Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: December 15, 2017 (via email)

Demonstration/Quarter Reporting Period:
Demonstration Year: 23 (10/1/2016-9/30/2017)
Federal Fiscal Quarter: 2/2017 (1/1/2017-3/31/2017)
State Fiscal Quarter: 3/2017 (1/1/2017-3/31/2017)
Calendar Year: 2017 (1/1/2017-12/31/2017)

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 January 2017 to March 2017.

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 01/2017-03/2017	Unduplicated Members 01/2017-03/2017
Mandatory State Plan Groups			
State Plan Children	State Plan Children	371,369	119,192
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	121,966	38,990
Aged	Aged w/Medicare Aged w/o Medicare	79,611	26,545
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	78,027	25,895
Expansion State Adults	Expansion State Adults	294,317	94,440
Newly Eligible Adults	Newly Eligible Adults	69,434	22,141
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,263	
Medically Needy Adults	Medically Needy Adults		
Demonstration Eligible Adults	Demonstration Eligible Adults		
Demonstration Eligible Children	Demonstration Eligible Children		
VIII-Like Group	VIII-Like Group		
Total		1,015,987	327,203

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	210,622
Title XXI funded State Plan	26,845
Title XIX funded Expansion	116,581
Enrollment current as of	03/31/2017

Outreach/Innovative Activities

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

The Health Care Outreach Branch (HCOB) continues to collaborate with Federally Qualified Health Centers (FQHCs) and contracted Kōkua Services 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) Individuals 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 second 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

The Statewide Transition Plan received initial approval on January 13, 2017. To receive final approval the state will need to review the CMS feedback and comments. 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 July 2017.

Expenditure Containment Initiatives

No expenditure containment planned.

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (January 2017)	Month 2 (February 2017)	Month 3 (March 2017)	Total for Quarter Ending 03/2017
EG 1-Children	123,205	124,790	124,637	372,632
EG 2-Adults	40,978	40,647	40,341	121,966
EG 3-Aged	26,412	26,570	26,629	79,611
EG 4-Blind/Disabled	26,209	25,973	25,845	78,027
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	120,680	121,839	121,232	363,751

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

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (January 2017)	Month 2 (February 2017)	Month 3 (March 2017)	Total for Quarter Ending 03/2017
State Plan Children	122,779	124,374	124,216	371,369
State Plan Adults	40,978	40,647	40,341	121,966
Aged	26,412	26,570	26,629	79,611
Blind or Disabled	26,209	25,973	25,845	78,027
Expansion State Adults	97,379	98,766	98,172	294,317
Newly Eligible Adults	23,301	23,073	23,060	69,434
Optional State Plan Children				
Foster Care Children, 19-20 years old	426	416	421	1,263
Medically Needy Adults				
Demonstration	0	0	0	0

With Waiver Eligibility Group	Month 1 (January 2017)	Month 2 (February 2017)	Month 3 (March 2017)	Total for Quarter Ending 03/2017
Eligible Adults				
Demonstration Eligible Children				
VIII-Like Group	0	0	0	0

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

QUEST Integration Consumer Issues

HCSB Grievance

During the second 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.

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During the second quarter of FFY17, the HCSB staff, as well as other MQD staff, processed approximately 63 member calls.

	Member	Provider
January 2017	28	1
February 2017	18	0
March 2017	17	1
Total	63	0

HCSB Appeals

The HCSB received five (5 member appeals in the first quarter of FFY17.
Of the five (5) appeals filed, the types of appeals were medication (1), LTSS (3), and travel reimbursement (1).

Types of Member Appeals	#
Medical	0
LTSS	3
Other: Medications	1
Travel reimbursement	1

Appeals	Member #
Submitted	5
DHS resolved with health plan or DOH-DDD in member's favor prior to going to hearing	0
Member withdrew hearing request	0
Resolution in DHS favor	4
Resolution in Member's favor	0
Still awaiting resolution	1

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 10599 members during the second quarter of FFY17. Of this group, 155 chose their health plan when they became eligible, 2625 changed their health plan after being auto-assigned.

In addition, DHS had 278 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, 11 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	155
Individuals who changed their health plan after being auto-assigned	2625
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	278
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	11

Long-Term Services and Supports (LTSS)

HCBS Waiting List

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

HCBS Expansion and Provider Capacity

During the second 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 17.7% since program inception.

The number of beneficiaries receiving HCBS has increased by approximately 207.5% 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 65.2% 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	4379	207.5%↑	42.6%	65.2%
NF	2,840	2,118	2338	17.7%↓	57.4%	34.8%
Total	4,950	6,723	6717	135.6%		

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)	169
Early Intervention Program (EIP/DOH)	636
Child and Adolescent Mental Health Division (CAMHD/DOH)	1130
Community Care Services (CCS/DHS)	5079

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 636 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 1130 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 socials 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) –
   - HSAG and the MQD had a follow-up conference call to discuss the 2017 PIP topics on 01/23/17.
   - Reminder e-mails to the health plans regarding the upcoming Module 4 and 5 submissions due in February 2017.
   - Provided PIP technical assistance to one health plan by e-mail.
   - HSAG received notification from the MQD of the 2017 PIP topics on 02/14/17.
   - HSAG reviewed the MQD's 2017 PIP topics; submitted feedback to the MQD on 02/16/17.
   - Reviewed the Module 4 and 5 PIP submissions from all health plans on 02/17/17.
   - HSAG provided the 2017 PIP training on 03/30/17.

2. Healthcare Effectiveness Data and Information Set (HEDIS) –
   - Completed CAHPS sample frame validation for sample frames for all five (5) health plans.
   - Provided locked sample frames to be made available to the CAHPS survey vendor.
   - Updated the HOQ with the supports reporting designation for all five (5) health plans.
   - Received completed Roadmaps from all five (5) health plans.
   - Sent updated specifications for the Follow-Up with Assigned PCP After Hospitalization for Mental Illness (FUP) measure.
   - Initiated Roadmap review for MRRV.
   - Completed vendor review of MRR vendors for the five (5) health plans.
   - Completed source code review walkthrough with Verscend for state specific measures.
   - Scheduled pre-onsite kick-off calls with all five (5) health plans.
   - Sent preliminary supplemental data reports to the five (5) health plans.
   - Initiated review of non-standard supplemental data.
   - Initiated the convenience sample process with all five (5) health plans.
   - Received corrected rates from three (3) health plans for the state Plan All-Cause Readmission measure.
   - HSAG submitted HEDIS 2015 (CY 2014) weighted rate spreadsheets to the MQD.
   - Finalized approval of all standard and non-standard supplemental data and sent a final supplemental data review report to the health plans on 03/31/17.
   - Conducted pre-onsite kick-off calls with the health plans.
   - Continued source code review for the non-HEDIS State-defined measures.
   - Submitted preliminary IS tracking grids to the health plans.
   - Ongoing technical assistance for the MQD and health plans by HSAG.

3. Compliance Monitoring –
   - Requested and received health plan documentation (dates were determined by date of completion of improvement activities as listed in the approved 2016 Compliance Monitoring Review CAPs).
   - Conducted document review and, as needed telephonic interviews and/or record reviews.
   - Prepared and delivered HSAG evaluations and recommendations on approving or denying the health plan responses pertaining to the 2016 Compliance Monitoring review CAPs.
     - Process will continue into the 1st quarter of 2017
   - HSAG worked with the MQD to finalize the 2017 Compliance Review Tools by 01/31/17.
     - Held weekly meetings with the MQD starting 01/13/17.
     - Targeting to have final MCO and BHO evaluation tools by 2/15/2017.
   - On 01/27/17, drafted and sent to each health plan and CCS health plan a letter describing HSAG's desk and on-site review processes, schedule, agenda, scope of review and the date/time for technical assistance session (webinar) on 03/17/17.
   - Prepared initial drafts of the desk review packs of material for requesting the health plans' information and documentation as well as prepared the FTP site with the folders.
     - Final documents posted to the HSAG FTP site on 03/1/17.
   - Notified health plans that all CAPs from 2016 Compliance Monitoring Reviews were closed on 02/07/17.
   - HSAG submitted D2 version of the health plan and BHO compliance review tools to the MQD on 02/16/17; approved by the MQD on 02/17/17.
   - Submitted proposed on-site review agendas to the MQD on 02/17/17 and received list of MQD's on-site attendees.
   - Prepared desk review packets for health plans containing on-site agenda, compliance review tool, and desk review form.
   - Posted compliance review tools, desk review form, and on-site agendas to the health plans on 03/01/17.
   - Conducted information session with CCS and QI plans on 03/17/17.
   - Compiled answers to questions raised by CCS and QI plans during information sessions and based on their review of the 2017 compliance tools.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) –
   - HSAG submitted supplemental questions to NCQA (chosen by MQD) for approval on 01/05/17.
   - HSAG received NCQA approval on CAHPS 2017 mail materials on 01/06/17.
   - HSAG submitted 2017 CAHPS survey timeline to MQD on 01/11/17.
   - HSAG received MQD's approval of 2017 CAHPS survey timeline on 01/12/17.
   - HSAG received sample frame files from MQD on 01/12/17.
   - HSAG received NCQA approval on the supplemental questions for 2017 CAHPS survey on 01/23/17.
   - HEDIS auditors completed validation of the sample frame files on 01/26/17.
   - Sent sample frame files to subcontractor on 02/03/17.
   - Translated NCQA-approved survey mail materials into predetermined non-English languages on 02/06/17.

- Received confirmation from the MQD that "Subscriber ID" can be considered "Member ID" on 02/10/17.
- Selected survey samples on 02/16/17.
- Ran survey samples through the U.S. Postal Service's National Changes of Address system on 02/21/17.
- Printed and produced survey packets on 02/24/17.
- Mailed first questionnaires and cover letters on 02/24/17.
- Mailed first postcard reminders to non-respondents on 03/03/17.
- Mailed second questionnaires and cover letters to non-respondents on 03/24/17.
- Mailed second postcard reminders to non-respondents on 03/31/17.
- Sent weekly disposition reports to the MQD.

5. Provider Survey –

None at this time. All activities were completed for this time.

6. Annual Technical Report –
   - HSAG submitted the draft EQR TR report to the MQD for review on 01/13/17.
   - HSAG responded to MQD questions and concerns to meet the 02/28/17 deadline for the final technical report.
   - Submitted revised CY 2017 timeline to accommodate longer time frame for HP follow-up documentation submission on 02/20/17.
   - HSAG received the MQD's approval on revised CY 2017 timeline on 02/21/17.
   - Submitted proposed revisions to 2016 EQR technical report addressing the MQD's feedback on 02/20/17.
   - Received the MQD's approval on proposed revisions to 2016 EQR technical report on 02/21/17.
   - Submitted D2 version of 2016 EQR technical report to the MQD on 02/24/17, and received approval to finalize draft.
   - Posted F1 version of 2016 EQR technical report to the MQD on 03/01/17.
   - Mailed hard copies of the 2016 EQR technical report to the MQD on 03/07/17.
   - Submitted the 2016 EQR technical report to the CCS and QI plans on 03/17/17.
   - Prepare *Follow-up to Prior EQRO Recommendations* document to support health plan documentation activities and interventions.

7. Technical Assistance to the MQD-
   - HSAG continued to support the MQD's efforts to finalize its P4P program.
   - The MQD requested technical assistance (TA) developing specifications a measure (i.e., Potentially Avoidable ED Visits) for the hospital P4P program on 02/10/17.
   - The MQD requested TA developing a sound benchmark for the Plan All-Cause Readmissions (PCR) measure.
   - Scheduled a meeting with the MQD to review TA requests for 03/03/17.
   - Submitted technical specifications for ED Visits for Ambulatory Care-Sensitive Conditions (NYU) measure to the MQD on 03/23/17.
   - Compiled information for developing example of proposed benchmark for the PCR measure.

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. The MQD then received feedback from CMS on March 10, 2017, and is preparing an updated Demonstration Evaluation for submission to CMS.

Enclosures/Attachments

Attachment A QUEST Integration Dashboard for January 2017 – March 2017

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- December 15, 2017 (via email)
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