DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

January 3, 2025

Judy Mohr Peterson, PhD
Med-QUEST Division Administrator
State of Hawai'i, Department of Human Services
601 Kanokila Blvd, Room 518
PO Box 700190
Kapolei, HI 96709-0190

Dear Director Mohr Peterson:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Hawai'i's Final Report for the Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Hawai'i QUEST Integration" (Project No: 11-W-00001/9). This report covers the demonstration period from January 2020 to December 2020. CMS determined that the Final Report, submitted on November 27, 2024 is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

The approved Final Report may now be posted to the state's Medicaid website. CMS will also post the Final Report on Medicaid.gov.

We appreciate the state's commitment to evaluating the Managed Care Risk Mitigation COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the Hawai'i QUEST Integration section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2025.01.03 04:36:28 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Brian Zolynas, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

Hawaii Med-QUEST: Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) Medicaid Section 1115 Demonstration Waiver Evaluation Report

Introduction:

Hawaii Med-QUEST Division (MQD) has historically maintained a risk sharing arrangement, an aggregate gain/loss risk corridor, between Hawaii's Managed Care Organizations (MCOs)(also known as "Health Plans") and the State. Under this arrangement, the State and its Health Plans have agreed to share profits or losses if aggregate covered expenditures fall above or below certain thresholds. Initial parameters proposed for calendar year (CY) 2020 agreed that if a particular Health Plan's calculated net gain/loss exceeded 3% of revenue for included health care expenses across all populations, the State would share equally in the gain/loss between 3% and 5%; and the State would recover/reimburse all gains/losses exceeding 5%. Due to the uncertainty from the public health emergency (PHE) that began in CY 2020, MQD negotiated with its Health Plans to temporarily tighten the aggregate gain/loss risk corridor. Based on the temporary agreement, if a Health Plan's calculated net gain/loss exceeded 1.5% of revenue for health care expenses across all populations, the State would share equally in the gain/loss between 1.5% and 3%; and the State would recover/reimburse all gains/losses exceeding 3%. Accordingly, MQD applied for a managed care risk mitigation COVID-19 PHE Medicaid Section 1115 demonstration waiver (here forth referred to as "waiver") to retroactively adjust the parameters of the aggregate gain/loss risk corridor. CMS approved the request on December 20, 2021. As part of the requirements set forth in 42 CFR §§ 431.424 and 431.428, Med-QUEST developed an evaluation and monitoring design plan. A mixed methods evaluation approach, including both qualitative and quantitative data and research methods, was approved by CMS on October 17, 2022. This report evaluates the impact of the requested and approved exemption from the regulatory prohibition in 42 CFR § 438.6(b)(1) that allowed MQD to make necessary retroactive modifications to its aggregate gain/loss risk corridor for CY 2020 in promoting the objectives of the Medicaid program.

Methods:

Quantitative Data Analysis:

The quantitative analysis for this evaluation was performed by Med-QUEST Division's actuary, Milliman. Actuarial analyses were used to calculate the CY 2020 managed care aggregate gain share settlements (the net amounts for CY 2020 that would be recouped from or reimbursed to Health Plans based on the parameters of the aggregate gain/loss risk corridor) under two conditions: the original aggregate gain/loss risk corridor parameters for CY 2020, and the modified parameters based on the approved waiver. The results were compared to one another to determine the net impacts of the modifications to MQD and the Health Plans respectively.

Methodological considerations applied and limitations were as follows:

1. Revenue included the full amount of withhold regardless of how much was earned.
2. Revenue covered by other settlements, supplemental payments, hospital P4P pool, health insurer fees, and premium tax were not included.
3. The health care services portion of the capitation revenues for Health Plans who participate on all islands was assumed to be 92.25% for Aged Blind and Disabled (ABD), and 90.0% for Family

and Children (F&C) and Expansion populations based on the administrative and surplus load in the capitation rates. Health Plans who did not participate on all islands had target MLRs of 92.5% for ABD and 90.5% for F&C and Expansion populations.

4. Expenses included incurred claims for medical, pharmacy, and long-term services and supports as well as other benefit costs including sub-capitation and care coordination/case management. Reportable expenses were the net of pharmacy rebates, recoveries, and expenses covered by the other settlements.
5. Expenses for supplemental payments, hospital P4P pool, health insurance fee, and costs for members beyond 15 days in an institution for mental disease were not included.

The total net gain/loss was calculated by taking each Health Plan's health care revenue and subtracting its health care expenses. Gain/loss was calculated separately for each Health Plan. The settlement amount for each Health Plan was calculated using the updated CY 2020 aggregate gain/loss risk corridor parameters, consistent with those described by MQD in its approved waiver; the calculated settlements using this method were presented as the "MODIFIED Risk Corridor Settlement" amounts. For comparison, simulated actuarial analyses applied the original aggregate gain/loss risk corridor parameters to the CY 2020 experience; the calculated settlements using this method were presented as the "ORIGINAL Risk Corridor Settlement" amounts. The calculated settlement amounts using the original and modified methods were compared to one another to determine the net financial impact of the waiver.

Qualitative Data Collection:

The qualitative portion of the evaluation was completed using a series of interviews conducted by MQD's Health Analytics Office. The evaluator conducted interviews of staff in multiple MQD program offices including its Finance Office, Healthcare Services Branch, Policy and Program Development Office, and the Office of the Director. In addition, the evaluator also interviewed lead staff who work for MQD's contracted actuary (Milliman) who led the risk sharing arrangement modification work in CY 2020. Interviews were recorded and transcribed, and responses summarized.

The interview consisted of the six key qualitative questions as outlined in the evaluation design:

1) What retroactive risk sharing agreements did the state ultimately negotiate with the MCOs under the demonstration authority?
2) In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?
3) What were challenges associated with implementing the retroactive risk mitigation strategies?
    a. How did the state address these challenges?
4) What were the lessons learned for any future PHEs in implementing the demonstration?
5) What problems would have been caused by the application of 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid?
6) What were the effects of these changes to Medicaid MCO financials?
    a. Did the MCOs avoid material losses as of a result of implementing the retroactive risk sharing agreements?

Finally, responses were organized into thematic groupings as described in the Evaluation Design.

Results

Across all five Health Plans in MQD's QUEST Integration (QI) managed care program, there were no material losses in CY 2020: all Health Plans had calculated total net gains. Therefore, the application of the aggregate gain/loss risk corridor, either using the original or the modified parameters, focused on a calculation of final settlement amounts that MQD would be able to recoup from each Health Plan. The original aggregate gain share parameters for CY 2020 would have resulted in a total recovery of $26.1M for MQD. The modified parameters applied based on the approval of the waiver resulted in a total recovery of $51.5M. Therefore, the implementation of the waiver authority recouped an additional $25.4M from Hawaii's Health Plans by MQD. See Table 1 for Health Plan-level calculations of the recoupment (settlement amounts) based on the original and modified methods.

TABLE 1: CY 2020 QI RISK SHARE CALCULATION AGGREGATE GAIN SHARE SETTLEMENT

HEALTH PLAN	ORIGINAL Gain Corridor Settlement	MODIFIED Gain Corridor Settlement	Net Additional Recoupment
ALOHA CARE	$4,867,635	$10,689,539	$5,821,904
HMSA	$0	$5,092,488	$5,092,488
KAISER	$65,984	$1,163,128	$1,097,144
OHANA	$2,532,676	$7,801,868	$5,269,192
UNITED HEALTHCARE	$18,621,947	$26,763,198	$8,141,252
TOTAL	**$26,088,242**	**$51,510,222**	**$25,421,980**

Interviews were conducted and responses to the qualitative questions were summarized as follows:

What retroactive risk sharing agreements did the state ultimately negotiate with the MCOs under the demonstration authority?

Prior to the PHE, Hawaii's QI managed care contract included an aggregate gain/loss risk corridor. During the PHE, Hawaii began prospective discussions with Health Plans in the State on the uncertainties of the pandemic. There were concerns both from the State and the Health Plans on the impact of the PHE on managed care costs in CY 2020. Hawaii's Health Plans were concerned that a huge influx of COVID-19 patients overwhelming the healthcare system could result in potentially unmanaged costs resulting in unmitigated losses to the Health Plans. MQD was concerned that potential service underutilization resulting from the delay and postponement of all non-essential healthcare services during the COVID-19 related shutdowns could result in a surplus of profits for the Health Plans. When MQD first proposed mutually beneficial aggregate gain/loss risk corridor modifications that would limit both the profits and losses for Health Plans, there was uncertainty and concern because the Health Plans had mostly focused up to that point on limiting their losses (and had not considered the State's perspective on limiting their profits); MQD leadership recalled a long pause of silence with none of the Health Plans indicating either their support or dissent for the proposal. However, during a particular conversation, the Chief Financial Officer of the largest Health Plan in Hawaii spoke up and said that she understood and supported MQD's efforts in remaining a good steward of government funds. She was able to acknowledge in front of the other Health Plans that any potential profits resulting from service underutilization would not have resulted from improved

management of care, but rather due to the unforeseen effects of the PHE; and as such, represented artificial gains by the Health Plans. Subsequent to this reflection, Hawaii's Health Plans were able to engage more collaboratively in the discussions around simultaneously tightening the aggregate gain/loss risk corridor and reducing the margins at both ends to limit either the potential loss or profit to the Health Plans. The negotiations productively focused on uncertainties and a desire to mitigate concerns for both parties (the State and Health Plans) and the parties were able to agree (pending CMS approval) upon specific modifications to the corridor to mutually limit their risk. The discussions and agreements were made prospectively early in the pandemic, allowing both parties to better anticipate the potential financial impacts of the PHE. Subsequently, MQD submitted the waiver request to CMS and received approval to implement the changes under the demonstration authority. The timing of the demonstration approval resulted in the retroactive application of the modifications to the aggregate gain/loss risk corridor; however, the key strength of the agreement was that it had been arrived at prospectively.

In what ways during the PHE did the demonstration support adding or modifying one or more risk sharing mechanisms after the start of the rating period?

Hawaii did not add any risk sharing mechanisms during the PHE; however, the demonstration authority permitted Hawaii to make critical modifications to the existing risk sharing methodology of the aggregate gain/loss risk corridor. The changes made allowed MQD to be a good steward of federal and state dollars and operate its Medicaid program efficiently during a period of uncertainty. As a result of the changes the waiver permitted, Hawaii significantly enhanced its ability to recoup unspent funds resulting from reduced healthcare utilization during the PHE.

What were challenges associated with implementing the retroactive risk mitigation strategies? How did the state address these challenges?

There were two important challenges MQD experienced with implementing the retroactive risk mitigation strategies (i.e. the modifications to the aggregate gain/loss risk corridor). First, while understandable, CMS was at or beyond capacity with the number and magnitude of requests it was receiving. As a result, it took significant time to receive approval for the modifications. Next, while Hawaii waited for approval, CMS released new guidance on how waiver requests needed to be submitted with new requirements that were not previously addressed in MQD's request. MQD was flexible in making a series of modifications to adapt to the new guidance. While these challenges prolonged the approval process and required re-work of the request, MQD remained productively engaged with CMS in obtaining the necessary approvals. Ultimately, once approval was granted, implementation was very efficient because the risk mitigation strategies were already in Hawaii's QI managed care contracts, and its Health Plans had been engaged and had agreed to the proposed modifications prior to the request to CMS. Therefore, MQD did not need to develop additional guidance or processes for implementation, with the exception of an evaluation design.

Aside from the administrative challenges described above, since MQD chose to discuss the design of a risk mitigation strategy prospectively with Health Plans during the early months of the PHE, substantial thought and negotiation went into obtaining stakeholder agreement as the

impacts of the PHE were unknown, and MQD's stakeholders needed reassurance that the modifications would effectively mitigate loss for all parties regardless of the direction and outcomes of the PHE. While the modifications were implemented retrospectively due to delays in approval, the design of the approach was developed prospectively after the approval of the rating period by CMS.

What were the lessons learned for any future PHEs in implementing the demonstration?

MQD posits that it is important to be adaptable and flexible while responding to rapidly changing environments, including rapidly changing legal and regulatory environments. Additionally, one of MQD's greatest facilitators was the good working relationships it enjoyed with its stakeholders including CMS, the Health Plans, and its provider communities prior to the PHE. Further, it was important to ensure that all parties achieved a shared vision for what MQD hoped to accomplish, as this provided a foundation for conversation, negotiation, and fast decision-making. Finally, based on experiences in other States, MQD appreciated the value of having an existing risk mitigation strategy in place that could be leveraged and modified quickly. MQD's contractual language and existing approaches offered the necessary flexibility to pivot and make modifications without the need for de-novo design or contract modifications, both of which would have been significantly more time consuming.

What problems would have been caused by the application of 438.6(b)(1) during the PHE that would have undermined the objectives of Medicaid?

During the PHE, the State of Hawaii experienced a protracted period during which the healthcare system became substantially focused on treating healthcare emergencies and severe cases of COVID-19. While some types of service utilization increase, for example outpatient behavioral health in the telehealth setting, routine preventive healthcare, and other elective care significantly declined. As a result of an overall reduction in utilization, Medicaid Health Plans in Hawaii had an abundant surplus of funding. The application of 438.6(b)(1) during the PHE would have prevented MQD from implementing any modifications to our existing risk mitigation strategy and efficiently recouping the surplus of funding that the Health Plans had received. In turn, our Health Plans would have experienced significant profits resulting from an unpredictable event that was unaccounted for during rate setting for the time period. In turn, both federal and state Medicaid dollars would have been wasted. Therefore, the strict application of 438.6(b)(1) during the PHE would have prevented CMS and MQD from remaining good stewards of government funding.

What were the effects of these changes to Medicaid Health Plans' financials? Did the Health Plans avoid material losses as of a result of implementing the retroactive risk sharing agreements?

There were no material losses to Hawaii's Health Plans due to the PHE; rather the Health Plans experienced a surplus (an artificial profit) due to lower than predicted utilization of the healthcare system. As a result of the changes made to the risk mitigation strategies, Hawaii's Health Plans incurred fewer artificial profits than they otherwise would have.

The major themes gathered from the qualitative interviews are described below.

- *Having existing risk mitigation strategies in managed care contracts is very beneficial in effectively navigating through periods of fiscal uncertainty.* MQD's existing risk mitigation strategies provided flexibility and a streamlined path for mitigating fiscal uncertainty. Health Plans were used to routinely managing risk sharing agreements and were open to mutually beneficial modifications. Given that the potential impacts of the PHE were unknown, the discussions with Health Plans were productive because the proposed solutions effectively addressed Health Plan concerns.
- *Trust and shared vision are critical to success during times of uncertainty.* MQD was successful in negotiating mutually agreeable risk mitigation strategies in part due to a long history of transparency and trust in actuarial processes with its Health Plans. This foundation of trust, along with the ability to have in depth discussions with Health Plan executives around the shared vision were critical to adoption and agreement. The discussions were important to helping Health Plans appreciate MQD's concerns about unmitigated waste while MQD navigated the Health Plans' concerns about unmitigated losses. Change champions among Health Plan leadership helped to achieve group consensus.
- *Flexibility and adaptability are key to success for all.* The PHE required nimble decision-making and responsiveness for all parties involved including Health Plans, MQD's actuaries, MQD leadership, and CMS. MQD adapted quickly to changing guidance to resubmit its request as needed, and all stakeholders worked within their constraints to achieve alignment. The overall efficiency of the implementation could be improved in the future by building in nimbleness as a forethought, with streamlined processes available for faster approvals of typical requests.
- *The waiver approval improved MQD's ability to remain a good steward of state and federal dollars.* MQD was able to recover $25.4M more than it otherwise would have from its Health Plans for CY 2020. The recoupment represented funds that were unspent due to depressed utilization of the healthcare system during the PHE; the inability to recoup these funds would have resulted in wastage. Therefore, the waiver approval created conditions that were mutually beneficial to both CMS and MQD; and would have also been beneficial for the Health Plans had the PHE resulted in excessive losses.

Discussion:

The State of Hawaii has a robust Medicaid managed care program, with greater than 99.9% of its beneficiaries enrolled in one of five QUEST Integration managed care Health Plans. The PHE in CY 2020 created an unprecedented period of uncertainty for Hawaii's Health Plans. Health Plans were concerned about a surge in healthcare utilization resulting in unmitigated losses. MQD was concerned that previously negotiated and approved capitation rates would result in wasteful expenditures that could not be recouped.

MQD prospectively negotiated with its Health Plans to modify the parameters of an existing risk mitigation strategy to tighten the aggregate gain/loss risk corridor margins, so that the Health Plans were better protected in the case of unmitigated losses and MQD was better protected in the case of excessive wastage and unspent funds. A COVID-19 PHE Medicaid Section 1115 demonstration waiver request was submitted and subsequently approved by CMS. In turn, the changes were implemented, resulting in a net additional recoupment of $25.4M from Health Plans.

In conclusion, having existing risk mitigation strategies in managed care contracts is very beneficial in effectively navigating through periods of fiscal uncertainty. MQD was able to leverage the strong partnership and foundation of trust it has built with its Health Plans to achieving a shared vision for the proposed changes; this in turn was critical to the overall success of the implemented changes. Flexibility and adaptability are key to success during challenging periods. The PHE produced much anxiety and uncertainty around financial risk, processes for requesting waivers, and timelines for approvals. The ability of all stakeholders to remain flexible and adaptable paved the path for success. Ultimately, CMS' waiver approval was beneficial to all stakeholders involved, including MQD's Health Plans, and resulted in lower wastage for Hawaii's Medicaid program.

Limitations:

There are some limitations to this evaluation design. MQD interviewed a significant number of key stakeholders involved in implementing this demonstration waiver, but due to availability challenges or turnover, was unable to interview all the key participants who participated in the process. Nevertheless, a diversity set of stakeholders was interviewed and the results are believed to be representative of the State's experience.

Additionally, there are several additional limitations that are inherent with most qualitative research designs. This includes biases, accuracy, and thoroughness of respondents' answers. Interviews were conducted in 2024 and may have been biased by the interviewees' recollection of discussions from CY 2020.

Despite these limitations, this evaluation reports on a successful case study of a PHE-related demonstration waiver that resulted in well-received positive financial consequences for Hawaii's Medicaid program.