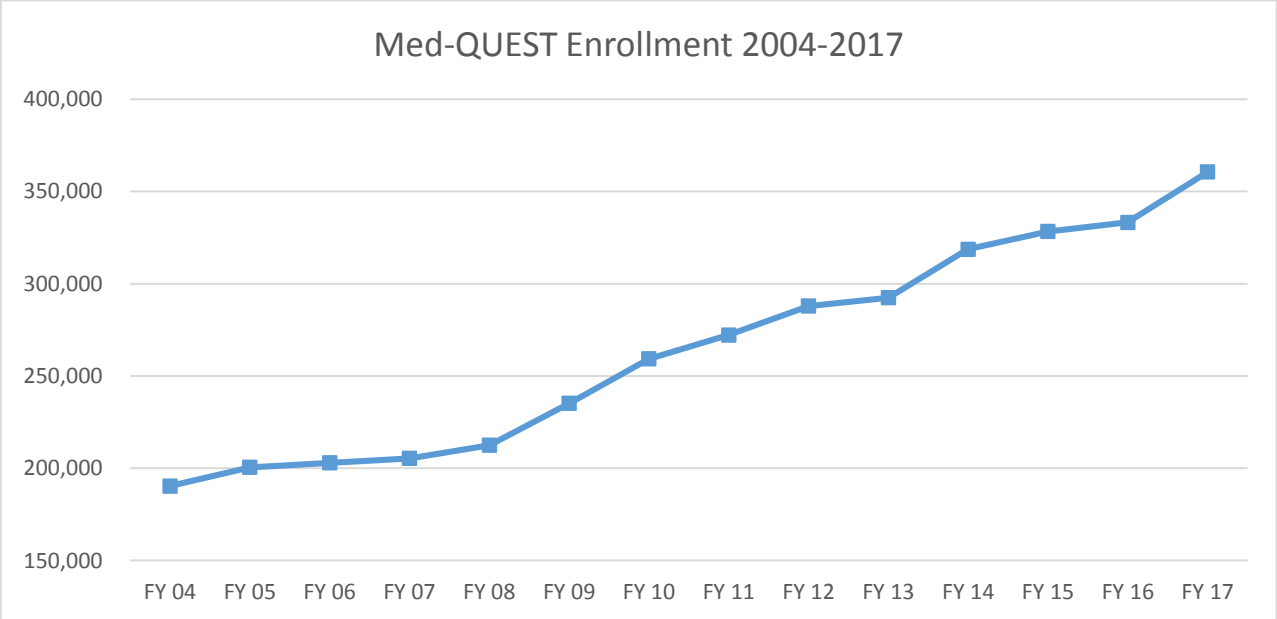
For those in the community who are below the 138% of the Federal Poverty Level, but who were deemed ineligible for Medicaid due to their citizenship status (Immigrants here less than 5-years and non-pregnant, non-blind, non-disabled 19-64 year olds from the Nations under the Compact of Free Association, 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.

The MQD began redesigning our website in March 2017. The last time our website was upgraded was before 2010, and it was suffering from poor design, outdated software, and lack of regular updates. Great progress was made through the Demonstration Year 23.

Enrollment

The Demonstration had a 39% percent increase in enrollment over State Fiscal Year 2010. The majority of this enrollment occurred in the QUEST program. See Table 1 for enrollment statistics.

The MQD has had an increase in enrollment of 78% since State Fiscal Year 2006. See chart below for visual of the increase in enrollment of the Demonstration program in Hawaii.



Outcomes, Quality and Access to Care

MQD Quality Strategy

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. In a letter from CMS dated July 8, 2016, Hawaii received final approval of its Quality Strategy from CMS. The approved quality strategy is mostly consistent with the previously approved 2010 version.

A copy of the Quality Strategy is posted at the MQD website (https://medquest.hawaii.gov). The 2016 Hawaii MQD Quality Strategy, our current Quality Strategy, was approved by CM on July 7, 2016.

MQD's continuing goal is to ensure that our clients receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. MQD has adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. An initial set of ambulatory care measures based on this framework was identified. HEDIS measures that the health plans report to us are reviewed and updated each year. A copy of the list of the QI programs' reported HEDIS 2015 and 2016 measures, including the validated HEDIS 2015 and 2016 measures, is attached in Attachment A. Below is more detailed information regarding HEDIS.

The MQD performed one Adult and one Child CAHPS surveys in the spring of 2015. The Adult CAHPS survey was for the QI programs and the Child CAHPS survey was for the CHIP enrollees.

In the spring of 2016, MQD performed one Adult and one Child CAHPS survey. The Adult CAHPS survey was for the QI programs and the Child CAHPS survey was for the CHIP enrollees. Members of the QI health plans that are Medicaid adults and children were provided an opportunity to participate in this survey. CHIP enrollees of QI had their own survey for reporting to CMS. The CHIP report is Statewide and not by health plan due to limited enrollment. See Attachment A for a copy of the QI CHIP CAHPS Star Report of the following points of information: Customer Service, Getting Care Quickly, Getting Needed Care, How Well Doctors' Communicate, Rating of All Health Care, Rating of Health Plan, Rating of Personal Doctor, and Rating of Specialist Seen Most Often.

QI HEDIS 2017 and 2018

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the *2016 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5.* The audit procedures were also consistent with the CMS protocol for performance measure validation: *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. The health plans that contracted with the MQD during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting,

analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health. The measurement period was CY 2016 (January 1, 2016, through December 31, 2016), and the audit activities were conducted concurrently with HEDIS 2017 reporting.
During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 33 measures, yielding a total of 96 measure indicators, for the QI population. 'Ohana CCS was required to report on 10 measures, yielding a total of 27 measure indicators, for the CCS program. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services. These domains included:

- Access to Care
- Children's Preventive Care
- Women's Health
- Care for Chronic Conditions
- Behavioral Health
- Utilization and Health Plan Descriptive Information

The most recent reported HEDIS year for QI is HEDIS 2018. The measurement period was CY 2017 (January 1, 2017, through December 31, 2017), and the audit activities were conducted concurrently with HEDIS 2018 reporting. The five QI health plans (AlohaCare QI, HMSA QI, Kaiser QI, 'Ohana QI, and UHC CP QI) were required to report the QI, aged, blind, or disabled (ABD), and non-ABD measures. In addition, 'Ohana CCS was required to report rates for the CCS program-specific measures.

During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 32 measures. 'Ohana CCS was required to report on 11 measures. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality and timeliness of, and access to, Medicaid care and services. Please note, as if May 2018, findings of the HEDIS audits are preliminary and the rates are forthcoming.

Measures

The graphs used to illustrate the various measures are, unless otherwise noted, scaled from 0% to 100%. This was done to facilitate comparisons between graphs and to present a consistent scale of measurement.

Initiatives related to these measures are reported separately in a subsequent section of this report.

HEDIS Measures

The Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure both the quality of healthcare delivered to, as well as the overall healthcare utilization levels of, the Hawaii QUEST Integration (QI) and the CCS recipients.

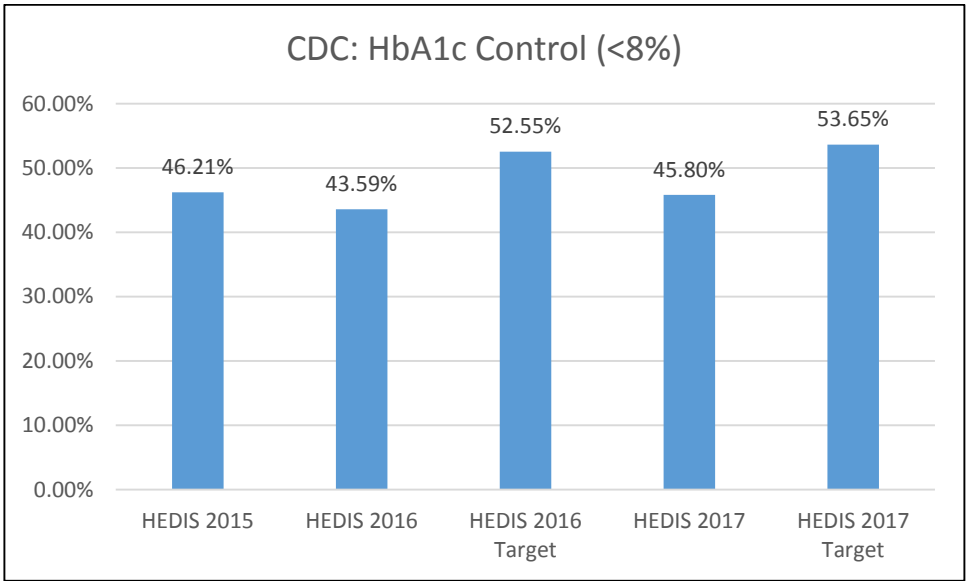
The HEDIS measures mostly involve ratios of a target behavior over the entire population that is eligible for that behavior. Occasionally ratios are reported on a sample of the population instead of the entire population, but on these occasions there are intensive internal claim audits applied to a sample of the claims. The HEDIS measures are based on self-reported HEDIS reports received from the five individual QI plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, 'Ohana Health Plan, and UnitedHealthcare Community Plan and also the CCS Program. HEDIS reports from the plans are based on a calendar year period, a twelve-month period beginning January 1st and ending December 31st of the report year, and are due to Med-QUEST on approximately June 30th of the following year. These are sent via standard NCQA electronic file (IDSS) to Med-QUEST, and are then weight-averaged to create composite HEDIS measures for the entire Med-QUEST population for a single year. The plans are required to report on most of the HEDIS measures in each year. The definitions of the various HEDIS measures reported by the plans are no different from the national standard HEDIS definitions – we do not have any HEDIS-like measures. We do though, have developed state-specific measures. All plans and the CCS program are concurrently audited by our External Quality Review Organization (EQRO).

Annual audits on how the plans calculate and report their HEDIS scores are conducted by the HEDIS-certified External Quality Review Organization (EQRO) entity under contract with, and under the direction of, Med-QUEST. Typically, these audits involve a sample of HEDIS measures. The measures presented below are a small sample of the complete set of HEDIS measures that are reported each year,

A longitudinal analysis is completed on the statewide QI rates to determine if there are broad trends in the measure over a period of several years. For most measures, scores are reported for each year from 2008 to 2016. A comparison is made to the 2016 and 2017 National Medicaid Median 75th Percentile score to bring perspective to where we score on a national level. Our Quality Strategy sets the National Medicaid 75th Percentile score as the target score for most of the HEDIS measures.

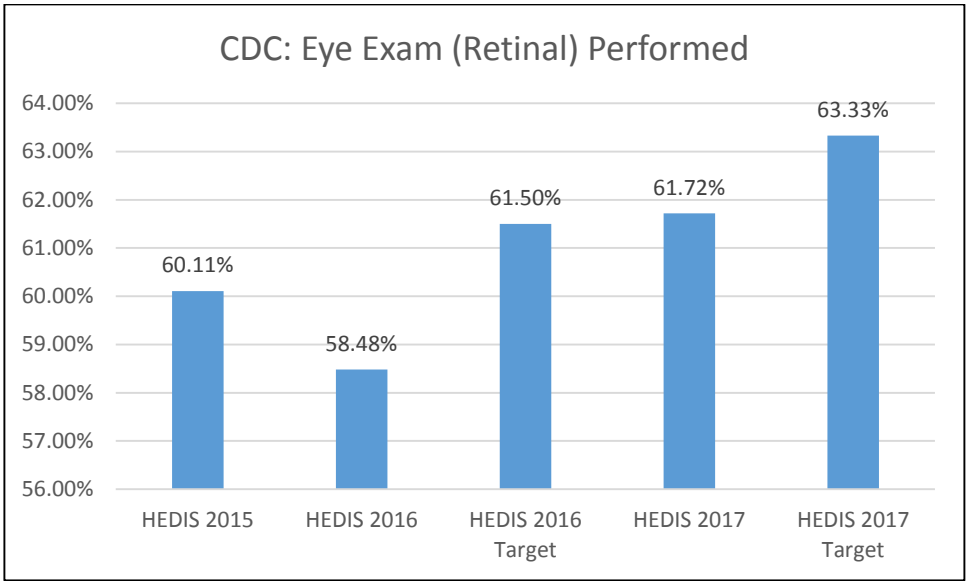
For all of the HEDIS measures except for the CDC: Poor HbA1c Control >9% and AMB: Emergency Department Visits and Plan All-Cause Readmissions (PCR) measures, higher numeric scores are considered positive and lower numeric scores are considered negative; for these exception measures lower numeric scores are considered positive and higher numeric scores are considered negative.

HEDIS 2017:



CDC – HbA1c Control <8.0%:

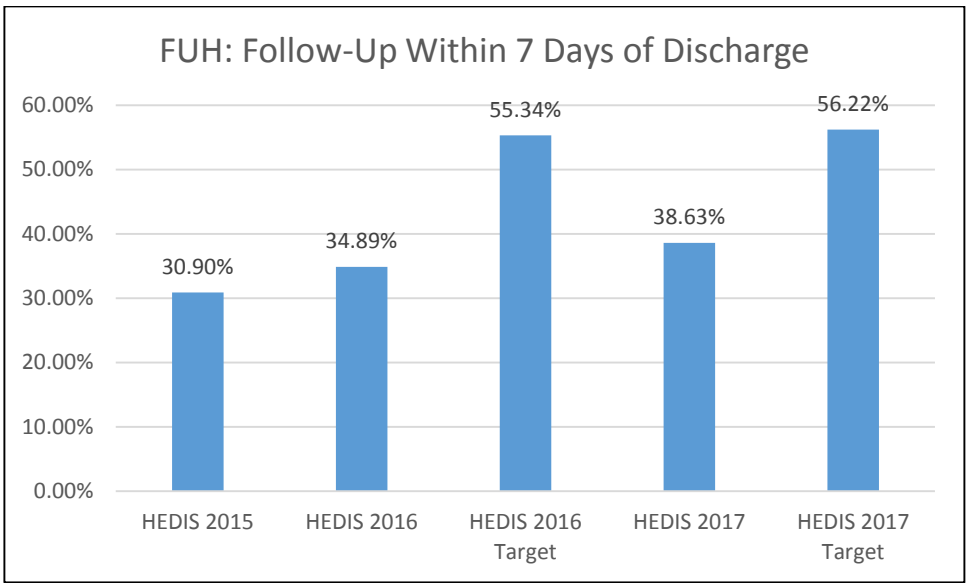
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c control (<8.0%).
- The previous year (2016) had a lower rate than the current year (2017).
- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75th percentile of the national Medicaid population. For the CY2016, the latest year with national averages, the target was not met.



CDC – Eye Exam (Retinal):

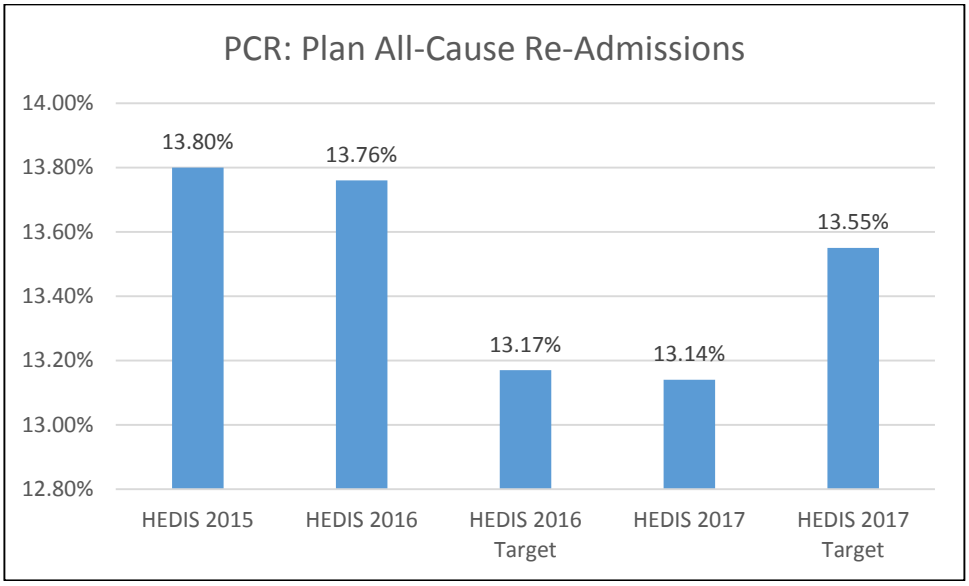
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had a retinal eye exam performed. There was a significant increase from the previous year (2016).

- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For 2017, the latest year with national averages, the target was not met.



FUH: Follow-Up Within 7 Days of Discharge

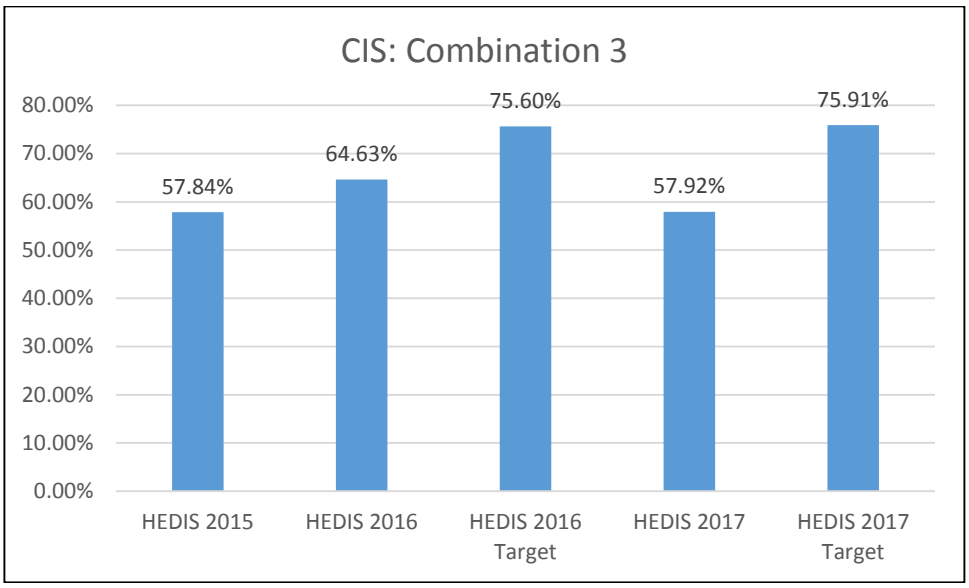
- The statewide Medicaid percentage of members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner increased from 34.89% to 38.63% in one year.
- The HI Quality Strategy target percentage for the FUH: Follow-Up Within 7 Days of Discharge measure is the 75th percentile of the national Medicaid population. The target has not been met these past two years.



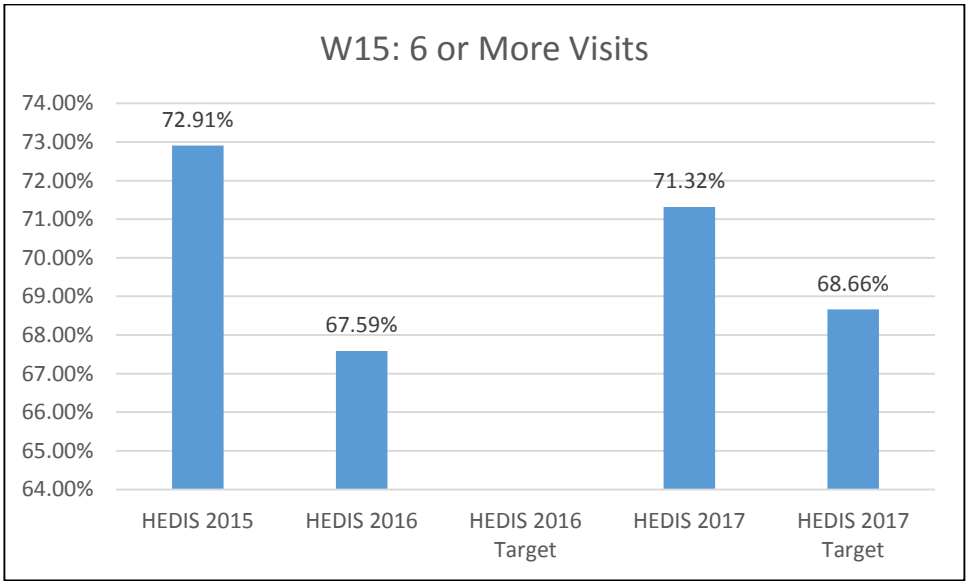
- The statewide Medicaid percentage of members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

  1. Count of Index Hospital Stays (IHS) (denominator).
  2. Count of 30-Day Readmissions (numerator).
  3. Average Adjusted Probability of Readmission.

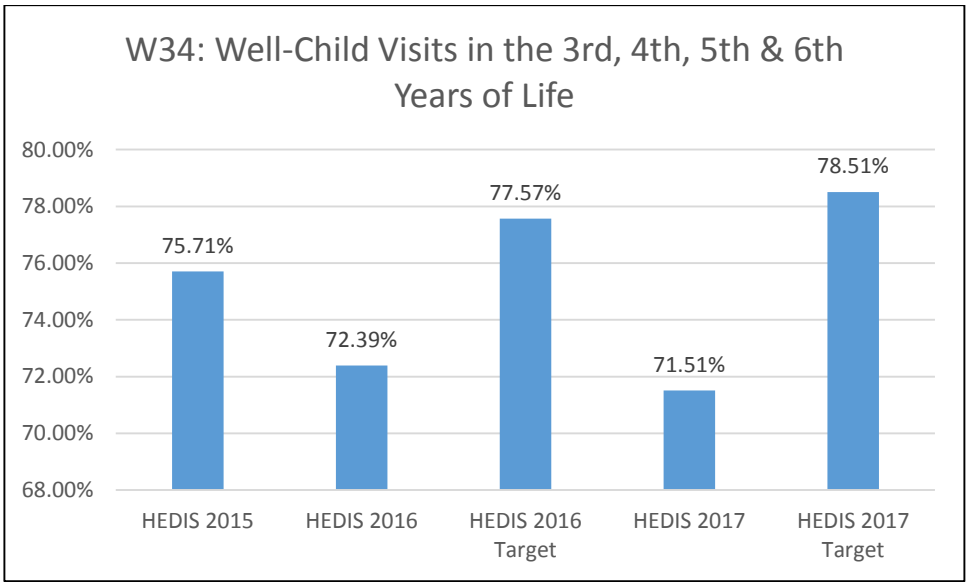
- This measure is an inverse measure, where a lower rate indicates better performance.
- The rate has continually decreased, which is an improvement, from 13.80% in 2015 to 13.14%, the past three reporting years.
- The HI Quality Strategy target percentage for this measure is the 75th percentile of the national Medicaid population. The target has been met the last year reported, 2017.



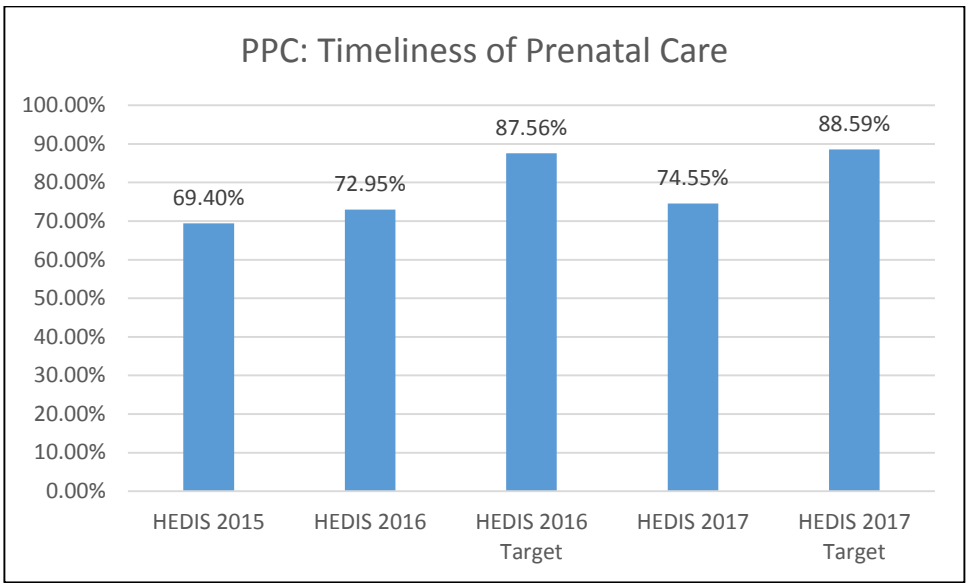
- The statewide Medicaid percentage of members 2 years of age who were given the recommended vaccines for their population. The rate decreased from 64.63% to 57.92% in one year.
- The HI Quality Strategy target percentage for this measure is the 75th percentile of the national Medicaid population. The target has not been met these past two years.



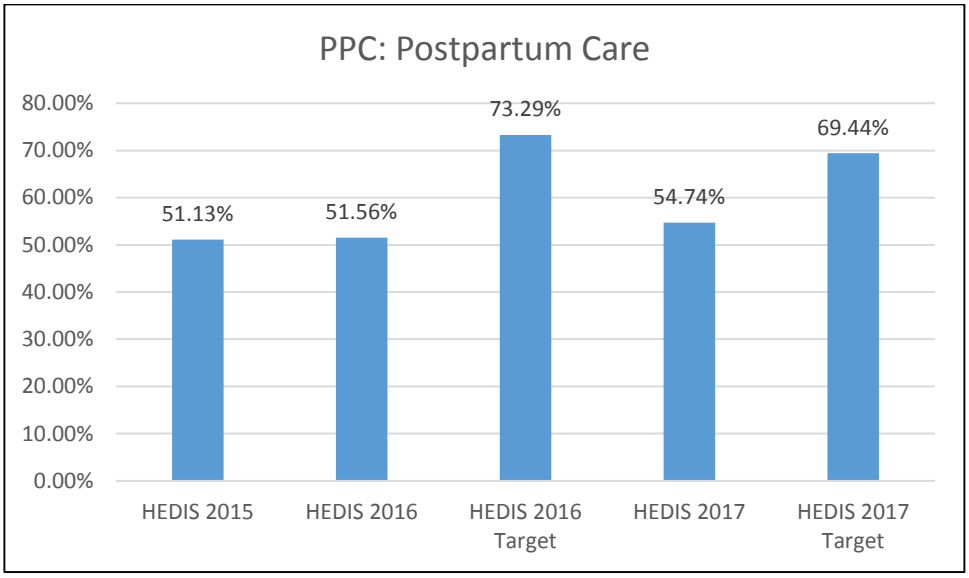
- The statewide Medicaid percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life. The rate increased from 67.59% to 71.32% in one year.
- The HI Quality Strategy target percentage for this measure is the 75th percentile of the national Medicaid population. The target was met for the latest year reported.
- HEDIS 2016 target was not available.



- The statewide Medicaid percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. The rate decreased from 72.39% to 71.51% in one year.
- The HI Quality Strategy target percentage for this measure is the 75th percentile of the national Medicaid population. The target was not met the past two recent years reported.



- The statewide Medicaid percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. For Timeliness of Prenatal Care, the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization. The rate increased from 72.95% to 74.55% in one year.
- The HI Quality Strategy target percentage for this measure is the 75th percentile of the national Medicaid population. Despite the upward trend, the target was not met for the last two years reported.



- The statewide Medicaid percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. For Postpartum Care, the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after deliver. The rate increased from 51.56% to 54.75% in one year, continuing the steady upward trend.
- The HI Quality Strategy target percentage for this measure is the 75th percentile of the national Medicaid population. Despite the upward trend, however, the target was not met for the last two years reported.

EPSDT Measures

The EPSDT measures are included in this report to measure the degree of comprehensive and preventive child healthcare for individuals under the age of 21.

The EPSDT measures are based on self-reported EPSDT reports received from the five individual plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan and UnitedHealthcare Community Plan. The scores from these individual plan reports are then weight-averaged to calculate Hawaii composite scores. All five plans create custom queries to calculate their scores, and all of the EPSDT measures are reported in each year. The format and method of calculation for the various EPSDT measures reported by the plans is no different from the national standard CMS-416 EPSDT format, aside from small differences in the periodicity of visits by state. Audits on how the plans calculate and report their EPSDT scores are not currently conducted; future health plan audits on the EPSDT calculation and reporting are being considered. EPSDT reports from the plans are based on the federal fiscal year, a twelve month

period beginning in October 1 and ending on September 30 of the report year, and are due to Med-QUEST on the last day of February in the year following the report year. The measures presented below are a small sample of the complete set of EPSDT measures that are reported each year.

Copies of the 2015 and 2016 EPSDT Reports (2015 and 2016 Hawaii CMS 416 Reports) are posted at the MQD website (https://medquest.hawaii.gov/en/plans-providers/managed-care-providers/provider-epsdt.html). Although the current reports are available for review, they have yet to be posted.

CAHPS Measures

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are included in this report to measure the degree of recipient satisfaction with Hawaii Med-QUEST.

Med-QUEST is required by the State of Hawaii to conduct an annual HEDIS CAHPS member survey. The CAHPS measures are based on annual surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The method of these surveys and the definitions of the various CAHPS measures strictly adhere to required national standard CAHPS specifications. The surveys were sent to a random sample of recipients.

In the 2017, the overall response rate was 23.52% which decreased from the 2016 response rate (8.08% points lower). The final 2018 QI Program aggregate's response rate is currently being reconciled.

The "question summary rates" are reported for the different measures used in this report. The Adult Medicaid surveys were done in 2008, 2010, 2012, 2014, 2016 and 2018. The Child Medicaid survey was done in 2009, 2011, 2013, 2015 and 2017. The survey asks which health plan the respondent is currently enrolled in, which enables the scores to be summarized by plan. Going forward and as required by the State of Hawaii, these surveys will continue to be done annually, with the Child and Adult surveys being done in *alternating* years. The measures presented below are but a small sample of the entire slate of questions that were presented on the survey.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Because the populations surveyed are different between the Adult and Child surveys, these surveys are analyzed separately as the data allows. A comparison is made to the National Medicaid Child CAHPS 2017 75th percentile score to bring perspective to where we score on a national level. The National Medicaid 75th percentile score will be the target score for all of the CAHPS measures, as is specified in our Quality Strategy.

For the CAHPS measures, higher numeric scores are considered positive and lower numeric scores are considered negative.

Copies of the 2017 EQRO Technical Reports (2017 External Quality Review Report of Results for QI Health Plans and the CCS Program) are posted at the MQD website:
https://medquest.hawaii.gov/en/resources/consumer-guides.html

Med-QUEST Internal Measures

The Med-QUEST internal measures are included in this report to measure the financial aspects of the Hawaii Med-QUEST program. How is money being spent, and on how many and what type of recipients, is the focus of these measures.

The member month measure used is a sum of member months, and will consist of entire populations based on reports run at the end of each month. The capitation payment file is a detail of all capitation payments made to each plan, and is the source of member month data. This file has enrollments for retro payments reflected in the month that payment was made. Initial months are paid pro-rated daily amounts based on the start date. Termination always occurs at the end of the month, except for retro termination for disability or death.

Recent Initiatives on Measures

HEDIS Initiatives

Please see Attachment B for the 2017 health plan initiatives.

CMS-416 EPSDT Measures Initiatives

The plan's EPSDT coordinator follows up on referrals documented on the EPSDT forms (8015 and 8016 forms) to ensure that pediatric members follow through on referrals made. In addition, the plan does not require a PCP to obtain authorization for a referral to an in-network specialist. This ensures that there are no delays with specialty referrals.

CAHPS (QUEST) Initiatives

Please see Attachment B for the 2017 health plan initiatives.

Home and Community Based Services (HCBS) Initiatives

- Streamlined ability to receive HCBS instead of nursing facility placement since start of QExA and continued into the QI.
    - By moving HCBS from the 1915(c) waivers into an 1115 demonstration waiver in health plans, MQD was able to minimize the silos that existed previously to "get into a waiver."
    - Health plan members are assessed for their choice of placement for long term supports and services (LTSS).
    - Choices offered include:
        - Their home with support provided by home care agencies or family members provided as a health plan paid consumer-directed personal assistant
        - Residential settings such as community care foster family homes or assisted living facilities
        - Institutional setting
    - Once member is assessed for needing long term supports and services, health plans are able to provide LTSS within approximately thirty (30) days.

- Standardized assessment tools for HCBS

    - At the start of the QI Program, MQD and the health plans began the process of developing an updated Health and Functional Assessment (HFA) tool. There are currently multiple HFA tools for various Medicaid populations, and this effort will streamline the HFAs into a single tool for all populations.

    - The use of these assessment tools have helped to streamline receipt of services.

Hawaii Medicaid Enrollment Initiatives

- MQD is focused on assuring processing of applications for Medicaid within 45-days or else providing presumptive eligibility.

- Effective October 1, 2013, MQD enacted eligibility for beneficiaries, ten-days prior to submittal of application.

- MQD has amended its 1115 demonstration waiver to provide eligibility up to 133% (with a 5% disregard) of Federal Poverty Level for implementation of ACA.

Other Quality Projects

MQD continues to work on strategies and measures related to home and community based services, that affect our QI health plans, the Developmental Disability and Intellectual Disability (DD/ID) program, and the Going Home Plus (GHP) program. MQD implemented the CMS Quality Framework for Home and Community Based Services (HCBS) in SFY 2012. 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.

MQD developed behavioral health monitoring tools to measure the transition and on-going implementation of providing behavioral health services for Hawaii's Medicaid SMI population. Some of the areas measured include:

- Services provided
- Health plans meeting case management acuity (i.e., assuring that case managers are meeting with their clients in accordance with timeframes established during a psychosocial assessment)
- Acute psychiatric hospitalizations
- Discharge planning and follow-up with seven days after an acute psychiatric hospitalization
- Management of sentinel events

Measures for long-term care will need to be developed in the future in partnership with our stakeholders.

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.

During demonstration years 21 and 22, MQD collaborated with QI health plans to improve the Pay-for-Performance (P4P) Incentive Program. Some of the improvements included: rewarding quality score improvements in addition to achieving benchmark targets; broadening the scope of quality measures that were included in the P4P program; considering quality measures that the QI health plans include in other lines of business (i.e., commercial and Medicare quality measures), and paying P4P incentives to each of the five QI health plans in calendar year 2015.

Quality Activities during the Demonstration Year

The State of Hawaii, Med-QUEST Division has a contract with Health Services Advisory Group (HSAG) to perform its EQRO activities. In 2015, MQD moved into the third of its three year cycle for mandatory external quality review that is described in Code of Federal Regulations (CFR) at 42 CFR 438.358. For the 2015 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the CCS program, using monitoring tools to assess and document compliance with a set of federal and State requirements. This review brought the CCS program into alignment with the review schedule for the QI plans to ensure all standards were reviewed within a three-year period for all health plans. The standards selected for review were related to the CCS program's State contract requirements and the federal Medicaid managed care regulations in the Code of

Federal Regulations (CFR) for five areas of review, or standards. A pre-on-site desk review and an on-site review with interview sessions and record reviews were conducted.

The second compliance review activity in 2015 involved HSAG's and the MQD's follow-up monitoring of the three health plans that were required to take corrective actions related to findings from HSAG's 2014 compliance review, and the follow-up monitoring of CCS' corrective actions related to its 2015 compliance review.

For this review, the HSAG performed a desk review of documents and an on-site review of the re-evaluation of health plan compliance that included reviewing additional documents and conducting interviews with key staff members from CCS. HSAG evaluated the degree to which CCS complied with federal Medicaid managed care regulations and associated State contract requirements in performance categories (i.e., standards) that related to the access and measurement and improvement standards in 42 CFR 438, Subpart D. The five standards included requirements that addressed the following areas:

- Member Rights and Protections and Member Information
- Member Grievance Systems
- Access and Availability
- Coverage and Authorization
- Coordination and Continuity of Care

CCS was provided a report that described their areas of success as well as areas for improvement. Corrective Action Plans (CAP) was required for areas requiring improvement. For CCS, the areas for oppurtunities of improvement were Member Grievance System and Coverage and Authorization. By July 2015, 'Ohana CCS completed all of the CAP activities as planned and was found to be in full compliance with the standards.

In Calendar Year (CY) 2016, a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program. The two activities conducted were a review of select standards for the QI and CCS programs and follow-up monitoring of CCS'corrective actions related to its 2015 compliance review.

The following are the five standard areas reviewed:

- Member Rights and Protections and Member Information
- Member Grievance Systems
- Access and Availability
- Coverage and Authorization
- Coordination and Continuity of Care

Overall, the health plans performed strong (97-99% out of 100% possible score) with all the standards except the Member Rights and Protections and Member Information standard. However, even with this last standard, the plans in the upper brackets at 93%.

For CY 2017, the second year for this cycle, the following were the five standard areas reviewed:

- Provider Selection
- Subcontracts and Delegation
- Credentialing

- Quality Assessment and Performance Improvement
- Health Information Systems
- Practice Guidelines

For this Compliance Review, the health plans continued their strong performance, scoring 92-100% out of 100% possible score.

Performance Improvement Projects (PIP):

PIPs are designed as an organized way to assist health plans in assessing their healthcare processes, implementing process improvements, and improving outcomes of care. In 2015, HSAG validated two PIPs for each of the QUEST Integration and CCS health plans, for a total of 12 PIPs. The five QUEST Integration plans were required by the MQD to conduct PIPs related to *All-Cause Readmissions* and a second topic to improve *Diabetes Care*. CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*.

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the health plan with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings.

In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement.[1-9] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The new methodology focuses on evaluating and refining small process changes in order to determine the most effective strategies for achieving real improvement.

The key concepts of the new PIP framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.

By 2016, all of the health plans progressed to testing intervention for the rapid-cycle PIPs. Module 5 (PIP conclusions), the last phase, was due at the end of the year and achievements will be evaluated in the early part of 2017.

Table 0-1 summarizes HSAG's key validation findings for the two PIPs conducted by the QUEST Integration health plans. The key validation findings include whether each PIP achieved its SMART Aim goal and the overall confidence level HSAG assigned to each PIP.

[1 -9] Institute for Healthcare Improvement. How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: September 24, 2015.

- The first finding, achieving the SMART Aim goal, represents the PIP outcomes and whether the PIP demonstrated meaningful improvement.
- The second finding, the confidence level, represents HSAG's overall validation findings based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels include *High Confidence*, *Confidence*, *Low Confidence*, depending on the performance of the PIP. HSAG assigned a level of *High Confidence* to a PIP only if the SMART Aim goal was achieved and the improvement strategies were clearly linked to the demonstrated improvement. HSAG did not assign a confidence level to a PIP when the reported PIP results were not credible.

The details of the rapid cycle PIP process and HSAG's scoring methodology are described in Appendix A.

Table 0-1—PIP Validation Findings for the QI Health Plans

Health Plan	Plan All-Cause Readmission		Diabetes Care	
	SMART Aim Goal	Confidence Level	SMART Aim Goal	Confidence Level
AlohaCare QI	Failed	*Low Confidence*	*Achieved*	High Confidence
HMSA QI	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*
KFHP QI	*Achieved*	Confidence	*Achieved*	*Low Confidence*
'Ohana QI	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*
UHCCP QI	*Achieved*	*Low Confidence*	*Achieved*	Confidence
Percent Achieved/ High Confidence	***80%***	***0%***	***100%***	***20%***

Health plan performance on the two PIPs demonstrates the continued need for further skill development around the application and documentation of the rapid cycle PIP process, especially in the area of intervention testing through Plan-Do-Study-Act (PDSA) cycles. Well-planned, appropriately executed, and clearly documented PDSA cycles are necessary to achieve a *High Confidence* level in a PIP and drive sustainable improvement.

Overall, the five QI health plans achieved the SMART Aim goal for all PIPs, except for AlohaCare QI on is *All-Cause Readmissions* PIP which failed to meet its SMART Aim Goal. These findings demonstrate that, in general, the health plans defined attainable goals as part of the rapid cycle PIP process and the goals were achieved during the life of the PIP.

While the health plans were successful in achieving the outcomes defined by the SMART Aim goals, they had considerable difficulty achieving a *High Confidence* level for most PIPs. AlohaCare QI was the only health plan that received a level of *High Confidence* for any PIPs. KFHP QI and UHCCP QI each achieved a moderate *Confidence* level for their *Diabetes Care* PIP while the remaining PIPs all received an assignment of *Low Confidence* due to the inability to clearly link to the interventions tested to the outcomes.

Table 0-2 summarizes HSAG's key validation findings for the two PIPs conducted by 'Ohana CCS.

Table 0-2—PIP Validation Findings for 'Ohana CCS

	Follow-Up After Hospitalization for Mental Illness		Initiation of Alcohol and Substance Abuse Treatment	
Health Plan	**SMART Aim Goal**	**Confidence Level**	**SMART Aim Goal**	**Confidence Level**
'Ohana CCS	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*

Similar to the QI health plans, 'Ohana CCS achieved the SMART Aim goal for both PIPs demonstrating that, in general, the health plan defined attainable goals as part of its rapid cycle PIP process and the goals were achieved during the life of the PIP. Further, both PIPs received an assignment of *Low Confidence* due to the inability to clearly link to the interventions tested to the outcomes.

Annual External Quality Review Report of Results For the QI Health Plans and the CCS Program:

In addition, the EQRO completed the Annual Technical Report, which includes follow-up and updates from the previous year's Technical report submitted from the health plans. The Annual Technical Report is posted on the MQD website. We also continue to do inter-rater reliability reviews with our PRO level of care determinations.

MQD is continuing to actively work on strategies and measures related to home and community based services. These include establishing guidelines and reporting requirements as well as oversight of grievance and appeals processes, nursing assessments, among others.

Improvement of Health Plan Report Forms and Monitoring Tools

In demonstration year 23, MQD continues to align the report forms and monitoring tools for these programs wherever possible. MQD has developed tools for health plan reporting and review tools for MQD staff to use to standardize report analysis. This process is ongoing and will continue into demonstration year 24.

Cost of Care

Financial Performance of the Demonstration

The Demonstration expended approximately $2.1 billion to provide services to Medicaid clients in Hawaii (both State and Federal funds) in demonstration year 23.

Financial/ Budget Neutrality Development/ Issues

The MQD submitted budget neutrality for each quarter in demonstration year 23.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	October to December 2016 (1st qtr totals)	January to March 2017 (2nd qtr totals)	April to June 2017 (3rd qtr totals)	July to September 2017 (4th qtr totals)
Children (EG1)	374,663	372,632	369,552	367,858
Adults (EG2)	123,279	121,966	119,935	119,105
Aged (EG3)	78,538	79,611	80,405	81,930
Blind/Disabled (EG4)	78,838	78,027	77,825	77,849
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	352,747	363,751	361,614	363,456

B. For Informational Purposes Only

With Waiver Eligibility Group	October to December 2016 (1st qtr totals)	January to March 2017 (2nd qtr totals)	April to June 2017 (3rd qtr totals)	July to September 2017 (4th qtr totals)
State Plan Children	373,450	371,369	368,249	366,565
State Plan Adults	123,279	121,966	119,935	119,105
Aged	78,538	79,611	80,405	81,930
Blind or Disabled	78,838	78,027	77,825	77,849
Expansion State Adults	287,205	294,317	293,777	295,023
Newly Eligible Adults	65,542	69,434	67,837	68,433
Optional State Plan Children				
Foster Care Children, 19-20 years old	1,213	1,263	1,303	1,293
Medically Needy Adults				
Demonstration Eligible Adults	0	0	0	0
Demonstration Eligible Children				

With Waiver Eligibility Group	October to December 2016 (1st qtr totals)	January to March 2017 (2nd qtr totals)	April to June 2017 (3rd qtr totals)	July to September 2017 (4th qtr totals)
VIII-Like Group	0	0	0	0

Audits and Lawsuits

Audits

The MQD undergoes a single-state audit annually by KMH LLP. In addition to the State audit, Hawaii also has a PERM audit. The PERM audit for FFY 2017 is still in progress. The PERM data submission is from 10/01/16 thru 9/30/17.

Lawsuits

Case 1:
In 2014, a class action suit was filed in the U.S.D.C., District of Hawaii. Plaintiffs are seeking a declaration that certain specific services for children suffering from Autism Spectrum Disorder are medically necessary and must be covered under the early periodic screening, diagnostic and treatment (EPSDT) mandate of the state Medicaid program. The State modified its new Medicaid program effective January 1, 2015, by issuing contract modifications to the five Medicaid health plans that would be providing services to Medicaid beneficiaries, including the Plaintiff class. The contract modifications do not specify that the specific services that are the subject of this lawsuit must be provided under the EPSDT mandate; it clarifies that those services are not excluded under another type of services provided under the Medicaid program, (i.e. the services are covered if they are determined to be medically necessary). The notice of modification was provided to the plans prior to the plaintiffs initiating their suit. Parties filed cross motions for summary judgment. The federal court granted in part and denied the motion in part, and determined Plaintiffs were prevailing parties for attorneys' fees purposes. In 2017, the State entered into a settlement agreement with the State paying Plaintiffs in the amount of $396,858.

Case 2:
In June 2016, Plaintiffs (elderly spouses) filed a civil rights lawsuit in the U.S.D.C., District of Hawaii, seeking declaratory and injunctive relief to allow them to live in the same care home. The couple are private pay patients who do not receive Medicaid benefits. Plaintiffs challenge the existing state authority that require community care foster family homes (CCFFH) to have a certain number of beds available for Medicaid patients. The CCFFH in which husband resides has three beds, but two are reserved for Medicaid patients. Plaintiffs allege that the law violates their fundamental right to family integrity under the due process clause of the 14th Amendment. Plaintiffs filed a motion for preliminary injunction to allow the wife to live together in the same home as the husband. The court ordered that, among other terms, Plaintiffs would be allowed to live in the same care home pending a decision on the constitutionality of the challenged statutes and rules. In May 2018, the parties settled this case and the State will be pay a settlement amount of $55,000 to Plaintiffs, subject to Legislative approval.

Case 3:
In Aug 2016, Medicaid provider filed appeal in State Circuit Court, challenging DHS' determination that provider was ineligible for enhanced primary care physician payments mandated under the Affordable Care Act. The agency determined that provider did not meet the qualifying requirements and requested

reimbursement for overpayment. The lower court affirmed the agency determination and provider appealed to the state Intermediate Court. The decision on appeal is still pending.

Case 4:
Medicaid applicant appealed DHS' decision denying long term care assistance based upon the individual's countable assets exceeded the maximum amount allowed (assets in the trust). The applicant requested an administrative appeal hearing. In April 2017, the hearing officer issued a decision affirming DHS' denial of the application. In May 2017, the applicant appealed the hearing officer's decision in State Circuit Court. In April 2018, the court reversed the hearing officer's decision in favor of the Medicaid applicant.

Case 5:
Medicaid individual's eligibility was terminated because his income exceeded the federal poverty level. Individual requested an administrative hearing after coverage under the Aged, Blind & Disabled program was terminated, and also requested aid-paid pending appeal. Administrative hearing was in favor of DHS and individual appealed to the State Circuit Court on March 20, 2017. The circuit court appeal hearing was held on October 25, 2017, and the Circuit Court issued its order on March 28, 2017, affirming the administrative hearing in favor of DHS. Individual appealed to the State Intermediate Court of Appeals on May 29, 2018, which appeal is still pending.

Cases 6 and 7 (both cases involve same legal issue and provider, but separate Medicaid applicants):
Nursing facility requested a fair hearing to contest denial of Medicaid coverage for a former patient over 2 years after patient died. DHS dismissed the hearing request because provider was not an authorized representative of the deceased individual. Provider appealed to State Circuit Court in October 2016 and Court issued its order in May 2017, reversing the dismissal and remanding the matter for an administrative hearing on the issue of whether provider had standing.

Demonstration Programmatic Information Specific to

QUEST Expanded Demonstration

QUEST Integration and Fee-For-Service (FFS) Concerns

HCSB Member Grievance

During FFY 2017, the HCSB continued to handle incoming calls. The clerical staff take the basic contact information and assign each call to one of the social workers. MQD tracks all of the calls and resolutions. If the client call is an enrollment issue (i.e., request to change health plan), then the HCSB staff will refer such telephone call to the Customer Service Branch (CSB) which will work with the client to resolve the issue(s).

During the FFY 2017, the HCSB staff, as well as other MQD staff, processed approximately 107 member grievance calls.

Member Grievance Phone Calls Received by HCSB

Period		Member
FFY 17	10/1/16 – 9/30/17	107

FFS Consumer Issues

MQD customer call center staff handles health plan enrollment, address change, new born add-ons, plan-to-plan changes, annual plan changes, and any plan enrollment related calls.

Provider Interaction

The MQD and the QI health plans continue to meet as issues occur and also maintain the monthly health plan meeting. The meetings with these agencies are focused around continually improving and modifying processes within the health plans related to HCBS.

MQD also meets with the Community Care Foster Home providers to discuss the new home and community based rules. A health plan HCBS training was held in May 2017.

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

The MQD started the provider enrollment validation in June 2017. The provider call volume and email inquiries had increased due to this project. Due to the large volume and limited resources, the provider enrollment validation is still in progress.

Appeals

During the demonstration year 23, the HCSB processed 26 appeals (see table to below). All of these appeals were appealing the health plans decision to reduce or deny services. In these appeals, the hearing officer felt that the actions taken by the health plan were not appropriate (i.e., the appeal was overturned) in 2 of the 10 appeals (20%). The hearing officer felt that the actions taken by the health plan were appropriate (i.e., the appeal was upheld) in 8 of the 10 appeals (80%). In addition, 16 of the 26 appeals through administrative resolution were withdrawn or dismissed because MQD did not agree with the health plan's denial or reduction or the member had not gone through the health plan appeal process first. In these situations, through MQD's intervention, the beneficiaries received the services that they had submitted the appeal for initially.

Appeal Category	#
Submitted	26
DHS resolved with health plan in member's favor prior to going to hearing	16
Hearings	
Resolution in DHS favor	8
Resolution in Member's favor	2

Types of Appeals	#
Medical	6
LTSS	9
Medications	3
ABA Services	4
Reimbursements	5
Others: Home Mod, DME, OT/PT	3

Enrollment of Individuals

The DHS enrolled approximately 41,625 members from October 1, 2016 to September 30, 2017. Of this group, 1,149 chose their health plan when they became eligible, 10,215 changed their health plan after being auto-assigned.

In addition, DHS had 714 plan-to-plan changes from October 1, 2016 to September 30, 2017. 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, 42 individuals in the QUEST Integration program changed their health plan during days 61 to 90 after a confirmation notice was issued.

	#
Individuals who chose a health plan when they became eligible	1,149
Individuals who changed their health plan after being auto-assigned	10,215
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	714
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	42

Behavioral Health Programs Administered by the DOH and DHS

MQD has approximately 5,000 individuals in the Community Care Services (CCS) program. Individuals in 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 Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (20). The information provided in the table below identifies the approximate number of Medicaid beneficiaries that each program continued to provide services to during the FFY 2017.

Program	As of September 30, 2017
Adult Mental Health Division (AMHD/DOH)	158
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,073
Community Care Services (CCS/DHS)	4,977

Reporting

The MQD receives reports consistent with the reporting requirement in the QI RFP. MQD staff review quarterly and annual reports for compliance with the QI program.

The MQD receives a monthly Dashboard report for the QI program. The Dashboard contains information on member and provider demographics, call center statistics, claims processing, complaints from both members and providers, and utilization data.

In addition, the MQD also created a Public Summary Report to share health plan information, including enrollment, utilization, appeal/grievance, service coordination and more, in a graphic visual aid report with the public.

Dashboard compilations constituting the FFY 2017 provided with this report as Attachments C and D.

Annual Plan Change

During QI Annual Plan Change (APC) in October 2016, individuals chose a new health plan that went into effect on January 1, 2017.

Annual Plan Change for QI October 2016	
	# of health plan changes (loss to plan)
AlohaCare	906
HMSA	4,679
Kaiser	0
‘Ohana	242
United	823
Total	6,650

Home and Community Based Services (HCBS) Waiting List

The QI health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

MQD monitors the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) are required. During the FFY17, the monthly average of beneficiaries requiring LTSS was approximately 6,719. Since the start of the program, the monthly average of beneficiaries receiving LTSS increased by approximately 35.7% for FFY17. The HCBS absorbed those increases, versus the nursing facility services. Since the program inception, the nursing facility services decreased by approximately 18.0% for FFY17.

At the start of the program, beneficiaries receiving HCBS was 42.6% of all beneficiaries receiving LTSS. This number increased to 65.4% for FFY17.

	2/1/09	FFY17, mo av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in FFY17
HCBS	2,110	4,391	108.1%↑	42.6%	65.4%
NF	2,840	2,328	18.0%↓	57.4%	34.6%
Total	4,950	6,719	35.7%↑		

Status of the Demonstration Evaluation

MQD submitted its QI 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. After a Demonstration Evaluation follow-up call that occurred on April 20, 2016, the MQD submitted on April 22, 2016 the quality measures/quality monitoring/quality projects related to the HCBS/LTSS populations that have occurred recently. The MQD then received feedback from CMS on March 10, 2017 and subsequently submitted a modified Demonstration Evaluation Design back to CMS on June 16, 2017. As of the end of the fourth quarter of FFY17, there were no updates to report.

Tables

Table 1A - Enrollment Counts from October 2016 to September 2017

QUEST Integration			
	October 2016	**September 2017**	**Percent Change**
Children	119,290	116,101	-2.67%
CHIP	23,852	24,678	3.46%
Current & Former Foster Care	5,985	6,016	0.52%
Pregnant Women	40,391	39,126	-3.13%
Low Income Adults	115,507	120,703	4.50%
Medical Assistance ABD	49,259	49,720	0.94%
State Funded ABD	2,245	2,569	14.43%
BHH	0	0	0.00%
Others	97	117	20.62%
Total	356,626	359,030	**0.67%**

Table 1B – Enrollment counts – FFS & Medicare Sharing Programs

	October 2016	September 2017	Percent Change
FFS	169	111	-34.3%
Medicare Savings	3,960	4,064	2.6%
Total	4,129	4,175	1.1%

Table 2A - Benefits for QUEST Integration

Cognitive rehabilitation services
Durable medical equipment and medical supplies
Emergency and Post Stabilization services
Family planning services
Home health services
Hospice services
Inpatient hospital services for medical, surgical, psychiatric, and maternity/newborn care
Maternity services
Other practitioner services;
Outpatient hospital services
Personal assistance services - Level I
Physician services
Prescription drugs
Preventive services
Radiology/laboratory/other diagnostic services
Rehabilitation services
Smoking Cessation
Sterilizations and hysterectomies
Transportation services
Urgent care services
Vision and hearing services
Inpatient psychiatric hospitalizations
Ambulatory mental health services and crisis management
Medications and medication management
Psychiatric or psychological evaluation and treatment
Medically necessary alcohol and chemical dependency services
Methadone management services
Intensive Care Coordination/Case Management
Partial hospitalization or intensive outpatient hospitalization

Table 2B - Long-Term Care Services

Home and Community Based Services:
Adult day care
Adult day health
Assisted living services
Attendant care
Community Care Management Agency (CCMA) services
Community Care Foster Family Home (CCFFH) services
Counseling and training
Environmental accessibility adaptations
Home delivered meals
Home maintenance
Moving assistance
Non-medical transportation;
Personal assistance services – Level I and Level II
Personal Emergency Response Systems (PERS)
Private duty nursing
Residential care
Respite care
Specialized medical equipment and supplies
Institutional Services:
Nursing Facility services

Table 2C - Fee-For-Service Benefits

State of Hawaii Organ and Tissue Transplant
Dental

Table 3 - Carve-Out Services

The following additional carve-out services are available to Medicaid beneficiaries outside of the QI program.

Adult Mental Health Division
Child and Adolescent Mental Health Division
Community Care Services (Behavioral Health program administered by DHS)
Dental Services
Developmental Disabilities/Intellectual Disabilities (DD/ID) 1915(c) waiver
School Based Services
State of Hawaii Organ Transplant Program (SHOTT)
Vaccines for Children
Zero to Three (Early Intervention)

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