

## **Hawaii QUEST Integration**

### **Section 1115 Quarterly Report**

**Submitted:** May 5, 2017 (and again on 02/13/18 via CMS.gov)

#### **Demonstration/Quarter Reporting Period:**

**Demonstration Year:** 23 (10/1/2016-9/30/2017)

**Federal Fiscal Quarter:** 1/2017 (10/1/2016-12/31/2016)

**State Fiscal Quarter:** 2/2017 (10/1/2016-12/31/2016)

**Calendar Year:** 4/2016 (10/1/2016-12/31/2016)

### **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. 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 2016 to December 2016.

<b>Medicaid Eligibility Groups</b>	<b>FPL Level and/or other qualifying Criteria</b>	<b>Member Months 10/2016-12/2016</b>	<b>Unduplicated Members 10/2016-12/2016</b>
<b>Mandatory State Plan Groups</b>			
State Plan Children	State Plan Children	373,450	119,471
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	123,279	39,270
Aged	Aged w/Medicare Aged w/o Medicare	78,538	26,269
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	78,8381	26,066
Expansion State Adults	Expansion State Adults	287,205	92,143
Newly Eligible Adults	Newly Eligible Adults	65,542	20,880
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,213	
Medically Needy Adults	Medically Needy Adults		
Demonstration Eligible Adults	Demonstration Eligible Adults		
Demonstration Eligible Children	Demonstration Eligible Children		
VIII-Like Group	VIII-Like Group		
<b>Total</b>		1,008,065	324,099

<b>State Reported Enrollment in the Demonstration</b>	<b>Current Enrollees</b>
Title XIX funded State Plan	231,956
Title XXI funded State Plan	27,481
Title XIX funded Expansion	92,143
Enrollment current as of	12/31/2016

**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.

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. HCOB collaborated with Federally Qualified Health Centers (FQHCs) and contracted Navigator organizations to focus 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 homelessness, 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. HCOB also reviewed and determined applicants' eligibility for the State of Hawaii's Premium Assistance Program (PAP). This program provides premium assistance to individuals who meet all four criteria: 1) Individual was deemed ineligible for Medicaid due to citizenship, 2) Individual's household is below 100% of the FPL, 3) Individual selected a Silver level plan on the Marketplace, and 4) Individual elected to use 100% of the APTC awarded toward their monthly premiums. The PAP program is an innovative approach Hawai'i uses to help those who are living in poverty gain access to the benefits of health insurance by paying for the remaining portion of a PAP qualified individual's premium not covered by APTC. This expanded assistance is vital to meeting the expectations of the ACA that require individuals without qualified exemptions be insured.

### **Operational/Policy Developments/Issues**

During the first quarter of FFY17, 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, and have since moved from transition-centric activities to on-going contract monitoring activities.

### **Submission of HCBS Settings Rule Statewide Transition Plan**

Based on CMS feedback provided on August 30, 2016, MQD updated the Statewide Transition Plan and resubmitted the plan on November 8, 2016. The CMS recommended changes did not require MQD to hold a 30-day public comment period before resubmission. MQD continues to hold monthly meetings with the My Choice My Way advisory group to discuss the implementation of the transition plan. Bi-annual public information sessions are held to provide updates regarding the transition plan and

guidance on the HCBS requirements. Information provided to the public may be in person, webinar, or written as stated in the transition plan. The next information session is scheduled for January 2017.

**Expenditure Containment Initiatives**

No expenditure containment planned.

**Financial/Budget Neutrality Development/Issues**

The budget neutrality for first quarter of FFY17 was already submitted.

**Member Month Reporting**

**A. For Use in Budget Neutrality Calculations**

<b>Without Waiver Eligibility Group</b>	<b>Month 1 (October 2016)</b>	<b>Month 2 (November 2016)</b>	<b>Month 3 (December 2016)</b>	<b>Total for Quarter Ending 12/2016</b>
EG 1-Children	125,393	124,860	124,410	374,663
EG 2-Adults	41,341	41,054	40,884	123,279
EG 3-Aged	25,820	26,208	26,510	78,538
EG 4-Blind/Disabled	26,092	26,378	26,368	78,838
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	116,870	116,438	119,439	352,747

This member month reporting related to the budget neutrality for first quarter of FFY17 was submitted.

**B. For Informational Purposes Only**

<b>With Waiver Eligibility Group</b>	<b>Month 1 (October 2016)</b>	<b>Month 2 (November 2016)</b>	<b>Month 3 (December 2016)</b>	<b>Total for Quarter Ending 12/2016</b>
State Plan Children	124,990	124,453	124,007	373,450
State Plan Adults	41,341	41,054	40,884	123,279
Aged	25,820	26,208	26,510	78,538
Blind or Disabled	26,092	26,378	26,368	78,838
Expansion State Adults	95,512	94,833	96,860	287,205
Newly Eligible Adults	21,358	21,605	22,579	65,542
Optional State Plan Children				
Foster Care Children, 19-20 years old	403	407	403	1,213
Medically Needy Adults				
Demonstration Eligible Adults	0	0	0	0
Demonstration				

<b>With Waiver Eligibility Group</b>	<b>Month 1 (October 2016)</b>	<b>Month 2 (November 2016)</b>	<b>Month 3 (December 2016)</b>	<b>Total for Quarter Ending 12/2016</b>
Eligible Children				
VIII-Like Group	0	0	0	0

This member month reporting related to the budget neutrality for first quarter of FFY17 was submitted.

**QUEST Integration Consumer Issues**

**HCSB Grievance**

During the first quarter of FFY17, the HCSB continued to handle incoming calls. 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 resolutions. If the clients’ call is an enrollment issue (i.e., request to change health plan), then the HCSB staff will refer those telephone calls to Customer Service Branch (CSB) that will work with the client to resolve their issues.

	<b>Member</b>	<b>Provider</b>
October 2016	8	0
November 2016	8	0
December 2016	6	0
<b>Total</b>	<b>22</b>	<b>0</b>

During the first quarter of FFY17, the HCSB staff, as well as other MQD staff, processed approximately 22 member calls.

**HCSB Appeals**

The HCSB received six (6) member appeals in the first quarter of FFY17. DHS resolved two (2) of the appeals with the health plans in the member’s favor prior to going to hearing. Of the six (6) appeals filed, the types of appeals were medical (4), medication (1) and LTSS (1).

<b>Types of Member Appeals</b>	<b>#</b>
Medical	4
LTSS	1
Other: Medications	1

<b>Appeals</b>	<b>Member #</b>
Submitted	6
DHS resolved with health plan or DOH-DDD in member’s favor prior to going to hearing	2
Member withdrew hearing request	0
Resolution in DHS favor	3
Resolution in Member’s favor	1
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 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 8,667 members during the first quarter of FFY17. Of this group, 172 chose their health plan when they became eligible, 2,793 changed their health plan after being auto-assigned.

In addition, DHS had 326 plan-to-plan changes during the first quarter of FFY17. 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, 14 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

	#
Individuals who chose a health plan when they became eligible	172
Individuals who changed their health plan after being auto-assigned	2,793
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 within days 61 to 90 after confirmation notice was issued	14

**Long-Term Services and Supports (LTSS)**

**HCBS Waiting List**

During the first quarter of FFY17, the QI health plans did not have a wait list for HCBS.

**HCBS Expansion and Provider Capacity**

During the first quarter of FFY17, 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 continues to increase. In the first quarter of FFY17, the increase is 34% since the start of the program receiving long-term services and supports. The number of individuals in nursing facilities increased this past quarter. HCBS usage has more than doubled since the start of the bringing the aged, blind, and disabled population into managed care (formerly QUEST Expanded Access (QExA), currently QUEST Integration). Nursing facility services have decreased by approximately 17% since program inception.

The number of beneficiaries receiving HCBS has increased by approximately 102% since program inception. At the start of the program, beneficiaries receiving HCBS was 42.6% of all beneficiaries

receiving long-term care services. This number has increased to 64.4% since the start of the program.

	2/1/09	4rd Qtr FFY16, av	1st Qtr FFY17, av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 1st Qtr FFY17
HCBS	2,110	4,605	4270	102.4%↑	42.6%	64.4%
NF	2,840	2,118	2359	16.9%↓	57.4%	35.6%
Total	4,950	6,723	6629	33.9%		

### **Behavioral Health Programs Administered by the DOH and DHS**

Individuals in Community Care Services (CCS) have a Serious Mental Illness (SMI) diagnosis or Serious and Persistent Mental Illness (SPMI) 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.

Program	#
Adult Mental Health Division (AMHD/DOH)	172
Early Intervention Program (EIP/DOH)	681
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,142
Community Care Services (CCS/DHS)	5,189

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 681 children during the first quarter FFY17.

The Child and Adolescent Mental Health Division (CAMHD) under the DOH provides behavioral health services to children from ages three (3) through twenty (21). CAMHD is providing services to approximately 1,142 children during the first quarter FFY17.

### **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. As the QI program matures, the MQD has begun more traditional and on-going contract monitoring and oversight activities.

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 listed 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.

## **3. Updating of the Health & Functional Assessment (HFA) & Service Plan (SP) Forms**

MQD staff is in the final stages of updating the HFA and SP forms. We have taken feedback from the service coordinators, health plans, and members during the Ride-Along program mentioned above, and used this feedback to revise and/or rewrite both of these forms. The main goals of these changes were to decrease the time needed to conduct the HFAs by streamlining the HFA, and to make changes so that the HFA and SP are more Person-Centered in the framing and language used. Plans are to complete these changes sometime in the next quarter.

## **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. In a letter from CMS dated July 8, 2016, Hawaii received final approval of its Quality Strategy from CMS.

### *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, in collaboration with MQD performed the following activities this quarter:



1. Validation of Performance Improvement Projects (PIPS) –
  - Provided pre-validation review feedback to the health plans and the MQD (for review) by 9/1/16.
  - Drafted the PIP reports for the 2016 validation year.
  - Sent Module 4 pre-validation review feedback to the health plans.
  - Finalized the reports and distributed them on 9/26/16.
  - HSAG provided PIP Module 4 technical assistance to some of the health plans.
  - HSAG and the MQD had a conference call to discuss potential 2017 PIP topics on 12/15/16.
  
2. Healthcare Effectiveness Data and Information Set (HEDIS) –
  - HSAG and MQD scheduled call to discuss HEDIS performance measures for 2017.
  - Draft HEDIS 2017 work plan submitted to the MQD for review.
  - MQD reviewed and approved the HEDIS 2017 work plan.
  - Continued discussion between HSAG and MQD regarding the HEDIS 2017 audit scope (i.e., reporting requirements and measure lists).
  - Forwarded the HEDIS 2017 Roadmap to the health plans on 10/12/16.
  - MQD finalized list of measures for validation for HEDIS 2017 on 11/16/16.
  - Provided technical assistance and participated in measure selection call with the MQD on 11/10/16.
  - CAHPS sample frame validation letters were sent to the health plans on 11/22/16.
  - HEDIS 2017 document request packet for reviewed and approved by MQD by 11/30/16.
  - Forwarded the HEDIS 2017 document request packet to all HI QI health plans for completion on 12/02/2016.
  - MQD sent source code for the CAHPS sample frame received on 12/14/2016.
  - Source code review findings forwarded to the MQD on 12/19/2016.
  - Questions with regards to measure reporting received from the health plans forwarded to the MQD for clarification and confirmation.
  - On-site visit dates confirmed with all HI QI health plans.
  
3. Compliance Monitoring –
  - Resolved any health plan questions/issues with reports.
  - Submitted final 2016 Compliance Review reports and corrective action plan (CAP) templates by 9/9/16.
    - Provided assistance/clarification to health plans regarding CAP submissions.
  - Resolved any health plan questions/issues with CAP Templates.
    - Received initial CAPS from health plans by 10/10/16.
    - Reviewed and evaluated the sufficiency of the health plans' CAPS prepared in response to HSAG's compliance review findings and recommendations.
  - Forwarded to MQD for review and approval.
    - The CAPs for all health plans were approved for implementation by 10/28/16.
  - By 10/28/16, prepared and delivered the HSAG reports of CAP evaluation to each of the health plans to begin their implementation of the CAPs.
  - Received approval of 2017 EQRO and PRO work plans.

- Requested and received health plan documentation (dates were determined by date of completion of improvement activities as listed in the approved CAPs).
  - Conducted document review and, as indicated telephonic interviews and/or record reviews.
  - Prepared and delivered HSAG reports of evaluation of compliance to the MQD and the health plans.
    - Process was ongoing during November and December.
  - Requested and received health plan documentation (dates were determined by date of completion of improvement activities as listed in the approved CAPs).
  - Conducted document review and, as indicated telephonic interviews and/or record reviews.
  - Prepared and delivered HSAG reports on updates of evaluation of compliance to the MQD and the health plans.
  - Developed and submitted to the MQD the 2017 Compliance Review Tools on 12/09/16.
  - Finalized the 2017 compliance review on-site schedule with the health plans and the MQD.
4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) –
- MQD sent HSAG feedback on the draft reports on 9/6/16.
  - HSAG incorporated the MQD’s feedback into final reports on 9/15/16.
  - Mailed hard copies of the Final 2016 HI CAHPS Reports to the MQD on 9/22/16.
  - HSAG attended NCQA HEDIS/CAHPS 2017 survey vendor training on 10/18/16.
  - HSAG prepared presentation of 2016 CAHPS results and presented results on 10/25/16.
  - HSAG submitted Final timeline for 2017 CAHPS activities on 10/26/16.
  - HSAG sent a survey notification letter with data submission and administrative requirements to the MQD, including supplemental questions on 11/21/16.
  - HSAG submitted administrative forms and associated documents to the MQD on 11/21/16.
  - MQD sent HSAG completed administrative forms, including letterhead, logo, and signature on 12/13/16.
  - MQD approved supplemental questions to include in the 2017 survey on 12/13/16.
  - MQD approved language block text for cover letters on 12/22/16.
5. Provider Survey –
- Mailed second provider surveys and cover letters to all non-respondents on 9/13/16.
  - Submitted weekly disposition reports to the MQD during survey administration.
  - Survey field officially closed on 10/11/16.
  - Received data files from Subcontractor on 10/26/16.
  - HSAG completed survey data analysis on 11/21/16.
  - HSAG incorporated analysis into Draft Provider Survey Report.
  - HSAG performed an internal review and validation of the Draft Provider Survey Report on 11/29/16.
  - MQD reviewed and approved the Draft Provider Survey Report on 12/20/16.
  - HSAG submitted the Final Provider Survey Report to the MQD on 12/29/16.
6. Annual Technical Report –
- Template updated and distributed internally in HSAG.

- Received and incorporated updates from the health plans regarding their 2015 Technical Report Recommendations into the 2016 report.
  - MQD worked with HSAG internal departments on report development.
7. Quality Strategy-
- Received notification from CMS that our Quality Strategy for the Hawaii's section 1115 demonstration, entitled QUEST integration (Project Number 11-W-00001/9), written in December 2014, was finally approved in early July 2016.
  - Quality Strategy posted on MQD website.
  - Forwarded to HSAG for review for their reference.
8. Quality Assurance Performance Improvement (QAPI) Reports-  
Reports currently being reviewed by MQD in order that they were received and reviews periodically paused due to other pressing reports or activities.
9. Quality Compass-
- MQD had ongoing discussions with NCQA to request for extended data usage approval.
  - NCQA granted MQD and HSAG one last year to continue to report as we have been doing in the past.
  - However, for next year, MQD is limited to using only up to thirty (30) measures or use a proxy (such as up and down arrows) and be silent on the actual score. Or, two separate reports can be produced, one with means and percentiles for the MQD and the health plans and one using proxies for the published report.
10. Technical Assistance to the MQD-
- On 10/4/16 HSAG and MQD discussed HEDIS 2017 measures and P4P measures.
  - HSAG provided analysis of P4P program recommendations from the health plans on 10/13/16.
  - HSAG and the MQD met to discuss list of recommended measures.
  - The MQD provided a list of potential P4P measures that have been discussed with the health plan.
  - HSAG provided an analysis of the P4P measures and respond to the MQD with comments and recommendations on 11/3/16.
  - MQD finalized HEDIS 2017 and P4P measures.

### **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. 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. As of the 1st quarter in FFY 2017, the MQD is still awaiting feedback from CMS.

**Enclosures/Attachments**

Attachment A QUEST Integration Dashboard for October 2016 – December 2016

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**Date Submitted to CMS**

- May 5, 2017
- December 15, 2017 (via email)
- April 26, 2018 (via PMDA/CMA)