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

Demonstration/Quarter Reporting Period

Demonstration Year:	24th Year	(10/1/2017 - 9/30/2018)
Federal Fiscal Quarter:	FFY 2018 2nd Q.	(01/01/2018 - 03/31/2018)
State Fiscal Quarter:	SFY 2018 3rd Q.	(01/01/2018 - 03/31/2018)
Calendar Year:	CY 2018 1st Q.	(01/01/2018 - 03/31/2018)

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, 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. 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 2018 through March 2018.

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	Member Months 01/2018 - 03/2018	Unduplicated Members 01/2018 - 03/2018
Mandatory State Plan Groups			
State Plan Children	State Plan Children	363,117	117,887
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/COFA	116,468	37,342
Aged	Aged w/Medicare Aged w/o Medicare	82,351	27,379
Blind of Disabled	B/D w/Medicare B/D w/o Medicare BCCTP	75,280	24,964
Expansion State Adults	Expansion State Adults	301,698	97,018
Newly Eligible Adults	Newly Eligible Adults	70,978	22,623
Optional State Plan Children	Optional State Plan Children		
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,268	
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		1,011,160	327,313

State Reported Enrollment in the Demonstration	Current Enrollees
Title XIX funded State Plan	207,672
Title XXI funded State Plan	27,852
Title XIX funded Expansion	119,641
Enrollment current as of	03/31/18

Outreach/Innovative Activities

The DHS continues to focus 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 conduct on-going outreach an education along with providing application assistance for many of the hardest to reach populations. HCOB continues to collaborate 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 Marketplace applications for health insurance if the individual qualified for a Special Enrollment Period. 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 were deemed ineligible for Medicaid due to citizenship; whose households are below 100% of the FPL and who enrolled in a Silver level plan on the Marketplace. 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 the APTC they are eligible for. This expanded assistance is vital to meeting the expectations of the ACA that require individuals without qualified exemptions be insured.

Med-QUEST, HCOB continues to work with the Department of Public Safety (DPS) to ensure we suspend coverage for those that enter incarceration. Additionally, working collaboratively to ensure applications are submitted to Medicaid for those leaving incarceration and if determined eligible they have coverage upon being released from the institution. We are focusing on the max-out population and those being released into programs, assisted by Honolulu County Offender Reentry Program (HCORP).

HCOB continues to work with the Hawaii State Hospital (HSH) to ensure those being admitted to HSH who have active Medicaid coverage, have their case suspended until which time they are released from HSH. HSH will alert MQD of members discharge date and MQD will re-activate Medicaid coverage if the member is still eligible.

Operational/Policy Developments/Issues

During the second quarter of FFY18, MQD continued its monitoring of the QUEST Integration implementation. QUEST Integration (QI) is a melding of both the QUEST and QUEST Expanded Access (QExA) programs. The QI program utilizes a patient-centered approach with provision of services based upon clinical conditions and medical necessity. QUEST Integration combines QUEST and QExA programs into one and eliminates the QUEST-ACE and QUEST-Net programs. In addition, beneficiaries remain with the same health plan upon turning 65 or when changes occur in their health condition. In QI, health plans will provide a full-range of comprehensive benefits including long-term services and supports. The MQD has lowered its ratios for service coordination.

QUEST Integration has five (5) health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, ʻOhana Health Plan, and UnitedHealthcare Community Plan.

Submission of HCBS Settings Rule Statewide Transition Plan

The state received initial approval on January 13, 2017. MQD is working in collaboration with the My Choice My Way advisory group on transition plan updates to achieve final approval. In addition, the state is working on completing the milestones requirement. MQD continues to hold quarterly meetings with the advisory group to discuss the implementation of the transition plan. Information and trainings are provided to the public in person, webinar, or written as stated in the transition plan.

Expenditure Containment Initiatives

No expenditure containment planned.

Financial/Budget Neutrality Development/Issues

The budget neutrality for second quarter of FFY18 was already submitted.

Member Month Reporting

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1 (January 2018)	Month 2 (February 2018)	Month 3 (March 2018)	Total for Quarter Ending 03/2018
EG 1-Children	120,637	122,303	121,445	364,385
EG 2-Adults	38,782	39,162	38,524	116,468
EG 3-Aged	27,315	27,531	27,505	82,351
EG 4-Blind/Disabled	25,018	25,199	25,063	75,280
EG 5-VIII-Like Adults	0	0	0	0
EG 6-VIII Group Combined	124,213	124,399	124,064	372,676

This member month reporting related to the budget neutrality for second quarter of FFY18 was submitted.

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1 (January 2018)	Month 2 (February 2018)	Month 3 (March 2018)	Total for Quarter Ending 03/2018
State Plan Children	120,227	121,876	121,014	363,117
State Plan Adults	38,782	39,162	38,524	116,468
Aged	27,315	27,531	27,505	82,351
Blind or Disabled	25,018	25,199	25,063	75,280
Expansion State Adults	100,400	100,824	100,474	301,698
Newly Eligible Adults	23,813	23,575	23,590	70,978
Optional State Plan Children				
Foster Care Children, 19-20 years old	410	427	431	1,268
Medically Needy Adults				
Demonstration Eligible Adults	0	0	0	0
Demonstration Eligible Children				
VIII-Like Group	0	0	0	0

This member month reporting related to the budget neutrality for second quarter of FFY18 was submitted.

QUEST Integration Consumer Issues

HCSB Grievance

During the second quarter of FFY18, 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 second quarter of FFY18, the HCSB staff, as well as other MQD staff, processed approximately 30 member calls.

Phone Calls Recvd. by HCSB:	**Member Grievance Calls**
January 2018	10
February 2018	13
March 2018	6
Total	29

HCSB Appeals

The HCSB received seven (7) member appeals in the second quarter of FFY18. DHS resolved three (3) of the appeals with the health plans in the member's favor prior to going to hearing.
Of the seven (7) appeals filed, the types of appeals were: four (4) medical; two (2) LTSS; and one (1) other.

Types of Member Appeals	**#**
Medical	4
LTSS	2
Other: Medication	1

Appeals	**Member #**
Submitted	7
DHS resolved with health plan or DOH-DDD in member's favor prior to going to hearing	3
Member withdrew hearing request	0
Resolution in DHS favor	2
Resolution in Member's favor	1
Still awaiting resolution	1

Provider Interaction

Med-QUEST Division and the health plans continue to have two regularly scheduled meetings with providers. One is a monthly meeting with Case Management Agencies. The focus of these meetings is to continually improve and modify health plan processes concerning the delivery of Home and Community Based Services.

In addition, every quarter, the MQD, AMHD and health plans meet with the behavioral health providers that directly serve the CCS population. The focus of these meetings is to address ongoing issues and the 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 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.

Enrollment of Individuals

During the second quarter of FFY18, 326 individuals chose their health plan when they became eligible, 2,172 changed their health plan after being auto-assigned. Also, 8,678 individuals had an initial enrollment which fell within the second quarter of FFY18.

In addition, DHS had 172 plan-to-plan changes during the second quarter of FFY18. 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, 13 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	326
Individuals who changed their health plan after being auto-assigned	2,172
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	172
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	13

Long-Term Services and Supports (LTSS)

HCBS Waiting List

During the second quarter of FFY18, the QI health plans did not have a wait list for HCBS.

HCBS Expansion and Provider Capacity

During the second quarter of FFY18, MQD monitored the number of beneficiaries receiving HCBS when long-term services and supports (LTSS) were required. The number of beneficiaries requiring LTSS has increased slightly from the previous quarter. Also, the second quarter of FFY18, yielded an

increase of 31.7% from the number of beneficiaries receiving long-term services and supports at the start of the program. The number of beneficiaries in nursing facilities increased this reporting quarter from the previous reporting quarter. Still, nursing facility services decreased by 25.6% since the program inception.

The second quarter of FFY18, yielded an increase of 108.8% in the number of beneficiaries receiving HCBS since the program inception. At the start of the program, beneficiaries receiving HCBS was 42.6% of all beneficiaries receiving long-term services and supports. This percentage is at 67.6% in the second quarter of FFY18. Finally, the number of beneficiaries receiving HCBS has slightly increased since the previous reporting period.

	2/1/09	1st Qtr FFY18, mo av	2nd Qtr FFY18, mo av	% change since baseline (2/09)	% of clients at baseline (2/09)	% of clients in 2nd Qtr FFY18
HCBS	2,110	4,384	4,406	108.8%↑	42.6%	67.6%
NF	2,840	2,048	2,112	25.6%↓	57.4%	32.4%
Total	4,950	6,432	6,518	31.7%↑		

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)	148
Early Intervention Program (EIP/DOH)	504
Child and Adolescent Mental Health Division (CAMHD/DOH)	1,108
Community Care Services (CCS/DHS)	4,863

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 504 children during the second quarter FFY18.

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 1,108 children during the second quarter FFY18.

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. **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.

2. **Updating of the Health & Functional Assessment (HFA) & Service Plan (SP) Forms**
   MQD and the health plans collaborated on the final 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. Changes were completed and the health plans have begun using the new forms.

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 (January 2018 to March 2018)

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

1. Validation of Performance Improvement Projects (PIPS) –
   - Finished reviewing the Module 3 initial submissions and provided feedback by 01/05/18.
   - Started receiving and reviewing Module 3 resubmissions.
   - Provided PIP technical assistance to AlohaCare, HMSA, Kaiser, and Ohana.
   - February:
   - Finished reviewing the remaining Module 3 resubmissions and provided feedback.
   - Provided PIP technical assistance to HMSA and Kaiser.
   - March:
   - Finished receiving Module 4 submissions and provided pre-validation review feedback.

2. Healthcare Effectiveness Data and Information Set (HEDIS) –
   Received completed HEDIS 2018 Roadmaps from health plans by 01/31/18.
   - February:
   - Provided specifications for the two-new state specific measures to the health plans.
   - Initiated source code review for the non-HEDIS measures.
   - Provided an extension to plans to submit the source code for the Emergency Department Use without Hospitalization (EDUH) until 03/16/18. Kaiser has requested an extension until 04/13/18.
   - Completed pre-onsite kick off calls with ‘Ohana, UHC and AlohaCare.
   - Initiated supplemental data review with health plans.
   - March:
   - Health plans stopped all non-standard supplemental data collection and entry and uploaded their non-standard supplemental databases containing all member cases to HSAG’s FTP site on 03/01/18.
   - Provided additional guidance to the health plans on 03/19/18 for reporting the Emergency Department Use without Hospitalization (EDHU) measure and an extension for source code submission until 04/13/18. Reviewed and approved ‘Ohana’s source code for the non-HEDIS Follow-Up With a Primary Care Practitioner After Hospitalization for Mental Illness (FUP) and ED Visits for Ambulatory Care-Sensitive Conditions (NYU) measures.
   - Completed pre-onsite kick off calls with Kaiser on 03/20/18 and HMSA on 03/21/18.
   - Completed supplemental data review and provided approval to health plans by 03/30/18.
   - Completed convenience sample over-reads for UHC on 03/16/18, and began convenience sample over-reads for HMSA, Kaiser, and ‘Ohana.

3. Compliance Monitoring –
   Continued review and evaluation of proposed health plan CAPs.
   - February:
   - Continued review and evaluation of proposed health plan CAPs
   - March:
   - Completed review of health plan CAPs; submitted to the MQD for review and approval.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS) –
   - Received sample frame file for the CHIP population from the MQD on 01/08/18.
   - Requested an updated CHIP sample frame file to include members with an age between 0 and 1 on 01/24/18.
   - Followed up with the MQD on the CHIP sample frame file on 01/30/18.
   - Received validated adult sample frame files from HEDIS auditors on 01/31/18.
   - Prepared the survey materials for the 2018 administration.
   - February:
   - Performed translation of NCQA-approved survey mail materials into predetermined non-English languages on 02/05/18.
   - Sent sample frame files to subcontractor on 02/09/18.
   - Selected survey samples on 02/16/18.
   - Survey samples ran through the U.S. Postal Service's National Change of Address (NCOA) system on 02/20/18.
   - Printed and produced survey packets on 02/26/18.
   - Mailed first questionnaires and cover letters to members on 02/26/18.
   - March:
   - Mailed first postcard reminders to non-respondents on 03/05/18.
   - Submitted disposition reports of survey responses throughout survey administration to date.

5. Provider Survey –
   Set up a kick-off meeting with the MQD on 04/06/18 to initiate discussions regarding the Provider Survey activity.

6. Annual Technical Report –
   Continued preparing for production of 2017 EQR technical report template.
   - FEB:
   - Continued preparing for production of 2017 EQR technical report template.
   - Mar
   - Began compiling 2017 results and preparing for production of 2017 EQR technical report template.

7. Technical Assistance to the MQD-

- Notified MQD that development of Successful Transitions measure not possible due to insufficient time and data; recommended alternative measures.
- MQD selected CMS' *Emergency Department Use without Hospitalization During the First 60 Days of Home Health* measure as a replacement measure.
- February:
- Submitted final *Emergency Department Use without Hospitalization During the First 60 Days of Home Health* (EDUH) measure specifications for review and approval on 02/21/18.
- Addressed questions from the health plans regarding state-specific measures.
- March:
- Drafted updates to the *Emergency Department Use without Hospitalization During the First 60 Days of Home Health* (EDUH) measure specifications in collaboration with the MQD. Submitted updated documentation to health plans on 03/19/18 and 03/29/18.
- Conducted technical assistance call with health plans regarding EDUH measure on 03/28/18.
- Continued addressing questions from the health plans regarding state-specific measures.
- Received request to validate 2017 P4P results. Submitted findings on 03/21/18.
- Received request to address Seek More Information (SMI) questions regarding the MQD's Adult and Child core quality measure MACPro submission. Submitted responses to the MQD on 03/25/18. Updated responses submitted on 03/29/18.

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 subsequently submitted a modified Demonstration Evaluation Design back to CMS on June 16, 2017. On February 27, 2018 MQD received final approval of the Demonstration Evaluation Design from Heather Ross.

Enclosures/Attachments

Attachment A: QUEST Integration Dashboard for January 2018 – March 2018

MQD Contact(s)

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Date Submitted to CMS

May 31, 2018