DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

February 27, 2018

Judy Mohr Peterson, Ph.D.
Med-QUEST Division Administrator
State of Hawaii, Department of Human Services
601 Kamokila Blvd., Room 518, P.O. Box 700190
Kapolei, HI 96709-0190

Dear Dr. Mohr Peterson:

This letter is to inform you that the Centers for Medicare and Medicaid Services (CMS) has approved the attached evaluation design for the Hawaii QUEST Expanded Medicaid section 1115(a) demonstration (Project Number 11-W-00001/9), as submitted by the state and as modified through our discussions. A copy of the approved evaluation design is enclosed.

We look forward to continuing to work with you and your staff on the QUEST Expanded Medicaid Demonstration. If you have any questions, please contact your project officer, Vanessa Khoo at Vanessa.Khoo@cms.hhs.org or 410-786-6033.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

Cc: Henrietta Sam-Louie, Associate Regional Administrator,
Region IX, San Francisco Regional Office

QUEST Integration
Evaluation Design

Submitted by the State of Hawaii, Department of Human Services,
Med-QUEST Division

December 18, 2014
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Table of Contents

Overview and Brief History of the Demonstration

Hawaii's QUEST Integration is a Med-QUEST Division (MQD) wide comprehensive section 1115 (a) demonstration that expands Medicaid coverage to children and adults. The demonstration creates a public purchasing pool that arranges for health care through capitated-managed care plans. The State of Hawaii implemented the first QUEST demonstration on August 1, 1994. The extension period for this evaluation design is from October 1, 2013 through to December 31, 2018.

QUEST is a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Assistance Program and its innovative State Health Insurance Program and offered benefits to citizens up to 300 percent FPL. Low-income women and children and adults who had been covered by the two State-only programs were enrolled into fully capitated managed care plans throughout the State. This program virtually closed the coverage gap in the State.

As QUEST was originally conceived, a second phase was planned that would have enrolled the ABD populations into managed care. CMS approved the second phase on February 1, 2008 and implemented on February 1, 2009 as the QUEST Expanded Access (QExA) program. A third planned phase would have combined the purchasing power of QUEST with that of the State employees' health benefits to further increase the cost efficiencies of the program. However, for a variety of reasons, phase three was never implemented.

A class action lawsuit under the Americans with Disabilities Act (ADA) was filed against the State in 1995 alleging that disabled individuals with incomes above 100 % of the FPL were kept out of the program based solely on their disability status. To address this issue, the State reduced its coverage of the uninsured under QUEST to those uninsured adults with incomes at or below 100 % FPLand uninsured children with family incomes at or below 200 percent FPL. In addition, a new program, QUEST-Net, was developed in 1995 for individuals who are no longer eligible for QUEST or Medicaid fee-for-service due to an increase in income or assets. For a reasonable premium share, QUEST-Net provided full Medicaid benefits for children from 201 to 300 % FPL and a limited benefit package for adults with incomes from 101 to 300 % FPL. QUEST eligibles who are self-employed were previously assessed a premium. These individuals were allowed to opt for QUEST-Net as a source of insurance coverage.

Below is a summary of changes to the QUEST program since its inception.

Timeframe	Summary of Change to QUEST program
July 1995	Changes to eligibility requirements Establish a fee-for-service window prior to QUEST health plan enrollment
September 1995	Cap QUEST enrollment at 125,000 expansion-eligibles participants
May 1996	Reinstate asset test and add a premium for QUEST-Net participants
March 1997	Changes to eligibility requirements for AFD-related covered groups
June 2001	Expand QUEST-Net program
July 2005	Significant changes to QUEST program
February 2008	Develop a managed care program for Aged, Blind, and Disabled population
May 2010	Development of Hawaii Premium Plus (HPP) program

Timeframe	Summary of Change to QUEST program
October 2010	Changes to HPP program Add pneumonia vaccine as a covered immunization
July 2012	Change eligibility and benefits for QUEST-ACE and QUEST- Net programs Eliminate QUEST enrollment limit for childless adults Eliminate HPP program Changes to uncompensated care (UC) payments
December 2012	Approval of a one-year waiver extension
October 2013	Consolidated programs Transitioned former programs (i.e., QUEST-ACE and QUEST-Net) into the new low-income adult group Added new populations Increased retroactive eligibility period to ten (10) days Added new benefits Changes to the UC pool

Refer to the information below for details regarding the summary table above. Since its implementation, the State has made several changes to the QUEST program.

- The first amendment, approved July 11, 1995, allowed the State to deem parental income for tax dependents up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing for expansion populations, impose a premium for self-employed individuals, and require the State to pay for State Plan services received prior to the date of enrollment in a QUEST health plan on a Fee-For-Service basis for an eligible QUEST client.

- The second amendment, approved on September 14, 1995, allowed the State to cap QUEST enrollment at 125,000 expansion eligibles.

- The third amendment, approved on May 10, 1996, allowed the State to reinstate the asset test, establish the QUEST-Net program, and require QUEST-Net participants to pay a premium.

- The fourth amendment, approved on March 14, 1997, lowered the income thresholds to the mandatory coverage groups and allowed the State to implement its medically needy option for the AFDC-related coverage groups for individuals who become ineligible for QUEST and QUEST-Net.

- The fifth amendment, approved on July 29, 2001, allowed the State to expand the QUEST-Net program to children who were previously enrolled in SCHIP when their family income exceeds the Title XXI income eligibility limit of 200 % FPL.

- In January 2006, the federal government approved a new Section 1115 waiver for Hawaii, QUEST Expanded (QEx) which incorporated the existing QUEST program with some significant changes including:
  - The addition of a dental benefit for adults of up to $500 a year;
  - Coverage was extended to all Medicaid-eligible children in the child welfare system;

- Coverage was extended to adults up to 100% of the FPL who meet Medicaid asset limits;
- Premium contributions for children with income at or below 250% of FPL were eliminated;
- The requirement that children have prior QUEST coverage was eliminated as a condition to qualifying for QUEST-Net; and
- Increased SCHIP eligibility from 200% of FPL to 300% of FPL.

In all, about 9,000 children and another 20,000 adults who were previously uninsured, were made eligible for the program. In addition, the waiver amendment authorized federal match on payments made by the State to its state-owned hospitals.

The current waiver for the Hawaii program was approved by CMS on January 31, 2006 with a retroactive start date of July 1, 2005. The waiver will require renewal on or before June 30, 2008. The waiver currently being negotiated for the ABD population was submitted as an amendment to the existing waiver.

- In February 2007, the State requested to renew the QUEST demonstration, and the State reaffirmed its 2005 request to CMS to amend the Demonstration to advance the State's goals to develop a managed care delivery system for the Aged, Blind, and Disabled (ABD) population. This amendment was effective on February 1, 2008.

- As a condition of the 2007 renewal the State was required to achieve compliance with the August 17, 2007, CMS State Health Official (SHO) letter that mandated by August 16, 2008, the State must meet the specific crowd-out prevention strategies for new title XXI eligibles above 250 percent of the Federal poverty level (FPL) for which the State seeks Federal Financial Participation (FFP). On March 30, 2009 the State requested that this provision be removed from the STCs. The State's request was a result of Public Law 111-3 The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), and the issuance of a Presidential memorandum to the Secretary of Health and Human services to withdraw the August 17, 2007 SHO letter. On February 6, 2009 the letter was withdrawn through SHO #09-001.

- On February 18, 2010 the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment. The proposed amendment would provide a 12 month subsidy to eligible employers for approximately half of the employer's share for eligible employees newly hired between May 1, 2010 and April 30, 2011. This amendment was effective May 1, 2010.

- On July 28, 2010, the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment to eliminate the unemployment insurance eligibility requirement for the Hawaii Premium Plus (HPP) program. The HPP program was recently created to encourage employment growth and employer sponsored health insurance coverage in the State. This amendment was effective October 15, 2010.

- On August 11, 2010, Hawaii submitted an amendment proposal to add the pneumonia vaccine as a covered immunization. In addition to the July 28 and August 11, 2010 proposed amendments, several technical corrections were made regarding expenditure reporting for both Title XIX and XXI Demonstration populations. This amendment was effective October 15, 2010.

- On July 7, 2011, Hawaii submitted an amendment proposal to reduce QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL, including the elimination of the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. QUEST- Adult Coverage Expansion (QUEST-ACE) was an eligibility expansion category for non-pregnant childless adults with income not exceeding 133% and for adults with children who have income 101-133%.

- On July 8, 2011, Hawaii filed a coordinating budget deficit certification, in accordance with CMS' February 25, 2011, State Medicaid Director's Letter. This certification was approved by CMS on September 22, 2011. This certification grants the State a time-limited non-application of the maintenance of effort provisions in section 1902(gg) of the Act and provides the foundation for CMS to approve the State's amendment to reduce eligibility for non-pregnant, non-disabled adults with income above 133 percent of the FPL in both QUEST-Net and QUEST-ACE. On April 5, 2012, CMS approved an amendment that reduced the QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL and eliminated the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL.

- In the July 7, 2011 amendment, Hawaii also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the Demonstration; eliminate the QUEST enrollment limit for childless adults; provide QUEST Expanded Access (QExA) individuals with expanded primary and acute care benefits; remove the Hawaii Premium Plus program, a premium assistance program, due to a lack of Legislative appropriation to continue the program, and allow uncompensated cost of care payments (UC) to be paid to government-owned nursing facilities. The July 7, 2011 amendment was effective July 1, 2012.

- In June 2012, Hawaii requested to extend the QUEST demonstration under section 1115(e) of the Social Security Act. Revisions were made to the waiver and expenditure authorities to update the authorization period of the demonstration, along with a technical correction clarifying that the freedom of choice waiver is necessary to permit the state to mandate managed care, and updates to the budget neutrality trend rates. A one year renewal was approved in December 2012. In December 2012, the state requested to amend the demonstration to provide full Medicaid benefits to former foster children under age 26 with income up to 300 percent FPL with no asset limit.

- In September 2013, CMS approved a five-year extension of the demonstration from October 1, 2013 through December 31, 2018. This five year demonstration extension:
  - Consolidated the four (4) programs within the demonstration (QUEST, QUEST-ACE, QUEST Expanded Access (QExA) and QUEST-Net) into a single "QUEST Integration" program which, effective January 1, 2014, provided the full Medicaid state plan benefit package to all enrollees in the demonstration;
  - Transitioned the low-income childless adults and former foster care children from demonstration expansion populations to state plan populations (new adult group);
  - Added additional new demonstration expansion populations, including a population of former adoptive and kinship guardianship children;
  - Increased the retroactive eligibility period to ten (10) days for the non-long term services and supports population;

- Provided additional benefits, including cognitive rehabilitation, habilitation, and certain specialized behavioral health services;
- Eliminated state enrollment limits;
- Removed the QUEST-ACE enrollment-related benchmarks from the UC pool; and
- Required additional evaluation on UC costs after January 1, 2014 and a June 2016 sunset date for UC authority.

Current Enrollment and Delivery System

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. See information in Table 1 that includes populations by eligibility groups, health plan enrollment, and eligibility by island.

Summary of QUEST Expanded Demonstration Evaluation-January 2014

The demonstration evaluation period for this report was from January 1, 2008 to September 30, 2013. This report concluded the 19th demonstration year for the QUEST Expanded Medicaid section 1115 demonstration waiver. The demonstration evaluation period saw several significant initiatives for the QUEST Expanded program:

- **Development and implementation of the QUEST Expanded Access (QExA) program on February 1, 2009.**
  Effective February 1, 2009, the majority of the fee-for-service (FFS) population was transitioned into managed care in the QUEST Expanded Access (QExA) program. The Medicaid population in QExA consists of beneficiaries 65 years or older or with a disability of any age. The QExA program has two health plans: ‘Ohana Health Plan and UnitedHealthcare Community Plan. As of September 30, 2013, the QExA program has approximately 46,000 beneficiaries. The QExA health plans provide a continuum of services to include primary, acute care, standard behavioral health, and long-term care services. The goals of the QExA program are:
  - Improve the health status of the member population;
  - Establish a “provider home” for members through the use of assigned primary care providers (PCPs);
  - Establish contractual accountability among the State, the health plan and healthcare providers;
  - Expand and strengthen a sense of member responsibility and promote independence and choice among members;

- Assure access to high quality, cost-effective care that is provided, whenever possible, in a member's home and/or community;
- Coordinate care for the members across the benefit continuum, including primary, acute and long-term care benefits;
- Provide home and community based services (HCBS) to persons with neurotrauma;
- Develop a program that is fiscally predictable, stable and sustainable over time; and
- Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals.

- **Reprocurement of the QUEST program.**
  The QUEST program is for Medicaid beneficiaries under the age of 65 without a disability. As of September 30, 2013, the QUEST program has approximately 243,000 beneficiaries. Through the demonstration evaluation period, the QUEST program had three health plans from July 1, 2008 to June 30, 2012: AlohaCare, Hawaii Medical Services Association (HMSA), and Kaiser Permanente. In August 2011, the Med-QUEST Division (MQD) reprocured the QUEST program and added two additional health plans on July 1, 2012: 'Ohana Health Plan and UnitedHealthcare Community Plan.

  In the new procurement effective July 1, 2012, MQD added or expanded on several new initiatives. These include:
  - Value-based purchasing (e.g., patient centered medical homes and accountable care organizations);
  - Financial incentives for improving quality to their members;
  - Integration of medical and behavioral health services;
  - Auto-assign algorithm based upon quality instead of cost; and
  - Standardization of capitation payments amongst health plans.

- **Implementation of the QUEST Adult Coverage Expansion (QUEST-ACE) program.**
  In April 2007, the MQD implemented a new program called QUEST-ACE that provides medical assistance to a childless adult who is unable to enroll in the QUEST program due to the limitations of the statewide enrollment cap of QUEST as indicated in HAR §17-1727-26. The QUEST-ACE benefit package encompassed the same limited package of benefits provided under the QUEST-Net program. This program continues to reducing the number of uninsured and underinsured adults in our community.

  On July 1, 2012, the MQD changed the benefit package from a limited package of benefits to the same benefits as provided under the QUEST program. By changing the benefits from a limited to a full benefit package, the enrollment in the QUEST-ACE program more than doubled (from approximately 13,850 on June 30, 2012 to 28,800 on September 30, 2013).

- **Implementation of revised Quality Strategy.**
  MQD implemented a new Quality Strategy in 2010 after receiving approval from CMS. As part of the implementation of the Quality Strategy, MQD has:
  - Increased health plan monitoring;
  - Standardized health plan reporting; and
  - Implemented public reporting of health plan quality results.

- **Implementation of Pay for Performance through financial incentives in the QUEST program.**
  MQD implemented a Pay for Performance program that provides financial incentives to QUEST health plans based upon improved quality results. MQD utilizes improvement of both Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to measure improved quality results. For calendar years 2010 to 2012, health plans had access to a financial incentive of $1.00 per member per month (pmpm) withhold. For calendar years 2010 to 2012, the quality measures were:
  - Childhood Immunization
  - Emergency Department (ED) Visits/1000
  - LDL Control in Comprehensive Diabetes Care
  - Chlamydia Screening
  - Getting Needed Care (from CAHPS survey)

  Health plans needed to either meet the Medicaid 75th percentile rate for each of the measures listed above or meet/exceed an improvement of 50% of the difference between the current rate and the rate the year before. The only exception to these measures is ED visits/1000. For this measure, health plans needed to meet or exceed the Medicaid 10th percentile.

  In the QUEST procurement that was implemented on July 1, 2012, MQD increased the financial incentive withhold described above to $2.00 pmpm and included the following measures:

  - Childhood Immunization
  - Chlamydia Screening
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care:
    - HBA1C Control (<8%);
    - LDL-C Control (<100 mg/dl); and
    - Systolic and Diastolic blood pressure levels (<140/90).
  - Getting Needed Care (from CAHPS survey)

  Below is a chart that describes the number of quality measures of the five (5) potential measures each year that each health plan met.

	AlohaCare	HMSA	Kaiser
HEDIS/CAHPS 2010 (CY 2009)	2	2	4
HEDIS/CAHPS 2011 (CY 2010)	1	2	4
HEDIS/CAHPS 2012 (CY 2011)	1	1	5
HEDIS/CAHPS 2013 (January to June 2012)	1	2	5
HEDIS/CAHPS 2013 (July to December 2012)	0	1	5

Neither ‘Ohana Health Plan or UnitedHealthcare Community Plan was able to participate in incentives for July to December 2012 due to QUEST data only from July 1 to December 31, 2012.

The implementation of these initiatives has occurred to decrease the uninsured population in

Hawaii and improve the quality of services to Hawaii's Medicaid beneficiaries. Though results have not consistently met the benchmarks, MQD has identified several recommendations to improve future results. These recommendations include improved data gathering, collaborative partnership with health plans, and financial incentives to improve quality of services.

Recommendations of QUEST Expanded Demonstration Evaluation-January 2014

Though the MQD has seen improvement in many of its performance measures over the past six years, we are not meeting all of the requirements that we have established in our Quality Strategy of at least 75th percentile of the national Medicaid population. MQD has the following recommendations for improving health plan performance:

1. Improve process for gathering information from providers

   The majority of Medicaid providers in Hawaii are single providers (i.e., not part of a group practice and are not part of an Independent Physician Association (IPA)). In addition, up to this point, both the QUEST and QExA health plans provide information to Hawaii Medicaid providers retrospectively. It has been very difficult to make changes in HEDIS results for critical areas such as diabetes or cardiovascular disease when the penetration into the provider community is provider-by-provider.

   Some recommendations for the future are:
   A. Encourage providers to move to electronic medical records and achieve meaningful use by implementing the Electronic Health Record (HRE) initiative that is part of the ACA.
   B. Offer reminders to providers in real-time for best practices (i.e., reminders for preventative screenings).

2. Explore mechanisms to improve health plans' supplemental data collection

   Health plans have identified that immunizations and certain screenings like Chlamydia are often performed and paid for outside the health plan. Therefore, these services are not captured for coordination of care or for reporting in the health plan's HEDIS measures. MQD is committed to support and encourage collaborative endeavors by the health plans to work with FQHCs and other large providers to obtain data for services paid through federal grants for Medicaid members.

3. Increase the Pay for Performance withhold from health plans

   MQD implemented a Pay for Performance (P4P) withhold from the QUEST program in 2010. In this program, MQD withheld $1.00 PMPM for every capitation payment for each member that has been with them for the entire month. Annually, MQD reviews the health plans' HEDIS and CAHPS results compared to 75th percentile of the national Medicaid population as well as look to see if they have improved their results by at least 50% over the past year. If a health plan has met one of the desired results, then they receive a payment of $0.20 PMPM for each performance measure they have met.

MQD increased the P4P withhold to $2.00 PMPM to encourage the health plans to strive for quality in the care they are providing to their members. In addition, payment of the P4P is based solely on meeting 75th percentile of the national Medicaid population.

4. Implement auto-assignment percentages based upon results of HEDIS and CAHPS results

   In the current QUEST contract effective July 1, 2012, MQD revised the auto-assignment percentages based upon results of HEDIS and CAHPS results. These auto-assign percentages will be revised annually based upon previous year results. The first auto-assign percentages will be implemented on July 1, 2014.

Goals and Objectives

Hawaii's goals and objectives in the extension of this demonstration are to:

1. Improve the health care status of the member population;
2. Continue the predictable and slower rate of expenditure growth associated with managed care;
3. 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, with a focus on preventative care;
4. Improve care coordination and decrease provider administrative burden by establishing a Patient Centered Medical Home (PCMH); and
5. Expand access to home and community based services (HCBS) and allow LTSS individuals to have a choice between institutional services and HCBS.

Hypotheses

Hawaii's hypotheses in the extension of this demonstration are to test the following:

- **Hawaii will both improve health care quality and reduce costs, by holding MCOs to outcomes and performance measures, and adjusting the financial pay-for-quality (P4Q) model to reward both improvement and excellence (relates to goal #1 and #2):** Hawaii understands that an 1115 waiver is an opportunity to both provider better care as well as show cost savings. We propose to do both by revamping our financial pay-for-quality (P4Q) model to achieve these twin goals. By having a diverse set of measures that evaluates different segments of our Medicaid population such as children/adults/LTSS/women of childbearing age/etc.; by being intentional in partnering with our MCOs to create some alignment among Medicare/Commercial and Medicaid product lines and increases alignment with MCOs P4Q efforts with their providers; by increasing the amounts that are at risk in the P4Q model; and by rewarding both improvement and excellence in the P4Q model; we expect the sum of these efforts to show cost savings and improved population health statistics. Results of the adjusted P4Q model will be posted on the Med-QUEST website. Some of the measures we will focus on are:
  - Improving the overall health of members with diabetes mellitus;
  - Improving the overall health of our keiki by boosting immunization and well-child visit rates;
  - Improving the overall health of our mothers by improving prenatal and postpartum

visit rates;
    - Improving the overall health of members that suffer from mental illness; and
    - Improving the delivery of care in the inpatient setting.
- **Hawaii will deliver improved quality of care and access to care in the community by offering cutting edge screening tools and collaborating with partner agencies (relates to goal #3)**: Hawaii agrees with current literature that says focusing on preventative care will lead to a healthier Medicaid population at a lower overall spend. Altering our delivery system to enhance and promote cutting edge screening tools is one way to achieve this focus. Policy changes including expanding the use of One Key Question, expanding access to Long Acting Reversible Contraceptives (LARC) for our maternity population, and expanding the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services will serve to enhance the screening available and boost preventative care for Hawaii's Medicaid individuals. Access to Medicaid can be disrupted by certain events that force a loss of Medicaid eligibility, which include being admitted to the Hawaii State Hospital and becoming incarcerated in the prison system. And often times when the individual returns to normal society, the Medicaid eligibility gaps and puts the individual at risk for returning to some form of incarceration. Hawaii sees collaborating with partner agencies as an effective way to prevent any disruption of coverage once the individual returns to normal society and is again eligible for Medicaid. Some of the opportunities are working with the Department of Health/Adult Mental Health Division to smooth member transition in and out of the State Hospital, and working with Department of Public safety to smooth member transition in and out of the prison system. Hawaii sees working with Department of Health/Alcohol & Drug Abuse Division to train providers on conducting SBIRT as fulfilling the twin goals of improving preventative care and collaborating with partner agencies.
- **Hawaii will improve coordination of care, increase appropriate utilization of the health care system and decrease administrative burdens of providers, by encouraging the development of PCMHs and implementing value-based purchasing (VBP) reimbursement methodologies to support PCMHs (relates to goal #4)**: Hawaii concurs with the many studies that show that coordinated and supportive care delivery leads to high quality medical care and continued independence for the individual. Hawaii also recognizes that non-clinical support services are often needed to assist individuals with complying with clinical guidelines. Often times these support services are not directly reimbursed in the current healthcare financing models. So Hawaii is strongly encouraging our MCOs to use VBP models, both with and without the use PCMHs, to change the delivery system in favor of the individual. are an integral piece in making the PCMH model viable to the provider community. By paying not on a per service basis but on a per patient basis, and combining this with additional reimbursement when specific quality metrics are met, VBP will free up the physicians to practice the medicine they were trained for and allow for funds to be redirected to surround the individual with support staff that will ensure that clinical guidelines are followed. All this to the benefit of the individual, increasing their wellness and independence.
- **Hawaii will continue to reduce the percentage of beneficiaries in institutional settings by initially offering the choice of HCBS to individuals with hospitalization discharges, continuing to support beneficiaries' ability to move out of an institutional setting, and expanding the provision of some HCBS to an 'at risk' population (relates to goal #5)**:

Hawaii recognizes that when an individual needing LTSS has choice and control over how care is delivered and in what setting, then the individual is more satisfied and can lead a more independent life. To that end Hawaii will continue to initially offer the choice of HCBS to individuals being discharged from acute care hospitalization and to those declining in the community. Also, Hawaii will continue to support individuals' ability and choice to transition out of an institution and into a home and community based setting. Finally, there are many individuals that are currently living independently but are one incident away from needing LTSS. To slow or prevent the progression to institutional level of care for those individuals that are not yet receiving LTSS and to further support their independent lifestyle, Hawaii will expand the provision of some HCBS to a population at risk of deteriorating to institutional level of care (called "at risk" population). These individuals will be determined 'at risk' by scoring at a lower acuity than those determined institutional level of care, using the same assessment tool. Metrics documenting the results of these efforts will be posted on the Med-QUEST website.

Population Groups Impacted

Based on the goals and objectives of this demonstration, the targeted populations groups to be impacted are the most vulnerable and needy who do not have access to any other form of healthcare coverage. Individuals and family members who are sixty-five years old or older, or are blind, or are disabled are generally disqualified from the outcome measures. The scope of the population groups impacted by the demonstration has consistently and regularly been expanding from its initial focus. In its current form, the following populations are expected to benefit from this demonstration:

- Pregnant women in families whose income is up to 185 percent of the FPL.
- Infants and children in families whose income is up to 300 percent of the FPL.
- Adults whose income is up to 133 percent of the FPL.
- Individuals 65 years or older receiving long-term services and supports (LTSS).
- Individuals with a disability of any age receiving LTSS.
- Uninsured individuals in general.

Outcome Measures

Current Measures

Hawaii has identified a number of outcome measures that we will use to evaluate the demonstration. These measures include the following:

- Childhood Immunizations (CIS): Increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the Medicaid 75th percentile.

- Frequency of Ongoing Prenatal Care (FPC): Increase performance on the state aggregate HEDIS Frequency of Ongoing Prenatal Care measure to meet/exceed the Medicaid 75th percentile.

- Timeliness of Prenatal Care (PPC): Increase performance on the state aggregate HEDIS Timeliness of Prenatal Care (Total) measure to meet/exceed the Medicaid 75th percentile.

- Breast Cancer Screening (BCS): Increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the Medicaid 75th percentile.

- Cervical Cancer Screening (CCS): Increase performance on the state aggregate HEDIS Cervical Cancer Screening measure to meet/exceed the Medicaid 75th percentile.

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services: Increase participant ratio on the state aggregate Participant Ratio to meet/exceed 80 percent for children of all ages.

- Comprehensive Diabetes Care (CDC):

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the HEDIS 75th percentile.

    - Improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c poor control (>9) to meet/fall below the HEDIS 25th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<8) to meet/exceed below the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<140/90) to meet/exceed the 2010 HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for eye exams to meet/exceed the HEDIS 75th percentile.

- Controlling High Blood Pressure (CBP): Increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the HEDIS 75th percentile.

- Use of Appropriate Medications for People with Asthma (ASM): Increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the HEDIS 75th percentile.

- Reduce the percent of asthma related Emergency Department visits for Medicaid beneficiaries ages 0 to 20: Decrease the percent of asthma related Emergency Department visits to less than or equal to 6%.

- Follow-Up After Hospitalization for Mental Illness (FUH): Increase performance on the state aggregate HEDIS Follow-Up After Hospitalization for Mental Illness measure to meet/exceed the HEDIS 75th percentile.

- Medication Reconciliation Post-Discharge (MRP): Increase performance on the state aggregate Medication Reconciliation Post-Discharge measure to meet/exceed the HEDIS 75th percentile.

- Plan All-Cause Readmission (PCR): Improve performance on the State aggregate HEDIS acute readmissions for any diagnosis within 30-days to meet/exceed HEDIS 75th percentile.

- Emergency Department Visits (AMB): Improve performance on the state aggregate HEDIS Emergency Department Visits/1000 rate to meet/fall below the HEDIS 10th percentile.

- Well-Child Visits in the First 15 Months of Life (W15): Improve performance on the State aggregate HEDIS Well-Child Visits in the First 15 Months of Life to meet/exceed HEDIS 75th percentile.

- Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life (W34): Improve performance on the State aggregate HEDIS Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life to meet/exceed HEDIS 75th percentile.

- Getting Needed Care: Increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Rating of Health Plan: Increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- How well doctors communicate: Increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Providing Quality Care: Prior Authorization Process: Increase performance on the State aggregate Provider Survey measure 'Providing Quality Care: Prior Authorization Process' to 75% of providers are either neutral or positive impact.

- Providing Quality Care: Formulary: Increase performance on the State aggregate Provider Survey measure 'Providing Quality Care: Formulary' to 75% of providers are either neutral or positive impact.

- Specialists: Adequacy of Specialists: Increase performance on the State aggregate Provider Survey measure 'Specialists: Adequacy of Specialists' to 70% of providers are either neutral or positive impact.

- Specialists: Adequacy of Behavioral Health Specialists: Increase performance on the State aggregate Provider Survey measure 'Specialists: Adequacy of Behavioral Health Specialists' to 50% of providers are either neutral or positive impact.

- Home and Community Based Service (HCBS) clients: Increase by 5% the proportion of clients receiving HCBS instead of institutional-based long-term care services over the next five (5) years.

Future Measures

All measures will be evaluated each year against national lists (CMS Child and Adult Core Set measures) and updates will be made as necessary. This evaluation will also include determining

measures that may need to be phased out (nearly all health plans nearing 75th percentile target) or phased in (new measures that might be more appropriate or effective), and to address changing MQD strategic initiatives.

Hawaii has identified a number of initiatives and measures that we will not be used to evaluate the current demonstration evaluation, but will be initiated during this demonstration to inform and progress toward the subsequent demonstration evaluation.

- Decreasing the percentage of discharges from the Hawaii State Hospital (HSH) and/or Department of Public Safety (DPS) that have Medicaid ineligible days post-discharge.

- Expanding the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in both the physician office and hospital settings.

- Expanding the use of One Key Question during the delivery of professional maternity services.

- Expanding access to Long Acting Reversible Contraceptives (LARC) for our maternity population by requiring separate and distinct reimbursement in the inpatient setting for LARC devices.

- Expanding the provision of Intensive Behavioral Therapy (IBT) services to populations with an Autism Spectrum Disorder (ABA) diagnosis.

- Expanding the settings that nursing services can be delivered to Medicaid clients, to include the Department of Education (DOE) school system.

- Expanding the use of tele-medicine.

Evaluation Design

Management and Coordination of Evaluation

Organization Conducting the Evaluation

The evaluation will be conducted internally within Med-QUEST Division (MQD), primarily by the Health Care Services Branch (HCSB). The MQD works in concert with its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), on collection of information from the health plans. This includes validation of several HEDIS measures, performing annual CAPHS survey and biennial provider surveys.

The HCSB receives the raw data from HSAG and analyzes it against demonstration goals. The MQD team that conducts the evaluation includes:

- Research Officer- primary lead
- MQD Medical Director
- Home & Family Access Program Manager

- Contract and Compliance Section Administrator
- Health Care Services Branch Administrator
- Finance Officer

Evaluation Timeline

Summary of Timeline for Annual Quality Activities

Time Frame	Activity
March	Mail CAHPS surveys to Medicaid beneficiaries
April/May	Health plan site visit by MQD and EQRO to gather HEDIS data from previous year
May	Close CAHPS surveys to Medicaid beneficiaries
June	Preliminary HEDIS results due to EQRO
July	Final HEDIS results released by EQRO to MQD
July	EQRO releases preliminary CAHPS star report to MQD
September	EQRO releases final CAHPS star report to MQD
October	Analysis of health plan HEDIS results to NCQA quality compass (i.e., compare to 75th and 90th results for Medicaid populations)
November	Develop consumer guides for QUEST Integration health plans Note: the consumer guide is a summary of several HEDIS measures and CAHPS survey results for health plans in the QUEST Integration program that is provided to the public
December	Release of the following items for public reporting: • EQRO annual report • QUEST Integration Consumer Guide

Summary of Timeline for Biennial Quality Activities

Time Frame	Activity
April	Mail survey to Medicaid health plan providers
June	Close survey to Medicaid health plan providers
October	EQRO releases final provider survey results to MQD
December	Release the provider survey for public reporting

Summary of Timeline for Annual Deliverables

Time Frame	Activity
February	Submit quarterly report for September to December
March	Submit annual report for State Fiscal Year (July to June) of previous year
May	Submit quarterly report for January to March
August	Submit quarterly report for April to June
November	Submit quarterly report for July to August

Summary of Timeline for Compilation of Demonstration Evaluation Report

July to November 2013	Analyze data from previous demonstration years

December 2017	Compile information into final demonstration evaluation report for demonstration ending December 31, 2018
August 2018	Submit final demonstration evaluation report to CMS for demonstration ending December 31, 2018
120 days prior to expiration of demonstration	Submit draft evaluation report

Process

Data Sources

The evaluation will include assessment of quantitative or qualitative process and outcome measures using the following data sources:

- Administrative data (i.e., claims; encounters, enrollment in Hawaii Prepaid Medical Management Information System (HPMMIS), health plan reports, etc.);
- Electronic Health Records; and
- Member and provider feedback (EQRO-conducted surveys, grievances, Ombudsman reports).

Measures were chosen for the evaluation design by focusing on the QUEST Integration goals and objectives established as part of Hawaii's Special Terms and Conditions. In addition, the evaluation design includes existing measures reviewing a range of ages, populations and programs in order to provide a broad representation of QUEST Integration. Existing reports include the following:

- Quantitative, performance measure reports using administrative and electronic health records, include the following:
  - Healthcare Effectiveness Data and Information Set (HEDIS®);
  - Health plan reporting on LTSS utilization;
  - Electronic Health Record reviews;
  - Performance Improvement Project (PIP) findings report;
  - Enrollment reports; and
  - Financial reports.
- Qualitative reports using surveys, and other forms of self-reported data including:
  - Consumer Assessment of Health Plans Study (CAHPS®);
  - Provider Survey; and
  - Grievance reports.

Given the length of this Demonstration, sources for the data and the entity responsible for calculation may change; the information provided in the measurement table reflects current data sources and entities responsible for calculation.

Encounter data will be used as input data to perform provider-specific HEDIS reporting. Determining the completeness and accuracy of our encounter data is an evolving process that is currently driven by the new rules around 42 CFR §438.242 Health information systems & 42 CFR §438.818 Enrollee encounter data. Steps toward complying with these regulations include:

- Revisiting and redesigning the monthly encounter review, validation, and reconciliation process, with the goal of obtaining a complete and accurate representation of the services provided to the enrollees under the contract between MQD and the health plans

- Working with our health plans to reconcile and resubmit ongoing differences in encounter submissions
- Working with our actuaries to catalog encounter differences between MMIS and actuary files directly from our health plans
- Engaging our EQRO in conducting an Encounter Data Validation study in 2018

Integration of the State Quality Improvement Strategy
MQD's goal continues to ensure that our beneficiaries 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 updated 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. An updated version of the quality strategy was submitted to CMS on September 30, 2015. MQD received final approval for this quality strategy on July 8, 2016. The revised quality strategy is consistent with the previously approved 2010 version.

Analysis Plan
The results of the data collection and calculation will be various values for the given period. These results will be displayed in graphical format. For most measures, a longitudinal comparison will be made among the various years' Hawaii statewide QUEST Integration scores. Where applicable, comparison to State Quality Improvement Strategy targets will also be reviewed.

A determination will be made if unexpected or expected factors are influencing the calculated values. These factors could be internal to DHS, specific to a plan's operations, or external at a state or national level. Either way, there will be a discussion on how we believe these factors are exerting influence on the values.

Initiatives related to each measure will be discussed. These may be conducted by the health plan or by the MQD, and in each case was implemented to improve the quality of care or collection of data

related to the measure calculation.

MQD will review its analysis plan to isolate the effects of the QUEST Integration demonstration from other initiatives in Hawaii. MQD will first complete a cataloguing of the various related initiatives occurring in Hawaii. MQD will contact various provider associations and other State agencies to identify, at a minimum, initiatives with potential to affect Medicaid populations in Hawaii. MQD will collect the following information about the other initiatives to help determine overlap with QUEST Integration initiatives:

- Member and provider populations impacted;
- Coverage by location/region;
- Available performance measure data; and
- Start dates and current stage of the initiative.

The evaluation will include baseline and cross-year comparisons. The first year of the QUEST Integration demonstration, calendar year (CY) 2014, will serve as a baseline year. If no major overlapping initiatives are identified for a particular measure and statistical improvement is identified when compared to prior Hawaii demonstration evaluations, or first year baseline rates, evaluation results will indicate the improvement is due to the effect of QUEST Integration. Examples include assessing outcomes related to the health plans value-based purchasing reimbursement and improved emphasis on positive health outcomes for individuals in QUEST Integration. See Figure 1 for examples of measurement of positive health outcomes.

When substantial overlapping initiatives are identified, MQD will determine whether control comparisons are possible. Since QUEST Integration is a statewide demonstration and Hawaii has been utilizing managed care since 1994, control groups may not be accessible.

If there is overlap with other initiatives within the state, MQD will determine whether the populations and areas impacted are distinct enough to warrant comparison between available performance measure results in the other initiatives, compared to the related QUEST Integration initiative. One example is the various initiatives regarding health homes and person centered medical home initiatives (PCMH). The MQD will be proposing implementation of a health home initiative outside of managed care. These health homes will be separate from the PCMH initiatives that the health plans are implementing as part of their value-based purchasing programs. If these settings and consumers served are distinctly different enough from the PCMH related initiatives in the State, it may be possible to compare rates of improvement, to help determine the effect of the health home initiative.

Additional analysis will we conducted on a plan specific basis to include longitudinal analysis on a single plan as well as single year comparisons across all plans, among other comparisons. Year-over-year trends will be noted and compared across plans. Differences in performance between plans will be used to inform evaluation objectives and possible conclusions. Root causes of positive differences will be determined as a best practice and then disseminated to other plans for cross-plan improvement.

Provider level analysis will also be conducted on selected measures. Hospital and FQHCs are two of the providers types that may be measured, with comparisons across different providers within the provider type in the same year, as well as longitudinal comparisons by provider.

Level of Analysis

The following table (Figure 1) includes design specifications for the Outcome Measures that are based upon the QUEST Integration goals, objectives, and hypotheses. The table includes the following elements:

- Goals and Objectives;
- Hypotheses;
- Measurement;
- Outcome;
- Type of measurement;
- Measurement crosswalk, if applicable;
- Source of data;
- Population/Stratifications;
- Comparison for determining effectiveness of the demonstration; and
- Evaluation frequency.

Table 1: QUEST Integration Enrollment

Eligibility Categories	**March 2017**
Children	116,915
CHIP	24,511
Current & Former Foster Care	6,047
Pregnant Women & Parent/Caretakers	39,502
Low Income Adults	120,095
Medical Assistance ABD	49,176
State Funded ABD	2,339
Others	89
Total	**358,674**
Health Plan	
AlohaCare Non-ABD	65,946
HMSA Non-ABD	160,355
Kaiser Non-ABD	29,425
‘Ohana Non-ABD	23,745
UnitedHealthcare Non-ABD	24,761
AlohaCare ABD	4,581
HMSA ABD	7,516
Kaiser ABD	1,490
‘Ohana ABD	19,722
UnitedHealthcare ABD	21,133
Total	**358,674**
Island	
Oahu	217,465
Kauai	21,410

Eligibility Categories	**March 2017**
Hawaii	74,985
Maui	40,145
Molokai	3,821
Lanai	848
Total	**358,674**

Figure 1

Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
Goal #1: Improve the health care status of the member population **Goal #2:** Continue the predictable and slower rate of expenditure growth associated with managed care.	**Hypothesis:** Hawaii will both improve health care quality and reduce costs, by holding MCOs to outcomes and performance measures, and adjusting the financial pay-for-quality (P4Q) model to reward both improvement and excellence.	Effectiveness of Care						
		Childhood Immunization (CIS) Combination 3	NCQA Quality Compass Medicaid 75th ile	• P4P • Quantitative	• NQF 0038 • CMS Child Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Children who turn two (2) years of age • Medicaid • CHIP	Annually
		Frequency of Ongoing Prenatal Care (FPC)	NCQA Quality Compass Medicaid 75th ile	• P4P (up thru 2014) • Quantitative	• NQF 1391 • CMS Child Core Set • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Pregnant Women • CHIP	Annually
		Timeliness of Prenatal Care (PPC)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quality auto-assign • PIP • Quantitative	• NQF 1517 • CMS Child Core Set • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Pregnant Women • CHIP	Annually
		Postpartum Care (PPC)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • PIP • Quantitative	• NQF 1517 • CMS Child Core Set • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from	• Pregnant Women • CHIP	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
						encounter data		
		Breast Cancer Screening (BCS)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0031 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Women 50 to 74 years • Medicaid	Annually
		Cervical Cancer Screening (CCS)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0032 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Women 21 to 64 years • Medicaid	Annually
		Early and Periodic Screening, Diagnostic and Treatment (EPSDT) participant ratio	80 percent for children of all ages	• Quality auto-assign • Quantitative	• CMS 416	ESPDT reports from health plan	• Children under 21 years of age	Annually
		Comprehensive Diabetes Care (5 measures)-CDC						
		CDC- HgA1c testing	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0057 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from	• 18 to 75 years • Medicaid	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
						encounter data		
		CDC- HgA1c poor control (>9)	NCQA Quality Compass Medicaid 25th ile	• Quantitative	• NQF 0059 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 to 75 years • Medicaid	Annually
		CDC- HgA1c control (<8)	NCQA Quality Compass Medicaid 75th ile	• P4P • Quantitative	• NQF 0575	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 to 75 years • Medicaid	Annually
		CDC- Blood Pressure Control (<140/90)	NCQA Quality Compass Medicaid 75th ile	• P4P (up thru 2014) • Quantitative	• NQF 0061 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 to 75 years • Medicaid	Annually
		CDC- Retinal screening	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quantitative	• NQF 0055	• HEDIS reports from health plan • HEDIS reports from	• 18 to 75 years • Medicaid	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
						encounter data		
		Controlling High Blood Pressure (CBP)	NCQA Quality Compass Medicaid 75th ile	• P4P (up thru 2014) • Quantitative	• NQF 0018 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 to 85 years • Medicaid	Annually
		Use of appropriate medications for people with asthma (ASM)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0036	• HEDIS reports from health plan • HEDIS reports from encounter data	• 5 to 67 years • Medicaid • CHIP	Annually
		Asthma related Emergency Department visits	Decrease the percent of asthma related Emergency Department visits to less than or equal to 6%.	• Quantitative		• MQD Data Warehouse	• 0 to 20 years • Medicaid • CHIP	Annually
		Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quality auto-assign • Quantitative	• NQF 0576 • CMS Child Core Set • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 6 years and older • Medicaid • CHIP	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
		Medication Reconciliation Post-Discharge (MRP)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0554	• HEDIS reports from health plan • HEDIS reports from encounter data	• >=18 years • Medicaid	Annually
		Utilization						
		Plan All-Cause Readmission (PCR)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quantitative	• NQF TBD • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 years and older • Medicaid • CHIP	Annually
		Emergency department visits (AMB) per 1000	NCQA Quality Compass Medicaid 10th ile	• Quantitative		• HEDIS reports from health plan • HEDIS reports from encounter data	• All ages • Medicaid • CHIP	Annually
		Well-Child Visits in the First 15 Months of Life (W15)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quantitative	• NQF 1392 • CMS Child Core Set	• HEDIS reports from health plan • HEDIS reports from	• 0 to 15 months • Medicaid	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
						encounter data		
		Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life (W34)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quantitative	• NQF 1516 • CMS Child Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 3 to 6 years • Medicaid	Annually
Goal #3: 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, with a focus on preventative care.	**Hypothesis:** Hawaii will deliver improved quality of care and access to care in the community by offering cutting edge screening tools and collaborating with partner agencies.	Access to Care						
		The percentage of discharges from the Hawaii State Hospital (HSH) and/or Department of Public Safety (DPS) that have Medicaid ineligible days post-discharge	Decreasing the percentage of discharges with post-discharge gaps of eligibility, year over year	• Quantitative		• Discharge files from HSH & DPS, and eligibility records from MMIS system	• 18 years and older • Medicaid	Annually
		Percent of identified hospital train-the-trainer staff that have been trained on SBIRT screenings	Training of at least 50% of identified train-the-trainer staff on SBIRT screenings	• Quantitative		• Training data from ADAD training partners, and hospital train-the-trainer lists	• Hospital train-the-trainer staff	Annually
		The percentage of Long Acting	Increasing the percentage of LARC devices	• Quantitative		• Encounter data from	• Women of child bearing age • Medicaid	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
		Reversible Contraceptives (LARC) delivered in the inpatient setting as a percentage of all LARC devices delivered	delivered in the inpatient setting by 50%			health plans	• CHIP	
Goal #4: Improve care coordination and decrease provider administrative burden by establishing a Patient Centered Medical Home (PCMH).	**Hypothesis:** Hawaii will improve coordination of care, increase appropriate utilization of the health care system and decrease administrative burdens of providers, by encouraging the development of PCMHs and implementing value-based purchasing (VBP) reimbursement methodologies to support PCMHs.	Access to Care						
		Percent of physicians that are a part of a PCMH	Increase the percent of physicians that are a part of a PCMH by 20% year over year	• Quantitative		• Utilization report from health plans	• Physicians	Annually
		Percent of PCMHs that are reimbursed in part using VBP methodology	Increase the percent of PCMHs that are reimbursed in part using VBP methodology by 20% year over year	• Quantitative		• Utilization report from health plans	• Physicians • PCMHs	Annually
		Providing quality care: Prior authorization process	75% or more of providers that respond to survey are either neutral or positive impact	• Qualitative		• Provider survey from EQRO	• All ages • Medicaid • CHIP	Biennially
		Providing quality care: Formulary	75% or more of providers that respond to	• Qualitative		• Provider survey	• All ages • Medicaid	Biennially

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
			survey are either neutral or positive impact			from EQRO	• CHIP	
		Specialists: Adequacy of Specialists	70% or more of providers that respond to survey are either neutral or positive impact	• Qualitative		• Provider survey from EQRO	• All ages • Medicaid • CHIP	Biennially
		Specialists: Adequacy of Behavioral Health Specialists	50% or more of providers that respond to survey are either neutral or positive impact	• Qualitative		• Provider survey from EQRO	• All ages • Medicaid • CHIP	Biennially
Goal #5: Expand access to home and community based services (HCBS) and allow LTSS individuals to have a choice between institutional services and HCBS.	**Hypotheses:** Hawaii will continue to reduce the percentage of beneficiaries in institutional settings by initially offering the choice of HCBS to individuals with hospitalization discharges, continuing to support beneficiaries' ability to move out of an institutional setting, and expanding the provision of some HCBS to an 'at risk' population.	Utilization						
		Members that receive long-term services and supports (LTSS) in a home and community based (HCBS) setting instead of an institutional setting	Increase the percent of individuals receiving LTSS in a HCBS setting by at least 5% over the demonstration	• Quantitative		• Utilization report from health plans	• All ages • Medicaid • CHIP	Quarterly
		Dollars spent on HCBS services as a percent of total dollars spent	Increase the percent of dollars spent on HCBS services year over year	• Quantitative		• Encounter data from health plans	• All ages • Medicaid • CHIP • Members receiving LTSS	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
		on LTSS services						
		Plan All-Cause Readmission (PCR)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF TBD • CMS Adult Core Set	• HEDIS reports from encounter data	• 18 years and older • Medicaid • CHIP • Members receiving LTSS	Annually