Hawaii QUEST Integration

Annual Monitoring Report to CMS

Federal Fiscal Year 2019

Reporting Period:

October 1, 2018 - September 30, 2019

(Demonstration Year 25)

Table of Contents

Attachments

I. Introduction

Hawaii's QUEST Integration (QI) is a Department of Human Services (DHS) and Med-QUEST Division (MQD) comprehensive section 1115 (a) Demonstration that expands Medicaid coverage to children and adults originally implemented on August 1, 1994. QUEST Integration uses capitated managed care as a delivery system unless otherwise indicated. Also, QI 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.

During the reporting period, MQD continued to focus on a comprehensive internal quality improvement project, called the HOPE Initiative. "HOPE" stands for Hawaii-Medicaid Ohana-Nui Project Expansion, and the goal of the initiative is to achieve the Triple Aim of better health, better care, and sustainable costs for our community. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and continued sustainable growth rate in healthcare spending from reductions in unnecessary care and shifts of care to appropriate settings. Weekly meetings were held through the federal fiscal year for the "HOPE Leadership Team" to ensure HOPE initiatives are weaved into the new QI Request For Proposal (RFP). On August 26, 2019, the new QI RFP was issued, which introduces an expanded care model to offer additional services for Hawaii's vulnerable population. An orientation for bidders was held on September 10, 2019, and a first round of technical proposal questions and responses was completed on September 27, 2019.

The 1115 waiver 5-year renewal was approved for the period August 1, 2019 – July 31, 2024.

This annual report meets the requirements of item *64 Annual Report* in the Special Terms and Conditions (STC) document of Hawaii's Medicaid State Plan, as well as, the Managed Care Program report required under 42 CFR 438.66(e).

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality spreadsheet for the quarter ending September 30, 2019 was submitted by the November 30, 2019 deadline.

III. Events Affecting Healthcare Delivery

A. Approval & Contracting with New Plans

On August 19, 2019, CMS approved Hawaii's QUEST Integration Supplemental Changes #11 with the existing five health plans, and the capitation rate for calendar year 2019, effective from January 1, 2019 through December 31, 2019. In this period there were no new QI health plans.

B. Benefits & Benefit Changes

Community Integration Services (CIS)

The CIS amendment to the current 1115 Demonstration waiver was approved on October 31, 2018. This amendment will increase access to CIS to individuals who are chronically homeless or in danger of losing public housing with either a physical or behavioral illness. MQD continues to work on provision of these services to eligible beneficiaries with providers and collaborative partners in the community.

1115 Demonstration Renewal

MQD submitted the 1115 Demonstration extension on September 17, 2018 and it was deemed complete by CMS on October 2, 2018. The thirty-day comment period for the waiver lasted from October 3, 2018 to November 1, 2018. In November, the State completed CMS' standard funding questions and one round of questions.

On December 6, 2018, CMS issued a 6-month temporary extension until June 30, 2019 to allow for more negotiation time between the CMS and MQD. MQD has notified CMS that its major priorities beyond a simple extension of the current program include keeping the 1115 as the vehicle for the creation of home and community-based services and expanding the CIS benefit to include more services.

MQD continued to work with CMS on approving the 1115 extension in the December 2018 – June 2019 timeframe. MQD answered all of CMS's questions in a timely manner and began the process of outlining its evaluation design with CMS subject matter experts. There continued to be issues in the negotiation that required more detailed follow up even after multiple rounds of CMS and MQD questions and answers, and the negotiation was not completed by the end of June. Recognizing this issue, CMS granted an additional temporary extension in June that ran until July 31, 2019.

MQD was awarded an extension of the QUEST Integration demonstration on July 31, 2019. MQD received approval for its existing expenditure and waiver authorities, with the exception of the waiver of retroactive eligibility rules. MQD had withdrawn its request to continue that policy in June 2019. MQD received additional expenditure authority to expand the set of CIS benefits available to beneficiaries. CMS also included new reporting requirements in the Special Terms and Conditions.

HOPE initiative

MQD staff from across the various branches continue to work with our consultants, stakeholders and other parties to develop implementation plans for the initiatives outlined in our HOPE document and the MCO Request for Proposal. A primary focus has been on planning for implementation of advanced Health Homes, which will be known as "Hale Ola", a new type of service delivery and coordination that was included in the MCO RFP. This has

required intensive discussions with the HOPE leadership team and the consultants assigned to this task. Health Prevention and Promotion, which includes services for Diabetes such as pre-diabetes counseling and education, asthma education, cardiac rehab, other disease management classes and counseling, has been the other focus area.

Department of Education (DOE) & School Based Services

Med-QUEST continues to partner with DOE and assist their staff with Medicaid billing issues to better enable them to appropriately bill Medicaid. This includes bi-weekly meetings, emails and written guidance to enable DOE to appropriately maximize Medicaid reimbursement for school-based medically necessary services.

During the reporting period, DOE staff conducted mass mail outs and telephone calls to inform and receive necessary consent forms from parents to work with Medicaid for medically necessary services during school hours. The process has been more challenging due to multiple and varied barriers encountered along the way. Despite the challenges, DOE successfully began billing for skilled nursing services November 1, 2019 and received their first reimbursement check shortly thereafter. The DOE also increased their administrative support, by creating a Medicaid office specifically tasked with working with MQD for claiming issues and has been actively recruiting to hire support staff.

Hawaii Administrative Rules

For the reporting period, the following State Plan Amendments were approved: 19-0001 (Optional State Supplementary Payment) approved by CMS 05/29/19, 19-0002 (Reduce tribal consultation period from 45 days to 14 days) approved by CMS 07/08/19, 19-0003 (Out Patient Drugs) approved by CMS 09/19/19, as well as additional SPAs in various stages of development.

Policy and Program Directives

Policy and Program Directives (PPDs) are issued to MQD staff for information, clarifications and actions to be taken relative to any policy change ranging from changes in federal rules and policy to changes in state rules and regulations. For the reporting period, six (6) PPDs were issued:

18-002 , Health Care Surrogates and Other Individuals Legally Appointed To Be An Authorized Representative for Medicaid; 18-003, 2019 Medicare Premiums, Deductibles and Co-Insurance Rates; 18-004 , 2019 Spousal Impoverishment Standards and the Home Equity Limit for Long Term Care Individuals: 18-005, 2019 SSA RSDI, SSI And VA Cost Of Living Adjustment (COLA) Increase; 19-003, Revised Actuarial Life Table; 19-004, Medical Mass Change 04/19 Due to the Increase in the Federal Poverty Levels for 2019.

C. Enrollment and Disenrollment

The Enrollment Services Section (ESS) operates a call center responsible for performing application intake, change of circumstance and enrollment or disenrollment for QUEST Integration health plans for clients, Medicaid provider inquiries, and public portal users support. The ESS completed 3,677 applications by phone and 2,890 pre-enrollments this reporting period.

The 2018 QUEST Integration Annual Plan Change was October 1 through 31, and enrollment began January 1, 2019. A total 326,306 Medicaid beneficiaries were eligible to participate in annual plan change. Of the total participants, 5,752 (1.8%) Medicaid beneficiaries elected to enroll in a different health plan for the 2019 benefit year (January to December 2019). The following is a summary of the annual plan change selections by island.

Program	Oahu	Kauai	Hawaii	Maui	Lanai	Molokai
MAGI	2,839	213	770	673	60	7
MAGI Excepted	831	36	217	88	17	1
Total	3,670	249	987	761	77	8

QUEST Integration health plans processed 408 plan change requests from its members.

The top five languages serviced using interpreter assistance included Chinese (Mandarin and Cantonese) (20%), Japanese (19%), Filipino (Ilocano, Tagalog, and Visayan) (16%), Korean (20%), and Spanish (11%).

D. Quality of Care and Clinical Care Guidelines

Med-QUEST (MQD) continued work on telehealth services and guidance as this continues to be an area of interest and growth for geographical areas that do not have a robust network of providers. More specifically we concentrated on tele-dentistry as it is a relatively new area so guidance on the provision of dentistry utilizing synchronous and asynchronous methods was needed. The Division worked with the Department of Health and the Department of Commerce and Consumer Protection (Board of Dental Examiners), researched other States to see what was being done, reviewed Hawaii's largest commercial dental plan to see how they were complying with the state statute as it related to the expanded scope of practice for hygienists and supervision requirements of dentists.

Work on the provision of palliative care in the community setting was conducted as it is an area the Division would like to explore in the near future. The structure would be similar to how hospice care is provided under one bundled reimbursement that would also include curative care and care management. This care model will improve the quality of care and quality of life for recipients.

Med-QUEST Division initiated work with the managed care health plans to begin receiving information and data for inclusion in the Drug Utilization Review annual report due to CMS. Prior to this, MQD only reported on fee-for-service claims. This change will result in more consistent application of drug policies that would benefit both providers and Medicaid beneficiaries.

Work was done to review One-Time Emergency-only claims as it was found that there were individuals who repeatedly went to the emergency room for care who could qualify for Medicaid or had third party insurance coverage. MQD worked with the hospitals and our Eligibility Branch to ensure those who used the emergency room frequently submitted applications for Medicaid. That way, if they were eligible for Medicaid, they could be enrolled into a health plan that would then ensure a PCP is assigned and the recipient would receive appropriate care rather than always going to the emergency room.

Work on the implementation of SUPPORT Act requirements was undertaken to ensure safety edits were in place and managed care plans would be in compliance by October 1, 2019.

E. Access that is Relevant to the Demonstration

During the reporting period, there were no major events affecting access.

F. Pertinent Legislative or Litigation Activity

MQD was notified of being party to a lawsuit along with the Children and Adolescent Mental Health Division, Dept. of Health for the provision of mental health services for a child/young adult.

The 2019 Legislative session concluded in May 2019. The following summarizes legislation that impacts the Medicaid program: the provider tax programs were continued that allows expanding the quality improvement and performance measurement programs with the hospitals and nursing facilities; several bills create task forces or workgroups with Medicaid representation addressing the continuum of care for behavioral health services and homelessness; eligibility criteria, and I/DD waiver home/community based services for individuals with autism or with fetal alcohol syndrome; and expanding eligibility criteria for employed persons with disabilities.

IV. Grievances, Appeals & State Fair Hearings

A. Grievance Events that Affected Health Care Delivery

See section IV.B. below.

B. Information On and Assessment Of Grievances and Appeals for the Managed Care Program

Grievances

The managed care health plans have policies, procedures, and systems for logging, tracking, and reporting appeals and grievances. The health plans have grievance coordinators who manage member grievances and interface with other departments in the process of investigating and responding to members. It was found that the health plans were timely in their acknowledgment and resolution letters to members. Letters were written at or below a 6.9 grade reading level and were based on templates required by MQD to communicate grievance acknowledgements and dispositions to the members.

It appears that members have been exercising member grievance rights and the Health Plans are striving to be on time with acknowledgement and resolution letters. If a member is not satisfied with the health plan's grievance decision, the member has been given the information on how to file a state grievance review with DHS/MQD. The grievance review determination made by DHS/MQD is final.

Appeals

The managed care health plans have policies, procedures, and systems for logging, tracking, and reporting appeals. The health plans have appeals coordinators that interface with the authorization and referral management, pharmacy management, and the medical director to make appeal decisions and respond to members. Individuals making appeal decisions have the appropriate credentials and were not involved in the initial decision. The health plans met timeliness requirements for the acknowledgement and resolution letters.

State Fair Hearings (Administrative Hearings)

Requests for a State Administrative Hearing are disseminated by the Administrative Appeals Office to MQD. It appears that members have been exercising their appeal rights and have made requests for administrative hearings.

C. Member Grievances and Appeals Filed During the Reporting Period by Type

The following tables provide information on the grievances and appeals received during this reporting period.

Grievances to MQD Health Care Services Branch (HCSB)

October 2018 – September 2019 Types of Member Grievances to MQD (HCSB)	
Description: The following are grievances received by the HCSB of MQD. These DO NOT include the grievances received by the Health Plans, which are reported in a separate table below.	
Health Plan Policy	13
Provider/Provider Staff Behavior/Services	9
Transportation Customer Service	4
Treatment Plan/Diagnosis	2
Fraud and Abuse of Services	7
Billing/Payments	3
Member Rights	9
Forward to Other Departments	9
Total	**56**

Month	# of Member Grievances Addressed by HCSB
October 2018	4
November 2018	2
December 2018	3
January 2019	5

February 2019	4
March 2019	4
April 2019	8
May 2019	6
June 2019	5
July 2019	3
August 2019	6
September 2019	6
Total	**56**

Status of Member Grievances Addressed by HCSB					
	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul–Sep 2019	**TOTAL**
Received	9	13	19	15	56
Status					
Referred to Subject Matter Expert	3	3	11	0	17
Health Plan resolved with Members	0	0	1	5	6
Member withdrew grievance	0	0	0	1	1
Resolution in Health Plan favor	0	5	1	1	7
Resolution in Member's favor	9	5	3	3	20
Still awaiting resolution	0	0	0	1	1
Carry-over from previous Quarter	0	0	0	5*	5

*This contains a carry-over from 5/14/19 working with eligibility to resolve issues related to bills received for services not used by member.

Grievances to Health Plans

Types of Member Grievances Reported to Health Plans					
	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul–Sep 2019	
Medical					**TOTAL**
Provider Policy	4	7	5	10	26
Health Plan Policy	29	42	33	32	136
Provider/Provider Staff Behavior	79	101	81	72	333
Health Plan Staff Behavior	45	54	34	38	171
Appointment Availability	5	5	8	9	27
Network Adequacy/ Availability	1	3	5	5	14
Waiting Times (office, transportation)	80	104	97	91	372
Condition of Office/ Transportation	4	4	9	4	21
Transportation Customer Service	37	29	25	21	112
Treatment Plan/Diagnosis	8	19	26	26	79
Provider Competency	15	24	27	43	109
Interpreter	0	0	0	0	0
Fraud and Abuse of Services	3	7	1	2	13
Billing/Payments	4	15	14	13	46
Health Plan Information	15	12	26	20	73
Provider Communication	18	22	31	22	93
Member Rights	0	1	3	10	14
Total	347	449	425	418	1639

Some members had multiple areas that need to be addressed within their one grievance report to MQD.

Status of Member Grievances Reported to Health Plans					
	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	**TOTAL**
Total number filed during the reporting period	325	408	351	350	1434
Status received from Health Plans					
Total number that received timely acknowledgement from health plan	318	399	316	346	1379
Total number not receiving timely acknowledgement from health plan	7	8	3	3	21
Total number expected to receive timely acknowledgement during next reporting period	0	1	32	4	37
Total number that received timely decision from health plan	296	389	280	326	1291
Total number not receiving timely decision from health plan	21	13	1	17	52

Total number expected to receive timely decision during next reporting period	17	7	40	30	94
Total number currently unresolved during the reporting period	17	10	40	30	97

Appeals to the Health Plans

There was a total of 1,176 appeals submitted for FFY 2019 with the health plans. Of those appeals submitted to the health plans, only 21 appeals were submitted with the Administrative Appeals Office. There were 13 resolved with the health plan or decided in Member's favor prior to going to a hearing. There were 8 resolved in DHS's favor.

Types of Member Appeals to Health Plans					
	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	**TOTAL**
Service denial	30	43	47	68	188
Service denial due to not a covered benefit	35	25	35	53	148
Service denial due to not medically necessary	152	195	230	230	807
Service reduction, suspension or termination	0	1	5	1	7
Payment denial	5	5	9	17	36
Timeliness of service	0	0	0	0	0
Prior authorization timeliness	0	0	0	0	0
Other	1	1	0	0	2

Status of Member Appeals to Health Plans					
	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	**TOTAL**
Total number filed during the reporting period	213	279	322	362	1176
Status received from Health Plans					
Total number that received timely acknowledgement from health plan	192	234	288	330	1044
Total number not receiving timely acknowledgement from health plan	15	42	32	30	119

Total number expected to receive timely acknowledgement during next reporting period	15	29	23	20	87
Total number that received timely decision from health plan	177	225	274	330	1006
Total number not receiving timely decision from health plan	25	42	29	19	115
Total number expected to receive timely decision during next reporting period	27	39	40	31	137
Total number currently unresolved during the reporting period	27	35	40	31	133
Total number overturned	108	142	192	208	650

Appeals to the State (State Fair Hearings)

Types of Member Appeals to State Administrative Appeals Office (AAO)					
	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	**TOTAL**
Medical	0	0	1	1	2
Long Term Services and Support (LTSS)	2	2	0	2	6
Van Modification	0	0	0	0	0
Applied Behavioral Analysis (ABA)	0	2	0	0	2
Durable Medical Equipment	0	0	0	0	0
Reimbursement	0	1	1	0	2
Medication	0	1	0	2	3
Miscellaneous	3	0	0	3	6

Status of Member Appeals to State Administrative Appeals Office (AAO)					
	Oct-Dec 2018	Jan-Mar 2019	Apr-Jun 2019	Jul-Sep 2019	**TOTAL**
Submitted	5	6	2	8	21
Status received from AAO					

Department of Human Services (DHS) resolved with health plan or Department of Health Developmental Disabilities Division (DOH-DDD) in Member's favor prior to going to hearing	3	3	2	5	13
Dismiss as untimely filing	0	0	0	0	0
Member withdrew hearing request	0	0	0	0	0
Resolution in DHS' favor	2	3	0	3	8
Resolution in Member's favor	0	0	0	0	0
Still awaiting resolution	0	0	0	0	0

V. Adverse Incidents

A. Long Term Services and Supports (LTSS)

In FFY 2019, a total of 1,176 adverse events related to the LTSS population were reported. The top five incident categories were: Fall, Hospital, Death, Emergency Room Visit, and Injury. Falls were the top occurring incident for three quarters. Hospitalization was the second most occurring incident.

Types of Adverse Events MQD					
	Oct 2018 Nov 2018 Dec 2018	Jan 2019 Feb 2019 Mar 2019	Apr 2019 May 2019 Jun 2019	Jul 2019 Aug 2019 Sep 2019	**TOTAL**
Fall	91	146	47	117	401
Hospital	60	58	79	73	270
Death	31	38	46	43	158
Emergency Room Visit	28	57	37	58	180
Injury	24	53	43	47	167
TOTAL	234	352	252	338	1176

The LTSS category includes a number of different provider types such as Community Care Foster Family Homes (CCFFHSs), Extended Adult Residential Care Homes (EARCHs), and nursing facilities. The following provides greater detail on the adverse incidents reported to MQD by the nursing facilities for the reporting period.

B. Medicaid Certified Nursing Facilities

Total of 57 reported adverse incident reports submitted during the period of October 2018 – September 2019.

- 34 unattended/unwitnessed falls
- 15 witnessed falls
- 5 unknown cause of pain/skin discoloration
- 2 self-inflicted unintended injuries
- 1 shortness of breath

Developmental Disability and Intellectual Disability (DD/ID) facilities are not included in the LTSS category. Below, are the adverse incidents reported to MQD by intermediate care DD/ID facilities for the reporting period.

C. Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities:

Total of 60 reported adverse incident reports submitted during the period of October 2018 – September 2019.

- 33 ER visits due to illness
- 19 ER visits due to physical Injury (Hernia)
- 2 ER visit-attended fall
- 1 ER visit-uncooperative behavior (refusal to walk)
- 1 ER visit-replaced catheter
- 1 L-Ear dx Basal Cell Carcinoma
- 1 teeth extraction
- 1 scheduled shunt operation
- 1 ER F/U Admit to monitor

VI. State Efforts Related to the Collection and Verification of Encounter Data and Utilization Data

MQD shares an MMIS system with the Arizona Heath Care Cost Containment System (AHCCCS); the encounter intake and validation systems are structured similarly, and enhancements and modifications are generally operationalized simultaneously for both states. However, AHCCCS has achieved better encounter data quality

than Hawaii. During FFY 2019, Med-QUEST Division ramped up its efforts related to the improvement of encounter data quality in multiple ways.

First, MQD participated in a Data Analytics Innovator Accelerator Program (IAP). MQD conducted a thorough analysis of pended encounters in the system, and developed a better understanding of the primary contributors to pends in our system. Based on the analyses, MQD is better prepared to prioritize targeted improvements to address pended encounters.

Second, MQD conducted a monthly encounter validation meeting with all participating MCOs throughout the year to address major issues in encounter data submission or validation. Ongoing engagement supported a continuous data quality improvement initiative aimed at decreasing the number of encounters that fail system edits. MQD also developed and implemented an encounter reconciliation process directly with the MCOs that accounted for financial discrepancies between encounters submitted by the MCOs and accepted by MQD. The protocol for this reconciliation process has undergone iterative improvements, and the reconciliation is conducted at least twice per year.

Third, MQD began work to investigate and address the sources of discrepancies between the MCOs' and MQD's systems. For example, MQD worked with its contracted actuary, Milliman, to refine a reconciliation process that would compare encounters submitted by the MCOs to Milliman for rate development to those submitted and accepted by MQD. This process has been conducted on an ad hoc basis in the past, but will be folded into an ongoing reconciliation process conducted annually beginning with FFY 2020. Triangulation of the reconciliation process to identify discrepancies found in the three systems (MCOs, Milliman, and MQD), and reconciliation of those differences, will enable improvements in data quality to support the use of data in the State Medicaid encounter system for future rate setting.

Fourth, in addition to encounter data reconciliation, MQD worked closely with Milliman to effectively increase the financial consequences to MCOs associated with poor data quality in the State Medicaid encounter system; specifically, risk sharing for high cost newborns is exclusively based on encounters found within the State Medicaid encounter system. Beginning in CY 2019, risk sharing for high cost drugs was also implemented to be based on encounters found within the State Medicaid encounter system.

VII. Action Plans for Addressing Issues Identified In:

A. Policy

During the reporting period, no policy issues were identified for any action plans.

B. Administration

MQD's Ombudsman contractor failed to comply with several contract requirements. MQD is working with the contractor to resolve these issues.

C. Budget

See section IX. below.

VIII. Expenditure Containment Initiatives

No new containment initiatives for this reporting period.

IX. Financial/Budget Neutrality Development/Issues

Throughout the year, there were no significant issues identified, so no corrective action plans were necessary.

X. Yearly Enrollment Reports for Demonstration Participants for the Demonstration Year

A. Enrollment Counts

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**10/2018 - 9/2019**	**As of 9/30/19**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	1,394,980	115,223
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	423,876	33,941
Aged	Aged w/Medicare Aged w/o Medicare	328,093	28,042

Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	287,758	24,057
Expansion State Adults	Expansion State Adults	1,116,655	91,877
Newly Eligible Adults	Newly Eligible Adults	250,426	20,194
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	5,989	531
CHIP	CHIP (HI01), CHIPRA (HI02)	351,736	28,917
Total		4,159,513	343,320

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	202,332
Title XXI funded State Plan	28,917
Title XIX funded Expansion	112,071
Enrollment current as of	9/30/2019

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total for Year Ending 9/30/19
EG 1 – Children	118,170	117,934	116,951	116,488	117,112	116,524	115,818	116,437	116,400	115,989	116,443	116,703	1,400,969
EG 2 – Adults	36,332	36,238	35,846	35,614	35,734	35,222	34,543	35,037	34,888	34,796	34,760	34,866	423,876
EG 3 – Aged	26,879	26,928	26,911	27,285	27,369	27,462	27,556	27,514	27,615	27,334	27,627	27,613	328,093
EG 4 – Blind/Disabled	24,136	24,410	24,251	24,055	24,154	23,938	23,848	23,588	23,790	23,768	24,087	23,733	287,758
EG 5 – VIII-Like Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
EG 6 – VIII Group Combined	114,694	115,384	115,824	116,057	114,746	114,050	112,959	112,513	113,195	112,269	111,909	113,481	1,367,081

(Entries of "n/a" indicate that the State of Hawaii does not report on the eligibility group.)

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total for Year Ending 9/30/19
State Plan Children	117,738	117,432	116,461	116,009	116,626	116,022	115,308	115,929	115,886	115,462	115,920	116,187	1,394,980
Sate Plan Adults	36,332	36,238	35,846	35,614	35,734	35,222	34,543	35,037	34,888	34,796	34,760	34,866	423,876
Aged	26,879	26,928	26,911	27,285	27,369	27,462	27,556	27,514	27,615	27,334	27,627	27,613	328,093
Blind or Disabled	24,136	24,410	24,251	24,055	24,154	23,938	23,848	23,588	23,790	23,768	24,087	23,733	287,758
Expansion State Adults	93,553	94,063	94,033	94,399	93,673	93,087	92,469	92,002	92,771	91,931	91,665	93,009	1,116,655
Newly Eligible Adults	21,141	21,321	21,791	21,658	21,073	20,963	20,490	20,511	20,424	20,338	20,244	20,472	250,426
Optional State Plan Children	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Foster Care Children, 19-20 years old	432	502	490	479	486	502	510	508	514	527	523	516	5,989
Medically Needy Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Demonstration Eligible Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Demonstration Eligible Children	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
VIII-Like Group	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Governmental	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Governmental LTC	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Private	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

(Entries of "n/a" indicate that the State of Hawaii does not report on the eligibility group.)

C. Enrollment in Behavioral Health Programs

Behavioral Health Programs Administered by the Department of Health (DOH)

Point-in-Time (1st day of last month in reporting quarter)

Program	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Enrollment			
Community Care Services (CCS) Adult (at least 18 years old) QI beneficiaries with a serious mental illness (SMI) or serious and persistent mental illness (SPMI) who meet the program criteria, receive all behavioral health services through the CCS program.	**4,598**	**4,493**	**4,342**	**4,277**
Early Intervention Program (EIP/DOH) Infant and toddlers from birth to 3 years old receive services to assist in the following developmental areas: physical (sits, walks); cognitive (pays attention, solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	**985**	**870**	**865**	**870**
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**1,006**	**1,005**	**1,149**	**1,165**

D. Enrollment of Individuals Eligible for Long Term Services and Supports (LTSS)

Long Term Services and Supports (LTSS) enrollment reported by the health plans is as follows.

(Combined Dashboard as of 2/19/19 2:03 pm)

1st Quarter Health Plan	Oct 2018	Nov 2018	Dec 2018
Aloha Care	449	533	544
HMSA	834	844	722
Kaiser	215	209	217
Ohana	3122	3014	2982
United Healthcare	2195	2221	2159
Total	**6815**	**6821**	**6624**

(Combined Dashboard as of 5/21/19 2:36 pm)

2nd Quarter Health Plan	Jan 2019	Feb 2019	Mar 2019
Aloha Care	593	488	518
HMSA	747	725	705
Kaiser	232	255	243
Ohana	3136	3081	2968
United Healthcare	2318	2226	2300
Total	**7026**	**6775**	**6734**

(Combined Dashboard as of 8/19/19 9:57 am)

3rd Quarter Health Plan	Apr 2019	May 2019	Jun 2019
Aloha Care	514	513	553
HMSA	696	685	686
Kaiser	232	244	259
Ohana	3038	2948	2940
United Healthcare	2335	2402	2381
Total	**6815**	**6792**	**6819**

(Combined Dashboard as of 11/19/19 9:52 am)

4th Quarter Health Plan	Jul 2018	Aug 2018	Sep 2018
Aloha Care	483	640	692
HMSA	688	698	708
Kaiser	276	292	280
Ohana	3051	2964	2812
United Healthcare	2384	2247	2311
Total	**6882**	**6841**	**6803**

Plan-to-plan change requests and results, specifically for LTSS members, are not tracked. The QI program includes LTSS services amongst its benefits.

XI. Outreach and Innovative Activities

The Health Care Outreach Branch (HCOB) actively planned and prepared for the Annual Medicaid Enrollment system (KOLEA) and Health Insurance Marketplace training to approximately 120 “Kōkua” (outreach/enrollment assisters), in-person assisters from Federally Qualified Health Centers (FQHC’s), Med-QUEST Kōkua Services Contractors, and other community health centers statewide. Trainings occurred on all islands, and covered a broad range of topics from HealthCare.gov, Advance Premium Tax Credits (APTC) and Cost Share Reductions

(CSR), and the need to reconcile APTC's from a 1095-A form with Annual Tax Filing by way of tax form 8962 to the IRS to Medicaid eligibility and enrollment system. Cultural Competency is incorporated in all the trainings.

HCOB's outreach and enrollment efforts were successful for open enrollment on the Health Insurance Marketplace for 2018 as Hawaii enrollments totaled, 20,000, showing an increase from the previous 2017 open enrollment. Hawaii showed an increase in enrollments as numbers across the nation decreased across the board.

HCOB issued an RFP for the Kōkua Services (outreach services) contract on March 29, 2019. Contracts were awarded on May 31, 2019 to Partners In Development (We Are Oceania), Legal Aid Society of Hawaii, and Hawaii Island HIV/AIDS Foundation who additionally subcontracted with the following community partners: West Hawaii Community Health Center, Kalanihale, and Hawaii Island YMCA, to conduct outreach, education, and provide assistance with health coverage enrollment on Hawaii Island and with Imua Family Services and Malama I Ke Ola on Maui to serve Maui County, which includes the islands of Maui, Molokai and Lanai. The contract began on July 1, 2019.

Significant work through the year continued in identifying and assisting hard to reach populations and 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, justice-involved populations and those who are admitted to and discharged from public institutions such as the Hawaii State Hospital.

Additionally, staff worked with clients and Health Insurance issuers to review and determine applicant eligibility for the State of Hawaii's Premium Assistance Program (PAP). PAP is the State's innovative approach to helping those who are living in poverty, are deemed ineligible for Medicaid due to their citizenship status, and whose households are below 100% of the Federal Poverty Level (FPL). In particular, PAP helps such individuals 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 Advanced Premium Tax Credit (APTC) they are eligible for, and meets the expectations of the Affordable Care Act (ACA) that require individuals without qualified exemptions to be insured.

XII. Number of Participants who Chose an MCO and Number of Participants who Changed Plans After Auto-Assignment

Member Choice of Health Plan Exercised

Number of Members	Oct 2018 – Dec 2018	Jan 2019 – Mar 2019	Apr 2019 – Jun 2019	Jul 2019 – Sep 2019	Total
Individuals who chose a health plan when they became eligible	608	634	747	901	2,890

Individuals who changed their health plan after being auto-assigned	2,561	2,496	2,359	2,358	9,774
Individuals who changed their health plan outside of choice period	134	94	90	90	408
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	14	9	8	14	45

During this reporting period, 2,890 individuals chose their health plan when they became eligible, and 9,774 changed their health plan after being auto-assigned. Also, 35,573 individuals had an initial enrollment which fell within this reporting period.

In addition, 45 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

XIII. Demonstration Evaluation and Interim Findings

As part of the negotiation process for the 1115 renewal, MQD and CMS worked on new 1115 evaluation requirements during FFY 2019. Those requirements were finalized when the demonstration was approved on July 31, 2019.

During FFY 2019, MQD established a Health Analytics Office within the division to oversee all data analytics including evaluation. MQD also progressed in identifying and developing agreements with an external evaluator. In June 2019, MQD finalized and executed a Memorandum of Understanding with the University of Hawaii at Manoa that established the financial and legal mechanisms by which MQD will contract with the University to provide evaluation support. In anticipation of the 1115 approval, a lead evaluation coordinator was recruited, and ongoing meetings were held to increase the coordinator's familiarity with the goals and objectives of the Medicaid program in general, and the proposed activities in the 1115 renewal in specific. Upon the finalization of the Special Terms and Conditions of the 1115 waiver, MQD worked with the evaluation coordinator between August and September 2019 to identify areas for in depth evaluation, recruit evaluators with subject matter expertise in these areas, and establish an evaluation team within UH to support the 1115 evaluation. Next, a planning process to (a) ascertain data needed for appropriate evaluation of demonstration activities, (b) identify data gaps where additional primary data collection is needed, and (c) develop mechanisms to ensure reporting of additional data elements was begun. FFY 2019 was primarily dedicated to the formation of the evaluation team

(both within and outside MQD), and orientation of the team to the 1115 demonstration goals and objectives. Plans have been established to develop an evaluation design for submission to CMS during FFY 2020.

XIV. Quality Assurance and Monitoring Activity

Quality Activities

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

1. Validation of Performance Improvement Projects (PIPs)

   Per Hawaii's Quality Strategy, each health plan was required by the MQD to conduct PIPs in accordance with 42 CFR 438.240. The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. For such projects to achieve meaningful and sustained improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

   And, as one of the mandatory EQR activities required under the Balanced Budget Act, the EQRO conducted annual validation of these PIPs. The EQRO completed their validation through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG follows guidelines established in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (the PIP protocol).

   The primary objective of the PIP validation was to determine the health plans' achievement of PIP module criteria, including:

   - Integration of quality improvement science.
   - Formation of teams.
   - Setting aims.
   - Establishing measures.

   Towards the end of 2017, the EQRO initiated validation activities for the following 12 new PIPs to be submitted by the Hawaii Medicaid health plans:

   1. For four QI health plans-
      - Prenatal and Postpartum Care and
      - Getting Needed Care.

   2. For one QI health plan-

- Medication Management for People with Asthma (ages 5-64) and
- Getting Needed Care

3. For CCS-
   - Follow-Up After Hospitalization for Mental Illness (7 days) and
   - Behavioral Health Assessment.

HSAG's validation of PIPs includes the following two key components of the quality improvement process:

1. Evaluation of the technical structure to determine whether a PIP's initiation (e.g., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation through the use of PDSA cycles, and sustainability and spreading successful change. This component evaluates how well the health plan executed its quality improvement activities and whether the desired aim was achieved and sustained.

HSAG evaluations were for the 2017 validation cycle. The core components of this standard approach involve testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.

Health Plan PIP results are provided in section XVIII.N. below.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

Validation of performance measures (PMs).

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the HEDIS 2019 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.1- The audit procedures were also consistent with the CMS protocol for performance measure validation: EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012.1- The health plans that contracted with the MQD during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health. The measurement period was CY 2018 (January 1, 2018, through December 31, 2018), and the audit activities were conducted concurrently with HEDIS 2019 reporting.

During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 31 measures, yielding a total of 113 measure indicators, for the QI population. 'Ohana CCS was required to report on 10 measures, yielding a total of 53 measure indicators, for the CCS program. The measures were organized into the following six categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services.

- Access to Care
- Children's Preventive Care
- Women's Health
- Care for Chronic Conditions
- Behavioral Health
- Utilization and Health Plan Descriptive Information

HSAG evaluated each QI health plan's compliance with NCQA information system (IS) standards during the 2019 NCQA HEDIS Compliance Audit. All QI health plans were Fully Compliant with the IS standards applicable to the measures under the scope of the audit except for UHC CP QI (IS 5.0: Partially Compliant). Overall, the health plans followed the NCQA HEDIS 2019 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of Reportable. Summarized results can be found on the MQD website under the tabs "Resources", and then "Quality Strategy".

3. Compliance Monitoring Review

Calendar year (CY) 2019 began a new three-year cycle of EQR compliance reviews for the QI health plans and the CCS program.

For the 2019 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs, using monitoring tools to assess and document compliance with a set of federal and State requirements. The second compliance review activity in 2019 involved HSAG's and the MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to findings from the 2019 compliance review, which were all addressed by the end of 2019 or early 2020.[1-1]

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

During this reporting period, the Child CAHPS survey for both Medicaid and CHIP was conducted. Results were provided to MQD at both the plan-specific and statewide aggregate report levels and are summarized later in this report in section XVIII.I below.

The Child CAHPS survey and the CHIP CAHPS survey used the CAHPS 5.0H Child Medicaid Health Plan Survey instrument (without the children with chronic conditions [CCC] measurement set) for child members 17 years of age or younger as of December 31, 2018 enrolled in the QI health plans. All parents/caretakers of sampled members completed the surveys from February to May 2019 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese. It is important to note that the CAHPS 5.0H Health Plan Survey is made available by NCQA in English and Spanish only. Therefore, prior to the start of the CAHPS Survey process, and in following NCQA HEDIS Specifications for Survey Measures, HSAG submitted a request for a survey protocol enhancement and received NCQA's approval to allow the parents/caretakers of sampled child members the option to complete the CAHPS survey in the designated alternate languages.

[1-1] KFHP QI completed all outstanding CAP items from the 2017 compliance monitoring reviews in March 2019.

5. Provider Survey

In 2018 the EQRO administered a provider survey, which is done biennially.
The provider survey revealed opportunities to improve provider satisfaction in the following areas:

- *Adequate Access to Non-Formulary Drugs*
- *Adequacy of Specialists*
- *Adequacy of Behavioral Health Specialists*
- *Compensation Satisfaction*
- *Timeliness of Claims Payments*
- *Prior Authorization Process*
- *Formulary*
- *Helpfulness of Service Coordinators*
- *Availability of Mental Health Providers*
- *Access to Substance Abuse Treatment*

The findings of the above can be found in the Hawaii External Quality Review Report of Results for the QI Health Plans and the Community Care Services program. This report summarizes the activities described above, as well as:

- An assessment of each health plan's strengths and weaknesses for providing healthcare timeliness, access, and quality across CMS-required mandatory activities for compliance with standards, performance measures, and performance improvement projects (PIPs). The report also includes an assessment of an optional consumer satisfaction child survey.
- Recommendations for the CMOs to improve member access to care, quality of care, and timeliness of care.

Findings, Conclusions, and Recommendations

The table below summarizes the results from the 2019 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

More findings from the 2019 compliance review are provided later in this report, in section XVIII.M.

Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
Coverage and Authorization of Services	78%	88%	75%	72%	88%	84%	**81%**
Access and Availability	100%	100%	88%	88%	100%	85%	**94%**
Coordination and Continuity of Care	90%	90%	80%	100%	100%	67%	**88%**
Member Rights and Protections	89%	56%	56%	89%	89%	89%	**78%**
Member Information	82%	64%	59%	77%	73%	76%	**72%**
Member Grievance System	56%	74%	70%	67%	78%	70%	**69%**
Totals	**78%**	**79%**	**72%**	**78%**	**85%**	**78%**	**78%**
***Totals*:** The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.							

XV. Quality Strategy Impacting the Demonstration

During this reporting period, MQD contracted with a vendor, Myers Stauffer, to assist with updating MQD's quality strategy. MQD's quality strategy will follow the pillars outlined in the HOPE Vision document.

XVI. Total Annual Expenditures for the Demonstration Population for the Demonstration Year

Please see Attachment C: Schedule C, Quarter Ending September 30, 2019.

XVII. Expenditures for Uncompensated Care Costs

Please see Attachment C: Schedule C, Quarter Ending September 30, 2019.

XVIII. Managed Care Delivery System

A. Accomplishments

Hawaii received approval for the 1115 Waiver to include Community Integrated Services. During this reporting period, initial funding for one CIS position in each health plan was dispersed by the Going Home Plus (GHP) project.

During this reporting period MQD completed and issued the new QUEST Integration RFP worth two billion dollars. This project involved coordinated efforts from the entire division and took over eighteen months of planning. It also included input from three consultants, other state departments, and community stakeholders.

MQD made significant progress with the provider management MMIS module project, HOKU. This upgrade will fast-track and improve the provider enrollment with the state.

For its Electronic Visit Verification (EVV) project, MQD contracted with the selected vendor, Sandata, and began planning and implementation work.

B. Status of Projects

During this reporting period, MQD completed the following projects.

1. National Take Back Initiative to receive unused or expired medications.
2. QI RFP supplemental changes to comply with 42 CFR 438 MCO Final Rules
3. Five-year 1115 Demonstration Waiver renewal
4. The new QI RFP scope of services

The following are on-going projects that MQD continues to make progress in.

1. Electronic Visit Verification (EVV)
2. Medicaid Provider Management System Upgrade (PMSU) – "HOKU" (Hawaii's Online Kahu Utility); HOKU in Hawaiian means, guiding star; Kahu in Hawaiian means caretaker, pastor, or one who looks after their flock
3. Additional My Choice My Way outreach and training
4. Collaborating with DOH and revising the Hawaii Administrative Rules for HCBS settings to comply with the HCBS Final Rules
5. Medicaid provider revalidation
6. Medicaid Information Technology Architecture (MITA) update
7. Community Care Services (CCS) on-site case management agency audits
8. Health Information Technology (HIT) investments
9. Department of Health (DOH) Immunization Record System
10. New Care Model design and planning
11. Addition of new Health Analytics Office (HAO) to analyze health plan data for quality assurance and performance improvements

C. Findings of Quantitative Studies

See section D below.

D. Findings of Case Studies and Reviews

During this period, audits were performed on a case-by-case basis by MQD Quality and Member Relations Improvement Section when issues were found during report reviews. Common findings were: lack of documentation; lack of person-centered language; and timeliness of assessments or re-assessments. Health Plans mitigated the issues found based on the recommendations of MQD.

Health Plans continued to train and re-train staff in documentation and service planning and provide MQD with the results of the training with staff. Periodic auditing will continue to measure improvements in the deficit areas.

E. Findings of Interim Evaluations

During this reporting period, Hawaii had its 5-year 1115 waiver approved. With the new waiver rapid cycle interim evaluations were stipulated in the Special Terms and Conditions (STC). Hawaii is prepared to comply with these STCS.

F. Utilization Data

Calendar Year (CY) 2018 incurred cost model data produced by our actuaries for our QI program is included as Attachment H. This data is aggregated for all of our MCOs (excluding Kaiser). It is broken out by non-expansion, expansion, and ABD population groups.

G. Progress on Implementing Cost Containment Initiatives

Discharge Planning for Difficult-to-Place Members

MQD continues to work with Queen's Hospital on placement of difficult to discharge members. Such members often have substance abuse issues, behavioral health issues, non-compliance issues, morbid obesity, and homelessness. So far, Queen's Hospital expanded their coalition working with the Department of Public Safety, Honolulu police department, homeless shelters and agencies, and managed care organizations.

One Key Question

One Key Question is an on-going screening program to address pregnancy options for women of child-bearing age. The goal is to both reduce unwanted pregnancies and promote healthy newborn outcomes.

Community Integration Services (CIS)

MQD and the health plans worked together to start the beginning stages of CIS services to their members. So far, they have defined the job requirements, qualifications, and salary of the mandated CIS Coordinator position. The next phase will be implemented in 2020.

H. Progress on Policy and Administrative Difficulties in the Operation of the Demonstration

At this time, MQD has no update.

I. CAHPS Survey

[Information on CAHPS activities performed during the reporting period, is provided above in section XIV.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS).]

Summary of Statewide Comparisons Results

Comparison of the QI health plans' scores to the 2017 NCQA adult Medicaid national averages revealed the following summary results:

- AlohaCare QI scored at or above the national average on two measures: Rating of Health Plan, and Health Promotion and Education. Conversely, AlohaCare QI scored below the national average on nine measures: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Coordination of Care and Shared Decision Making.
- HMSA QI scored at or above the national average on seven measures: Rating of health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making, and Health Promotion and Education. Conversely, HMSA QI scored below the national average on four measures: Getting Needed Care, Getting Care Quickly, Customer Service, and Coordination of Care.
- Kaiser QI scored at or above the national average on seven measures: Rating of Health Plan, Rating of Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, and Coordination of Care. Conversely, Kaiser QI scored below the national average on three measures, Rating of All Health Care, Getting Needed Care, and Customer Service.
- 'Ohana QI scored at or above the national average on two measures: Rating of Specialist Seen Most Often, and Shared Decision Making. Conversely, 'Ohana scored below the national average on seven measures: Rating of All Health Care, Rating of Personal Doctor, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service.
- UHC CP QI scored at or above the national average on three measures: Shared Decision Making, Coordination of Care, and Health Promotion and Education. Conversely, UHCCP QI scored below the national average on eight measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service.

Summary of Plan Comparisons Results

Comparison of the QI health plans for Service, and Coordination of Care revealed the following summary results:

- AlohaCare QI did not score statistically significantly lower or higher than the QI Program aggregate on any of the measures.
- HMSA QI did not score statistically significantly lower than the QI Program aggregate on any one measure and scored statistically higher on the measure How Well Doctors Communicate.
- Kaiser QI scored statistically significantly higher than the QI Program aggregate on two measures; Getting Care Quickly, and How Well Doctors Communicate.
- 'Ohana QI scored statistically significantly lower than the QI Program aggregate on one measure, Getting Care Quickly.
- UHC CP QI did not score statistically significantly lower or higher than the QI Program aggregate on any of the measures.

Summary of Trend Analysis Results

The trend analysis revealed the following summary results:

- The 2019 QI Program aggregate scores were not statistically significantly higher than the 2017 scores in any measure.
- AlohaCare QI's 2019 scores were not statistically significantly higher than the 2017 scores in any measure.
- HMSA QI's 2019 scores were not statistically significantly higher than the 2017 scores in any measure
- Kaiser QI: This health plan's 2019 scores were not statistically significantly higher or lower than the 2017 score on any measure.
- 'Ohana QI's 2019 score was not statistically significantly higher or lower than the 2017 score on any measure.
- UHCCP QI's 2019 scores were not statistically higher than the 2017 scores in any measure.

The QI Program's scores were at or above the national averages on four measures: How Well Doctors Communicate, Shared Decision Making, Coordination of Care, and Health Promotion and Education.

Conversely, the QI Program's scores were below the national averages on seven measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, and Customer Service.

The following observations from the key drivers of satisfaction analysis indicate areas of improvement in access and timeliness for the QI Program:

- Respondents reported that it was often not easy for their child to obtain appointments with specialists.
- Respondents reported that when their child did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed one.
- Respondents reported that it was not always easy to get the care, tests, or treatment they thought their child needed through their health plan.

- Respondents reported that when their child needed care right away, they did not receive care as soon as they needed it.

The following observation from the key drivers of satisfaction analysis indicate areas of improvement in quality of care for the QI Program:

- Respondents reported that when they talked about their child starting or stopping a prescription medicine, a doctor or other health provider did not ask what they thought was best for their child.
- Respondents reported that their child's personal doctor did not always seem informed and up to date about the care their child received from other doctors or health providers.
- Respondents reported that they did not always receive the information or help they needed from customer service at their child's health plan.
- Respondents reported that forms from their child's health plan were often not easy to fill out.
- Respondents reported that their child's personal doctor did not talk with them about how their child is feeling, growing, or behaving.
- Respondents reported that their child's personal doctor did not always spend enough time with them.
- Respondents reported that they did not always receive courtesy and respect from customer service staff at their child's health plan.
- Respondents reported that a doctor or other health provider did not always talk to them about specific things they could do to prevent illness in their child.

J. Outcomes of any Focused Studies Conducted

Using specific case reviews, MQD began state-wide audits of the case management agencies that participate with the Community Care Services (CCS) program. Audit outcomes will be available during the next annual report.

K. Outcomes of any Reviews or Interviews Related to Measurement of any Disparities by Racial or Ethnic Groups

There was an internal civil rights investigation conducted and the findings were negative.

L. Annual Summary of Network Adequacy by Plan

MQD continues to review the Network Adequacy reports from all the health plans and communicate with the health plans that have issues on meeting the provider ratios.

Also, due to Hawaii's unique geography, there are select areas on the neighbor islands with shortages of behavioral health professionals and certain physical health specialists. This is not unique to the Medicaid line of business, but also prevalent in the commercial and Medicare lines. Recent telehealth policy changes at MQD will serve to increase provider access for members.

M. Summary of Outcomes of On-Site Reviews

EQRO

[Information on EQRO activities performed during the reporting period, is provided above in section XIV.]

Findings for the 2019 compliance review were determined from its:

- Desk review of the documents the QI health plans and CCS submitted to HSAG prior to the on-site portion of the review.

- On-site activities that included reviewing additional documents and records, interviewing key administrative and program staff members, system demonstrations, and file reviews.

For each of the individual elements (i.e., requirements) within each standard, HSAG assigned a score of *Met*, *Partially Met*, *Not Met,* or *Not Applicable* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

The following tables present a summary of the performance results.

Standards and Compliance Scores- AlohaCare QUEST Integration

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	25	7	78%
II	Access and Availability	16	16	0	100%
III	Coordination and Continuity of Care	10	9	1	90%
IV	Member Rights and Protections	9	8	1	89%
V	Member Information	22	18	4	82%
VI	Member Grievance System	27	15	12	56%
	Totals	**116**	**91**	**25**	**78%**
Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.					

Standards and Compliance Scores- HMSA QUEST Integration

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	28	4	88%
II	Access and Availability	16	16	0	100%
III	Coordination and Continuity of Care	10	9	1	90%

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
IV	Member Rights and Protections	9	5	4	56%
V	Member Information	22	14	8	64%
VI	Member Grievance System	27	20	7	74%
	Totals	**116**	**92**	**24**	**79%**
Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.					

Standards and Compliance Scores- Kaiser Foundation QUEST Integration

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	24	8	75%
II	Access and Availability	16	14	2	88%
III	Coordination and Continuity of Care	10	8	2	80%
IV	Member Rights and Protections	9	5	4	56%
V	Member Information	22	13	9	59%
VI	Member Grievance System	27	19	8	70%
	Totals	**116**	**83**	**33**	**72%**
Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.					

Standards and Compliance Scores- ‘Ohana QUEST Integration

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	23	9	72%
II	Access and Availability	16	14	2	88%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Member Rights and Protections	9	8	1	89%
V	Member Information	22	17	5	77%
VI	Member Grievance System	27	18	9	67%
	Totals	**116**	**90**	**26**	**78%**
Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.					

Standards and Compliance Scores- UHC QUEST Integration

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	28	4	88%
II	Access and Availability	16	16	0	100%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Member Rights and Protections	9	8	1	89%
V	Member Information	22	16	6	73%
VI	Member Grievance System	27	21	6	78%
	Totals	**116**	**99**	**17**	**85%**
Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.					

Standards and Compliance Scores- CCS

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Total Compliance Score
I	Coverage and Authorization of Services	32	27	5	84%
II	Access and Availability	13	11	2	85%
III	Coordination and Continuity of Care	9	6	3	67%
IV	Member Rights and Protections	9	8	1	89%
V	Member Information	21	16	5	76%
VI	Member Grievance System	27	19	8	70%
	Totals	**111**	**87**	**24**	**78%**
Total Compliance Score: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.					

During 2018, the EQRO and MQD followed up on the Corrective Action Plans (CAPs) from the Compliance Reviews. Currently, in January 2019, the CAPs for each health plan and CCS are in different phases.

Financial

There is an ongoing joint investigation by MQD and the Medicaid Fraud Control Unit involving a Medicaid provider that is allegedly co-mingling patients' financial accounts, and failing to keep a detailed accounting record of all transactions.

Other Types of Reviews Conducted by the State or Contractor of the State

During this period, there were no additional types of reviews conducted.

N. Summary of Performance Improvement Projects (PIPs) Conducted by the State & Outcomes Associated with the Interventions

[Information on PIP activities performed during the reporting period, is provided above in section XIV.1 Validation of Performance Improvement Projects (PIPs).]

The State contracted with HSAG as the MQD EQRO. One of the required functions of EQRO is to conduct the PIP activities. The following provides a summary of PIP results from the reporting period.

For each of the Performance Improvement Projects, health plans and CCS defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement sets the framework for the PIP and identifies the goal against which the PIP will be evaluated for the annual validation. HSAG provided the following parameters for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

The following are summaries of this year's Module 5 progress:

AlohaCare:

Intervention Testing for Getting Needed Care PIP

Intervention	Key Driver	Failure Mode	Conclusion
Reminder calls to targeted members two to three business days prior to the scheduled ophthalmologist visit	Geographical remoteness, lack of transport/accommodation /finances	Members not reminded of the final upcoming travel accommodation	The health plan chose to *adapt* the intervention.

SMART Aim Results for Getting Needed Care PIP

SMART Aim	Average Score After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, AlohaCare will increase the mean score by 5% (from 4.11 to 4.32) using the third question of the member survey as it relates to the ease of access to ophthalmology services reported by members paneled to the five (5) Community Health Centers (CHCs).	4.38	Yes	Yes	*High Confidence*

Intervention Testing for Improving Timeliness of Prenatal and Postpartum Care PIP

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
1. Telephonic outreach to female members ages 16–50 years paneled at Kalihi Palama Health Center (KPHC) to schedule an appointment (if the member was not seen in the past 12 months)	Provider awareness of paneled pregnant patients	Member does not schedule an appointment within the first trimester Member did not receive education on preconception/prenatal health/family planning services	The health plan chose to *abandon* the intervention.
2. Identify and outreach telephonically newly enrolled pregnant members to assist with scheduling a prenatal appointment	Provider awareness of paneled pregnant patients	Member did not schedule an appointment on time, or after the first trimester	The health plan chose to *adapt* the intervention.
Postpartum Interventions	**Key Drivers**	**Failure Modes**	**Conclusion**
1. Incentivize a community health worker who has developed a relationship with the community and the member to outreach and ensure the member receives postpartum care	Community/provider bilingual support/resources	Member does not understand the importance of routine follow-up postpartum care Member attended the first postpartum visit but does not want to attend the second postpartum visit	The health plan chose to *abandon* the intervention.

2. Individualized reminders by text, telephone, and mail	Community/provider bilingual support/resources	Member attended the first postpartum visit but does not want to attend the second postpartum visit	The health plan chose to *continue testing* the intervention.

Status of the Improving Timeliness of Prenatal and Postpartum Care PIP

SMART Aim	Measure	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
By December 31, 2018, AlohaCare aims to increase the timeliness of prenatal care from **73%** to **87%** and timeliness of postpartum care from **46%** to **56%** among women seen at KPHC.	Prenatal	93.5%	Yes	Yes	*Low Confidence*
	Postpartum	37.5%	No	Not Applicable	

Conclusions

The validation findings suggest that AlohaCare QI was successful in executing the rapid-cycle *Getting Needed Care* PIP. The health plan met the SMART Aim goal; the quality improvement processes and intervention could be linked to the demonstrated improvement. Therefore, HSAG assigned a level of *High Confidence* to the *Getting Needed Care* PIP.

For the *Improving Timeliness of Prenatal and Postpartum Care* PIP, HSAG assigned the health plan a level of *Low Confidence.* The health plan did not achieve the SMART Aim goal for the postpartum care measure.

HMSA:

Intervention Testing for Getting Needed Care PIP

Interventions	Key Drivers	Failure Modes	Conclusion
1. Online Referral Tool	Appointment availability Communication barriers	Provider does not have a quicker system to send a referral	The health plan chose to *abandon* the intervention.
2. Appointment Tips Brochure	Member knowledge of available resources, involvement in care, and communication barriers between the member and provider/health plan	Members do not seek care due to an expectation of improvement of illness, time constraints, and issues finding an appointment time	The health plan chose to *abandon* the intervention.

SMART Aim Results for Getting Needed Care PIP

SMART Aim	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
By December 31, 2018, for QUEST members under the age of 18 who had a specialty office visit of dermatology, ophthalmology, or psychiatry, increase the percentage of "yes" responses to the 2017 Specialist Satisfaction Survey question, "Did you child get an appointment to see Dr. <FName><LName> as soon as you needed?" from 93% to 98%.	100%	Yes	No	*Low Confidence*

Intervention Testing for Improving Timeliness of Prenatal and Postpartum Care PIP

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
1. Telephonic Deadline Reminders	Adherence to appointment scheduling	Member does not follow up with insurance process in a timely manner	The health plan chose to *abandon* the intervention.
2. Text Messaging	Understanding the importance of care visits Adherence to appointment scheduling	Member does not receive sufficient information in the member's fluent language Member is not interested in understanding the information provided	The health plan chose to *continue testing* the intervention.
Postpartum Interventions	**Key Drivers**	**Failure Modes**	**Conclusion**
1. Translation/Interpretation Services	Communication barriers between member and provider/health plan	Member does not receive sufficient information in the member's fluent language	The health plan chose to *abandon* the intervention.
2. Text Messaging	Understanding the importance of care visits Adherence to appointment scheduling	Member does not receive sufficient information in the member's fluent language Member is not interested in understanding the information provided	The health plan chose to *continue testing* the intervention.

Status of the Improving Timeliness of Prenatal and Postpartum Care PIP

SMART Aim	Measure	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
By December 31, 2018, for members attributed to either Kokua Kalihi Valley, Waikiki Health Center, or Waimanalo Health Center, increase the overall percentage of deliveries that received a prenatal visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment, from 64.8% to 68.0%.	Prenatal	75.0%	Yes	No	*Low Confidence*
By December 31, 2018, for members attributed to either Kokua Kalihi Valley, Waikiki Health Center, or Waimanalo Health Center, increase the overall percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery from 28.1% to 30.9%.	Postpartum	33.3%	Yes	No	

Conclusions

The validation findings suggest that even though **HMSA QI** met the SMART Aim goal for both PIPs, the quality improvement processes and tested interventions could not be linked to the demonstrated improvement. HSAG assigned a level of *Low Confidence* to both PIPs.

Kaiser:

Intervention Testing for Getting Needed Care PIP

Intervention	Key Driver	Failure Mode	Conclusion
Outreach by Member Care Service Associates (MCSAs) to provide transportation options to members	Patient barriers	Lack of transportation	The health plan chose to *adapt* the intervention.

SMART Aim Results for Getting Needed Care PIP

SMART Aim	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, increase the percentage rate at which adult QUEST Integration members are seen within 21 days of the initial request for an initial routine outpatient BH evaluation by internal providers on Oahu from 50% to 55%.	73.0%	Yes	Yes	*Confidence*

Intervention Testing for Medication Management for People with Asthma, Ages 5–64 PIP

Intervention	Key Driver	Failure Mode	Conclusion
Clinical pharmacists assess members with home clinic locations in Honolulu, Waipio, and Maui Lani, ages 5–64, identified in December 2017 and reconfirmed in April 2018 with an AMR less than 0.5; outreach to members occurs if indicated by the assessment.	Member education	Unaware of when to use inhalers	The health plan chose to *adapt* the intervention.

Status of the Medication Management for People with Asthma, Ages 5–64 PIP

SMART Aim	Lowest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, decrease the rate of QUEST Integration members, ages 5–64 years old with home clinic locations in Honolulu, Waipio, and Maui Lani, with an AMR of less than 0.5 from 26.3% to 24.3%.	21.1%	Yes	Yes	*High Confidence*

Conclusions

The validation findings suggest that KFHP QI was successful in executing the rapid-cycle PIPs. The PIPs were methodologically sound, achieved the SMART Aim measure goals, and linked the quality improvement processes and interventions to the demonstrated improvement. The *Getting Needed Care* PIP received a *Confidence* rating, and the *Medication Management for People with Asthma, Ages 5–64* PIP received a *High Confidence* rating.

Ohana QI:

Intervention Testing for Getting Needed Care PIP

Intervention	Key Driver	Failure Mode	Conclusion
Care gap coordinator(s)/patient care advocate(s) outreach members, locate and schedule appointment with a provider.	Member behavior	Members cannot locate a provider for their condition.	The health plan chose to *abandon* the intervention.

SMART Aim Results for Getting Needed Care PIP

SMART Aim	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, increase responses set as "Always" or "Usually" from 82.2% to 87.2% for the Getting Needed Care domain.	68.9%	No	Not Applicable	*Low Confidence*

Intervention Testing for Improving Timeliness of Prenatal and Postpartum Care PIP

Intervention	Key Drivers	Failure Modes	Conclusion
Care gap coordinators and/or patient care advocates to assist providers with scheduling member appointments, providing an online portal for navigation, transportation, and translation services through telephonic member outreach.	Provider lack of engagement—lack of tracking whether or not the member completed the visit and outreaching; lack of provider's resources to follow up on members.	Prenatal: Provider does not schedule a woman's prenatal visit in a timely manner, within the first trimester. Postpartum: Provider does not schedule a woman's postpartum visit in a timely manner, between 21 and 56 days after delivery.	The health plan chose to *continue testing* the intervention.

Status of the Improving Timeliness of Prenatal and Postpartum Care PIP

SMART Aim	Measure	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, 'Ohana Health Plan aims to increase the timeliness of prenatal care from 63% to 73% for pregnant members residing in Honolulu,	Prenatal	65.8%	No	Not Applicable	*Low Confidence*

SMART Aim	Measure	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
Waianae, Waipahu, Ewa Beach, Kailua Kona, and Hilo.					
By December 31, 2018, 'Ohana Health Plan aims to increase the timeliness of postpartum care from 37% to 47% for members who delivered and reside in Honolulu, Waianae, Waipahu, Kailua Kona, Hilo, and Ewa Beach.	Postpartum	31.9%	No	Not Applicable	

Conclusions

The validation results suggest that 'Ohana QI's tested interventions were not successful in achieving the goals for the PIPs. None of the SMART Aim measure results achieved the SMART Aim goals. HSAG assigned a level of *Low Confidence* to both PIPs.

UnitedHealthcare CP QI:

Intervention Testing for Getting Needed Care PIP

Intervention	Key Drivers	Failure Modes	Conclusion
1. Member Services and Provider Types Training	Inappropriate referral (i.e., wrong BH provider type, provider non-par, provider not accepting members with certain conditions) or lack of referral by originating provider and/or Member Services. Member Services is not correctly intervening when the member calls and there is an incorrect/lack of referral by the member's PCP or other practitioner.	Member attempts to go or goes to an incorrect type of provider. Member may not be aware that the health plan provides direct-to-consumer BH support services.	The health plan chose to *adapt* the intervention.
2. Member Services and PCP Training on Telehealth	Shortage of BH providers in Hawai'i County across all health plans.	Provider office may not know exactly what kind of services or supports the health plan provides.	The health plan chose to *adapt* the intervention.

	Rural landscape poses transportation challenges due to the provider's and member's locations (time and distance of travel).	Current telehealth services are being underutilized. Members may not be able to get an appointment that fits their schedule.	

SMART Aim Results for Getting Needed Care PIP

SMART Aim	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
By December 31, 2018, increase the rate of ease of access to a mental health specialist appointment as soon as the members felt they needed one, from 57.46% to 61.46%.	100%	Yes	No	*Reported PIP results were not credible*

Intervention Testing for Improving the Timeliness of Prenatal Care and Postpartum Care in Hawai'i County PIP

Prenatal Interventions	Key Drivers	Failure Modes	Conclusion
1. Provider Partnership: Early Identification—Provider List	Member does not know what to do once she finds out she is pregnant. Member does not have enough time (clinic hours, appointment does not address her needs, competing social determinants of health [SDOH]). Member has other children, so she does not feel it is important to schedule an early appointment.	Woman has had other children and defers visits until she feels it is critical to attend. Woman is not provided with information about the importance of seeking prenatal care in the first trimester.	The health plan chose to *adapt* the intervention.
2. Provider Partnership: Early Identification—Partnering with the Women, Infants, and Children (WIC) program.	Member does not know what to do once she finds out she is pregnant. Member does not have enough time (clinic hours, appointment does not address her needs, competing SDOH).	Woman is not provided with information about the importance of seeking prenatal care in the first trimester. Woman has other children and defers visits until she feels it is critical to attend. Prenatal visits may not be captured by claims.	The health plan chose to *adapt* the intervention.

Postpartum Interventions	Key Drivers	Failure Modes	Conclusion
1. Provider Partnership: Early Identification—Provider List	The members do not know that they need to go to the doctor again for a postpartum visit between 21–56 days after delivery. This is not the member's first child, so she does not feel a need to follow up with her provider. The member is focused on her newborn and does not have time to attend her own appointment or does not prioritize her appointment needs.	Woman has had other children and does not feel it is important to schedule an appointment. Member has a scheduling conflict; member is rescheduled, but not within HEDIS time frame. Woman is not provided with information about the importance of seeking postpartum care 21–56 days post-delivery.	The health plan chose to *adapt* the intervention.
2. Member Rewards Program	The member does not know that she needs to go to the doctor again for a postpartum visit between 21–56 days after delivery. This is not the member's first child, so she does not feel a need to follow up with her provider. The member is focused on her newborn and does not have time to attend her own appointment or does not prioritize her appointment needs.	Woman has had other children and does not feel it is important to schedule an appointment. Member has a scheduling conflict; member is rescheduled, but not within the HEDIS time frame. Woman is not provided with information about the importance of seeking postpartum care 21–56 days post-delivery.	The health plan chose to *adapt* the intervention.

Status of the Improving the Timeliness of Prenatal Care and Postpartum Care in Hawai'i County PIP

SMART Aim	Measure	Highest Rate After Interventions Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Interventions Tested	Confidence Level
By December 31, 2018, UHC CP QI aims to increase the timeliness of prenatal care hybrid rates from 76.6% to 79.6% and timeliness of postpartum care hybrid rates from 46.8% to 49.8% among members located in Hawai'i County.	Prenatal	70.1%	No	Not Applicable	*Low Confidence*
	Postpartum	33.3%	No	Not Applicable	

Conclusions

The validation findings suggest that for the *Getting Needed Care* PIP, UHC CP QI did not execute the PIP methodology as approved. Therefore, HSAG assigned a confidence level of *Reported PIP results were not credible* to the PIP.

For the *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i* County PIP, UHC CP QI did not meet the SMART Aim goal for either prenatal or postpartum care, and all the monthly results were below the reported baselines and goals. HSAG assigned the PIP a level of *Low Confidence*.

Ohana CCS:

Intervention Testing for Follow-Up After Hospitalization (FUH) for Mental Illness PIP

Intervention	Key Driver	Failure Mode	Conclusion
Community Based Case Management (CBCM) agency staff to visit the member while inpatient or make arrangements for community outreach.	Member cannot be reached for reminder regarding follow-up appointment within seven days.	Member cannot be reached for reminder regarding follow-up appointment within seven days.	The health plan chose to *abandon* the intervention.

SMART Aim Results for Follow-Up After Hospitalization (FUH) for Mental Illness PIP

SMART Aim	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, increase mental health 7-day follow-up compliance rates of CCS members in four CBCM agencies (Community Empowerment Resources, Helping Hands Hawaii, North Shore Mental Health, and State of Hawaii Department of Health—Adult Mental Health Division) from 53% to 61%.	86.0%	Yes	No	*Low Confidence*

Intervention Testing for Behavioral Health Assessment PIP

Intervention	Key Driver	Failure Mode	Conclusion
Follow-Up email notification from health plan to agency.	CBCM agency is not aware of the new member.	CBCM agency is not aware of the new member.	The health plan chose to *adopt* the intervention.

Status of the Behavioral Health Assessment PIP

SMART Aim	Highest Rate After Intervention Began	SMART Aim Goal Achieved	Improvement Clearly Linked to Intervention Tested	Confidence Level
By December 31, 2018, improve BHA compliance rates of newly enrolled CCS members assigned in CBCM agencies (Community Empowerment Resources, Institute of Human Services, North Shore Mental Health, Aloha House, Mental Health Kokua on Oahu and Kauai) from 16% to 50%.	74.0%	Yes	No	*Low Confidence*

Conclusions

The validation findings suggest that even though 'Ohana CCS met the SMART Aim goal for both PIPs, the quality improvement processes and tested interventions could not be linked to the demonstrated improvement. Therefore, HSAG assigned a level of *Low Confidence* to both PIPs.

O. Outcomes of Performance Measure Monitoring

Summaries of the HEDIS 2019 Compliance Audit Final Report of Findings will be included for review in the 2019 External Quality Review Report of Results for the QUEST Integration Health Plans and the Community Care Services Program. This report was posted to the Med-QUEST website in March 2020.

Please see Attachment G for the Hawaii Calendar Year 2018 HEDIS 2019 Rate Spreadsheet.

P. Summary of Plan Financial Performance

The MLR experience for CY 2018 for our five MCOs are as follows:

- AlohaCare – 92.9%
- HMSA – 94.9%
- Kaiser – 93.4%
- Ohana – 95.1%
- UHC – 96.2%

XIX. Managed Care Organization and Program

A. Enrollment and Service Area Expansion of each MCO, PIHP, PAHP, and PCCM Entity

There were no service area expansions during the reporting period.

B. Modifications to, and Implementation of, MCO, PIHP, or PAHP Benefits Covered under the Contract with the State

Due to the 1915 (c) waiver for the developmentally disabled removing skilled nursing services from their waiver the health plans have been working on transferring the skilled nursing services to the health plans. As it was a waiver service, the skilled nursing services were provided under the 1915 (c) waiver program. The health plans have had to conduct assessments and provide medically necessary skilled nursing services for their members.

Work with the Department of Education continued to prepare their staff and the DOE information system to be able to properly chart services that were provide, bill for services and claim federal match dollars.

C. Grievance, Appeals, and State Fair Hearings for the Managed Care Program

See section IV. above.

D. Evaluation of MCO, PIHP, or PAHP Performance on Quality Measures

See sections XVIII.I, M and N above.

E. Results of any Sanctions or Corrective Action Plans Imposed by the State or Other Formal or Informal Intervention with a Contracted MCO, PIHP, PAHP, or PCCM Entity to Improve Performance

There were no sanctions or corrective action plans imposed by the State during this reporting period.

F. Activities and Performance of the Beneficiary Support System

The MQD Beneficiary Support System is a combination of internal staff support along with an external contracted vendor. The Health Care Outreach Branch (HCOB) within MQD is the internal staff who identifies and assists hard to reach populations and 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, justice-involved populations and those who are admitted to and discharged from public institutions.

HCOB is present on all major islands, and also assists beneficiaries with submitting applications and enrollment into health plans for Medicaid and the Federal Health Insurance Marketplace. The MQD

contracts with Hilopa'a to provide Ombudsman services for Medicaid beneficiaries, including member education, member advocacy, and fulfillment of person-centered goals. Hilopa'a uses both traditional and unconventional communication modalities to communicate and interact with beneficiaries, including the use of webinars, Ted Talks, social media, face-to-face meetings, text messaging and phone/fax.

G. Other Factors in the Delivery of LTSS not otherwise addressed

There were no other factors impacting the delivery of LTSS during the reporting period.

XX. Other

Final Rules

In continuous compliance of MCO Final Rules, Hawaii incorporated required provision in QUEST Integration Supplemental Changes #11 and the capitation rate for calendar year 2019. CMS approved on August 19, 2019.

During the reporting period, MQD continued to work with CMS on the QI RFP Supplemental Changes #12 which includes more MCO Final Rules provisions and capitation rate for January to June 2020.

HOKU (Hawaii Online Kahu Utility)

In partnership with Arizona Health Care Cost Containment System (AHCCCS), MQD used the same vendor CNSI to design Hawaii's HOKU. Weekly calls were set up between MQD and CNSI to discuss Hawaii needs and unique provider types. A project manager was assigned by AHCCCS in Hawaii to assist MQD.

The Internal Verification & Validation (IVV) vendor, Grant Thornton, staff also came two times to Hawaii during the reporting period to ensure the HOKU design and progress meet CMS requirements and timeline.

Electronic Visit Verification (EVV)

In accordance with the 21st Century Cures Act, Med-QUEST Division (MQD) is working towards the implementation of Electronic Visit Verification (EVV). In the federal fiscal year (FFY) 2019, plans for EVV were developed and work was accomplished towards system model design and procurement of a statewide EVV vendor. MQD submitted the Good Faith Letter to CMS and received approval for implementation for the calendar year 2020.

FFY2019 continued with EVV information gathering, including selecting and awarding a statewide EVV vendor, as well as conducting statewide information forums throughout Hawai'i. Work in the middle of the FFY was primarily in finalizing the state plan, working on required documentation for EVV design. FFY 2019 ended with full efforts focused on EVV design. Throughout FFY2019, MQD communicated progress to stakeholders via several modes of communication including email, face-to-face meetings, virtual meetings, and EVV webpage updates.

MQD's future work will include, regular communications with stakeholders, working with the IV&V vendor, and working with the EVV vendor towards an implementation date in the Fall of 2020.

FFY2019 summary:

MQD worked with AHCCCS to respond to two hundred eight questions received from prospective EVV vendor offerors. An EVV progress update was given in person and via telephone conference at the monthly Managed Care Organization (MCO) meeting, including a reminder that the request for proposal (RFP) for a statewide EVV vendor was posted to the website on September 28. This update was also emailed to the MCOs, Department of Health-Developmental Disabilities Division, and home and community-based service providers, and all who attended the MQD EVV information sessions in February and March 2018.

EVV vendor proposals were received and reviewed by the RFP evaluation team on an individual basis. Work was started in response to the return of our Planning Advanced Planning Document from CMS which was accompanied with a table of questions and guidance for the next update. In anticipation of the need for more staffing support for the upcoming EVV implementation, MQD conducted interviews for a full time MQD EVV Project Manager. MQD also received further EVV guidance from CMS by attending the CMS EVV Open Door Forum on November 7 and also the National Association of States United for Aging and Disabilities all state call on November 28 where the idea of the CMS EVV learning collaborative workgroup was introduced.

MQD was delighted to receive a CMS invitation to participate in the CMS Learning Collaborative which would convene on January 10, 2019. Unfortunately, the January date conflicted with the ability to present since procurement for the EVV vendor would be in progress. MQD and AHCCCS look forward to future EVV discussions after the projected EVV vendor award date of April 2019. The RFP evaluation team, consisting of AHCCCS and MQD staff, met in person over four days for the sole purpose of evaluating all received EVV vendor

MQD worked with AHCCCS in the vendor selection process narrowing the field of viable candidates. MQD recorded the current caregiver workflows ensuring a smooth transition from paper to electronic. Stakeholders involved with the current workflows were identified and contacted establishing a flow of communication.

Collaborated with a Financial Intermediary providing an EVV project update that was posted in their February 2019 newsletter. The EVV vendor selection of Sandata was announced on February 26th, 2019. The announcement was posted on MQDs EVV webpage and an email announcement was sent to over 150 representatives from MCOs, Providers, Associations, Agencies, and Workers.

Weekly meetings established with IVV vendor SLI Government Solutions, AZ, HI, and CMS. The first EVV Vendor (Sandata) / AZ / HI meeting was held to introduce the teams, discuss the process, and the next steps. The Implementation Advanced Planning Document was submitted to CMS in March. Engaged in communication outreach with Healthcare Association of Hawaii (HAH) and HHCS agencies on March 27th discussing the EVV initiative and its projected timeline. Concerns were raised about the amount of time remaining in the year to implement IT changes that would automate the process relating to EVV. MQD is reviewing the issue and the options.

Continued engaging EVV related providers to gather critical information to ensure a smooth integration. MQD representatives met with the IVV vendor, SLI Government Solutions individually providing input for reporting purposes.

Met with EVV vendor to review implementation strategy and how it will impact MQD. After CMS review, the AHCCCS / MQD EVV vendor selection was approved in mid-May.

Reviewed and aligned on a coordinated Program / Project Management methodology between MQD and AHCCCS. Consolidated MQD and AHCCCS project documentation into one repository. Aligned EVV vendor kick-off agenda between MQD and AHCCCS. R1 documentation was submitted to CMS the week of June 10th, 2019 for review and response.

EVV Update #2 posted to MQDs EVV webpage and emailed to over 180 representatives from MCOs, Providers, Associations, Agencies, and Workers.

Attended consolidated EVV vendor kick-off meeting in Arizona to review the implementation approach. The three-day session was held with Sandata reviewing the solution and its capabilities. It was a very productive meeting aligning MQD requirements with Sandata.

Parallel efforts took place in July as MQD continued to be in communications with QUEST Integration Managed Care Organizations (MCOs) regarding efforts to request an exemption from the Federal medical assistance percentage (FMAP) reduction for personal care services if the implementation deadline of January 1, 2019 was not met. A letter was drafted to CMS with this request highlighting the ongoing good faith efforts and unavoidable delays encountered. MQD continued to track proposed legislation to extend the deadline for FMAP reduction and when H.R. 6042 became law on July 30, all efforts were shifted to completing the request for proposal and project partnership understanding document which were submitted to CMS for approval.

In August, MQD and AHCCCS completed a system model design document and project timeline. These documents provided information for all stakeholders about our EVV implementation objectives and a tentative timeline. These documents were uploaded to the MQD EVV webpage and distributed via email to QI MCOs with the request for MCOs to distribute the information to all applicable stakeholders via their usual communication modes. The EVV updates were also announced during the monthly MCO meeting and other applicable in-person meetings. Also, in August, MQD staff attended the annual National Home and Community Based Services conference where further EVV implementation clarification was gathered from CMS. At the conference, MQD staff exchanged EVV information with other states and stakeholders and worked face to face with AHCCCS staff on the EVV project.

In September, CMS approved our RFP and it was posted for bidding. This was announced via email, our EVV webpage, our monthly MCO meeting and other applicable in-person meetings. For the next quarter, MQD will be engaged in the RFP process, including answering submitted questions from prospective vendors, reviewing responses, and identifying a selected vendor group for further consideration.

XXI. MQD Contact

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