Attachment B

Hawai‘i QUEST Integration
§1115 Waiver Interim Evaluation

State of Hawai‘i, Department of Human Services,

Med-QUEST Division

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Introduction

The State of Hawai‘i implemented QUEST on August 1, 1994. QUEST was a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery system. QUEST stands for:

Quality care
Universal access
Efficient utilization
Stabilizing costs, and
Transforming the way health care is provided to QUEST members.

The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditure. The State combined its Medicaid program with its then General Medical Assistance Program and its State Children’s Health Insurance Program. Low-income women, children, and adults who had been covered by the two programs were enrolled into fully capitated managed care plans throughout the State. This program virtually closed the coverage gap in the State.

Since its implementation, CMS has renewed the demonstration five times. Over the years, the State has made significant changes to the demonstration, including several eligibility expansions and a renewal in 2007 that authorized managed long-term services and supports.

The current section 1115 demonstration for the State of Hawai‘i is entitled “QUEST Integration” (Project Number 11-W-00001/9). The QUEST Integration demonstration began in October 2013 and is effective through December 2018. This evaluation covers the CY2014 to CY2016 time period, which falls under the waiver extension period. Some metrics in the evaluation use data from CY2017 and CY2018 for illustrative purposes.

The demonstration integrated the demonstration’s eligibility groups and benefits within the context of the Affordable Care Act and accomplished several programmatic changes, including:

- Streamlining eligibility pathways by transitioning low-income childless adults and former foster care children from demonstration expansion populations to state plan populations, adding former adoptive and kinship guardianship children as demonstration expansion populations, and decreasing retroactive eligibility period to 10 days for non-long-term services and supports population;
- Consolidating QUEST, QUEST-Net, QUEST-ACE, and QExA into a single QUEST Integration program;
- Removing QUEST-ACE enrollment-related benchmarks from the uncompensated care cost (UCC) pool, evaluating UCC costs, and winding down federal financial participation for UCC pool payments in June 2016; and
- Providing additional benefits like certain specialized behavioral health services, cognitive rehabilitation, and habilitation.

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

Evaluation Questions and Hypotheses

The goals of the QUEST Integration renewal demonstration were laid out in the Special Terms & Conditions and were as follows:

- Improve the health care status of the member population;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Align the demonstration with Affordable Care Act;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP);
- Expand access to home and community-based services (HCBS) and allow individuals to have a choice between institutional services and HCBS;
- Maintain a managed care delivery system that assures access to high- quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations;
- Establish contractual accountability among the contracted health plans and health care providers;
- Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

The goals of the demonstration were grouped into three broad areas for measurement to serve the purpose of "evaluation hypotheses." The first area was centered on access to care and beneficiary engagement. The area specifically addressed the following goals:

- Align the demonstration with Affordable Care Act;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system; and
- Expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS.

The second area was centered on improving health, ensuring high-quality care, and managing costs. It specifically addressed how the QUEST Integration's managed care program and the focus on pay-for-performance and alternative payment methodologies could address the following goals of the demonstration:

- Improve the health care status of the member population;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP); and
- Continue the predictable and slower rate of expenditure growth associated with managed care.

The third area was centered on health plan and provider accountability and addressed the following goals:

- Maintain a managed care delivery system that assures access to high- quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations; and
- Establish contractual accountability among the contracted health plans and health care providers.

Methodology

MQD has devised a number of different measurement strategies for the evaluation. Several measurement strategies used measures developed by the National Committee for Quality Assurance (NCQA). The source for data contained in this publication is Quality Compass® 2015, 2016, and 2017 and is used with the permission of NCQA. Quality Compass 2015, 2016, and 2017 includes certain Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Access to Care and the Beneficiary Experience Methods and Limitations

For the first area, MQD presented a qualitative narrative and analysis on activities to demonstrate how the program aligned with the Affordable Care Act; CAHPS survey results to measure access to care and beneficiary engagement, and enrollment and encounter data to measure utilization for institutional services, HCBS, and at-risk population services.

The CAHPS measures are based on annual surveys conducted by the External Quality Review Organization (EQRO) entity under contract with, and under the direction of, MQD. The method of these surveys and the definitions of the various CAHPS measures strictly adhere to required national standard CAHPS specifications. The surveys were sent to a random sample of recipients. The overall survey response rate was 39.9 percent in 2014, 19.6 percent in 2015, 31.6 percent in 2016, and 23.5 percent in 2017. A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Because the populations surveyed are different between the Adult and Child surveys, these surveys are analyzed separately as the data allows.

Improving Health, Ensuring High-Quality Care, and Managing Costs Methods and Limitations

For the second area, Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure improvement in the health care status of QUEST Integration (QI) beneficiaries and improvement in care coordination. Specifically, HEDIS measures from the 2018 CMS Adult and Child Core Sets were picked, as well as the measures MQD used for its P4P Program.

The HEDIS measures mostly involve ratios of a target behavior over the entire population that is eligible for that behavior. Occasionally ratios are reported on a sample of the population instead of the entire population, but on these occasions, there are intensive internal claim audits applied to a sample of the claims. The HEDIS measures are based on self-reported HEDIS reports received from the five individual QUEST plans.

HEDIS reports from the plans are based on a calendar year period, a twelve- month period beginning in January 1 and ending on December 31 of the report year, and are due to MQD on approximately June 30 of the following year. These are weight-averaged to create composite HEDIS measures for the entire

Med-QUEST population for a single year. The plans are required to report on most of the HEDIS measures in each year. The definitions of the various HEDIS measures reported by the plans are no different from the national standard HEDIS definitions – we do not have any HEDIS-like measures. All five plans are concurrently audited by the EQRO vendor.

Annual audits on how the plans calculate and report their HEDIS scores are conducted by the HEDIS-certified EQRO entity under contract with, and under the direction of, Med-QUEST. Typically, these audits involve a sample of three to six HEDIS measures.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. For most measures scores are reported for each year from HEDIS year 2015 to 2017 (CY2014 to CY2016). A comparison is made to the corresponding year's National Medicaid Average Rate and the Median 75th Percentile score to bring perspective to where MQD scores on a national level.

For all of the HEDIS measures except for the CDC: Poor HbA1c Control >9% and AMB: Emergency Department Visits, higher numeric scores are considered positive (higher performance) and lower numeric scores are considered negative; for these measures lower numeric scores are considered positive and higher numeric scores are considered negative.

Provider and Health Plan Accountability Methods and Limitations

For the third area, MQD measured provider and health plan accountability by reviewing qualitative data it gained from providers.

In calendar year (CY) 2016, MQD required the administration of surveys to health care providers who serve QI members through one or more QI health plan. MQD and a vendor developed a survey instrument designed to acquire meaningful provider information and gain providers' insight as it relates to the QI health plans' performance and potential areas of performance improvement. A total of 1,500 providers were sampled for inclusion in the survey administration: 200 Kaiser providers and 1,300 non-Kaiser providers (i.e., AlohaCare QI, HMSA QI, 'Ohana (WellCare) QI, and/or UHC CP QI providers). Providers completed the surveys from August to October 2016.

The State was interested in surveying Federally Qualified Health Center (FQHC) providers and increasing responses from primary care physicians (PCPs). Therefore, for non-Kaiser plans, all FQHC providers were surveyed, with the remaining sample size consisting of PCPs and non-PCPs. Since there were no FQHC providers for Kaiser, the sampling consisted of PCPs and non-PCPs. FQHC providers made up 17 percent of the sample size for the non-Kaiser plans.

The response rate is the total number of completed surveys divided by all eligible providers within the sample. Eligible providers included the entire sample minus ineligible surveys, which included any providers that could not be surveyed due to incorrect or incomplete mailing address information or had no current contracts with any of the QI health plans. A total of 267 Hawai`i providers completed the survey, including 50 providers from the Kaiser sample and 217 providers from the non-Kaiser sample.

The response rate for the non-Kaiser sample was considerably lower than the Kaiser sample (18.0 percent and 28.2 percent, respectively). The low response rates increased potential for non-response bias and likelihood that provider responses are not reflective of all providers serving QI members.

Results

Strengthening Access to Care and Beneficiary Engagement

Activities to Align with the Affordable Care Act

MQD started determining eligibility for Medicaid individuals using new Modified Adjusted Gross Income (MAGI) criteria on October 1, 2013. In addition, MQD fine-tuned its work within its eligibility system called Kauhale (community) On-Line Eligibility Assistance System (KOLEA). MQD encouraged applicants to apply on-line at its mybenefits.hawaii.gov website.

MQD implemented other Affordable Care Act (ACA) requirements in October 1, 2013. This included the FQHCs becoming navigators with the Hawaiʻi Health Connector, the state's original state-based exchange. Hawaiʻi became a state-based exchange using the federal platform for the individual market in 2015, and switched to a fully-federally-run exchange in 2017. FQHCs were able to submit applications for Hawaiʻi Medicaid through the KOLEA system as well.

In addition to encouraging applicants to apply through the KOLEA system, MQD established a new branch in December 2015. The Health Care Outreach Branch (HCOB) was created in response to a demonstrated community need for additional application assistance for some of the hardest to reach populations. The program focused its outreach and enrollment assistance efforts on those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers and justice-involved populations. Due to the multiple challenges faced by these individuals/families, they were traditionally less likely to proactively enroll themselves in health insurance. Having an outreach team in the field that met people where they congregate and offered on-the spot application assistance was helpful in serving this high-risk population.

Beneficiary Engagement

MQD had a varied experience with Child CAHPS measures from CY2015 to CY2017 as described in the table below. The QI program showed improvement on all composite measures, but showed a drop in three out of the four global ratings and both individual item measures.

Table 1: Child CAHPS

Child CAHPS		
Global Ratings	CY2015	CY2017
Rating of Health Plan	68.7%	69.1%
Rating of All Health Care	65.5%	65.0%
Rating of Personal Doctor	76.0%	74.1%
Rating of Specialist Seen Most Often	72.5%	72.9%

Composite Measures		
Rating of Health Plan	80.3%	82.8%
Rating of All Health Care	85.8%	86.4%
Rating of Personal Doctor	93.9%	94.4%
Rating of Specialist Seen Most Often	83.1%	86.9%
Shared Decision Making	82.4%	82.7%
Individual Item Measures		
Coordination of Care	86.6%	83.8%
Health Promotion and Education	77.1%	75.8%

From CY2014 to CY 2016, MQD showed improvement in all adult CAHPS composite and individual item measures, and all the global ratings except for the rating of personal doctor. Of particular note, the QI program showed over a 30 percentage point increase on the Shared Decision Making composite measure.

Table 2: Adult CAHPS

Adult CAHPS		
Global Ratings	CY2014	CY2016
Rating of Health Plan	56.2%	59.2%
Rating of All Health Care	52.7%	56.8%
Rating of Personal Doctor	65.1%	64.9%
Rating of Specialist Seen Most Often	61.3%	68.3%
Composite Measures		
Rating of Health Plan	75.8%	82.2%
Rating of All Health Care	76.5%	80.3%
Rating of Personal Doctor	90.3%	91.7%
Rating of Specialist Seen Most Often	82.6%	86.1%
Shared Decision Making	50.9%	81.6%
Individual Item Measures		
Coordination of Care	81.1%	84.4%
Health Promotion and Education	72.9%	76.0%

The At-Risk Expansion

One of the goals of the demonstration was to expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS. MQD sought to accomplish this by opening up HCBS to individuals at-risk of deteriorating to institutional level of care.

Coverage was intended to prevent a decline in health status and maintain individuals safely in their homes and communities. During the current demonstration, the at-risk population had access to a set of HCBS that included personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS) and skilled nursing.

For the at-risk population, Hawaiʻi has seen some positive results in the numbers of individuals that receive care in a nursing home in relation to those that receive HCBS. The number of individuals

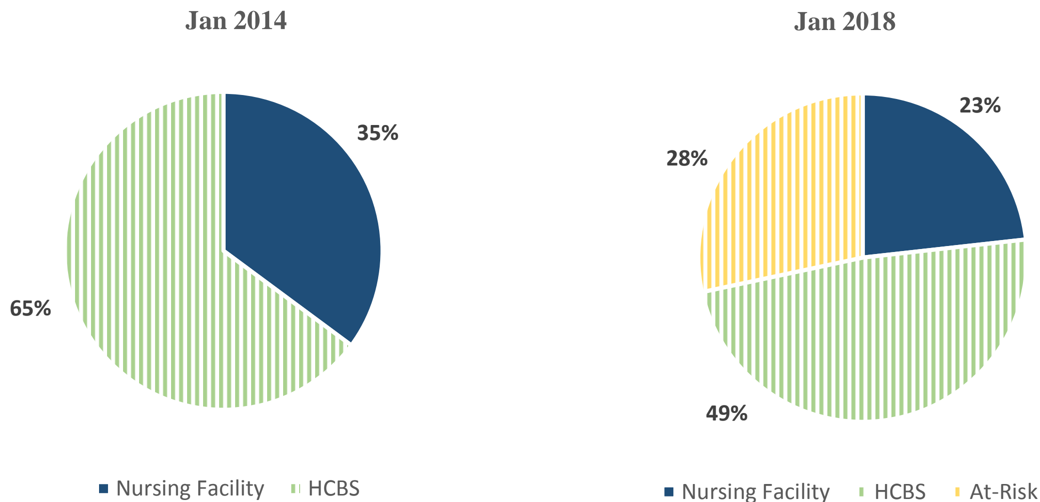
receiving care in a nursing home decreased 17.6 percent between January 2014 and January 2018. The number of individuals meeting an institutional level of care receiving HCBS also decreased 7 percent. These shifts happened at the same time as more beneficiaries received at-risk services.

While the term of this evaluation is CY2014 through CY2016, enrollment data up to January 2018 has been included in this table to show enrollment trends over time.

Table 3: Nursing Facility, HCBS, and At-Risk Service Enrollment over Time

	January 2014	July 2014	January 2015	July 2015	January 2016	July 2016	January 2017	July 2017	January 2018
Nursing Facility	2,584	2,605	2,479	2,442	1,917	2,148	2,356	2,250	2,129
HCBS	4,770	4,765	4,556	4,829	4,062	4,846	4,194	4,493	4,434
At-Risk					1,403	1,587	2,379	2,530	2,599

Figure 1: Proportion of Individuals Receiving LTSS in NF and HCBS Settings - Jan 2014-Jan 2018



It should be noted that beneficiaries in Hawai‘i must meet a relatively high standard in order to receive HCBS or nursing facility services through a nursing facility level-of-care assessment. If the at-risk population were to be removed from the analysis, MQD still reduced the percentage of those receiving LTSS in a nursing facility from 35.1 percent to 32.4 percent from January 2014 to January 2018.

Improving Health, Ensuring High-Quality Care, and Managing Costs

The rationale for the implementation of managed care is improved access, quality, and cost-efficiency. Under this theory, using managed care systems improves the care delivered to Medicaid beneficiaries by improving coordination of care, consistent application of managed care principles, strong quality assurance programs, partnership with providers, emphasis on the medical home, and achieving cost-effective service delivery.

The HEDIS measures below show how the QI program performed in both improving health outcomes and its performance in aspects of providing a medical home – namely, the use of primary and preventive care, chronic care management, and behavioral health. Three rates are depicted graphically – the statewide aggregate rate for the QI program, the average Medicaid rate, and the 75th Medicaid percentile, which is typically MQD's quality target. The average Medicaid rate is depicted to give greater context to MQD's performance, specifically to show how far the statewide aggregate may be off from the national average when the QI program may not meet the 75th percentile.

Adult Core Set – Primary Care Access and Preventive Care

<u>Cervical Cancer Screening</u>

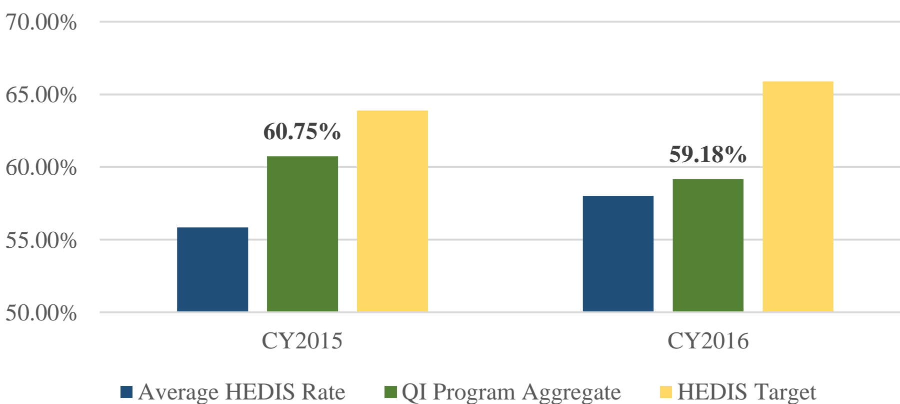
The QI program experienced a decrease in performance on the "Cervical Cancer Screening" measure during the measure period for the adult population. However, the QI program performed better than the average HEDIS rate.

The measure assesses women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years; or
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

MQD began reporting this measure in CY2015, so only two years of data are available. Performance decreased by approximately 1.5 percentage points between CY2015 and CY2016.

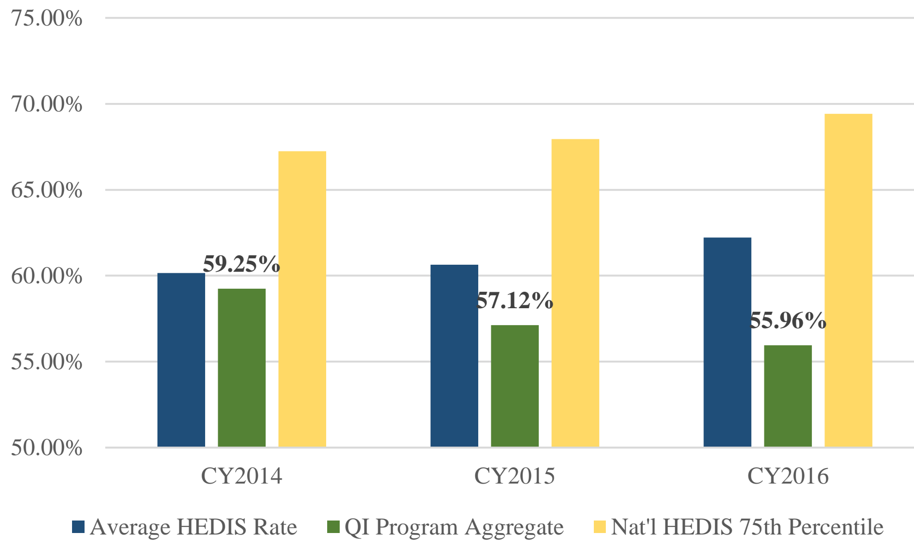
Figure 2: Cervical Cancer Screening



Chlamydia Screening in Women

The QI program experienced a decrease in performance on the "Chlamydia Screening in Women" measure between CY2014 and CY2016. The measure assesses women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. MQD reported on two age breakouts – 16-20 years of age and 21-24 years of age. The results for women age 21-24 years are shown below. Performance went down 3.25 percentage points between CY2014 and CY2016.

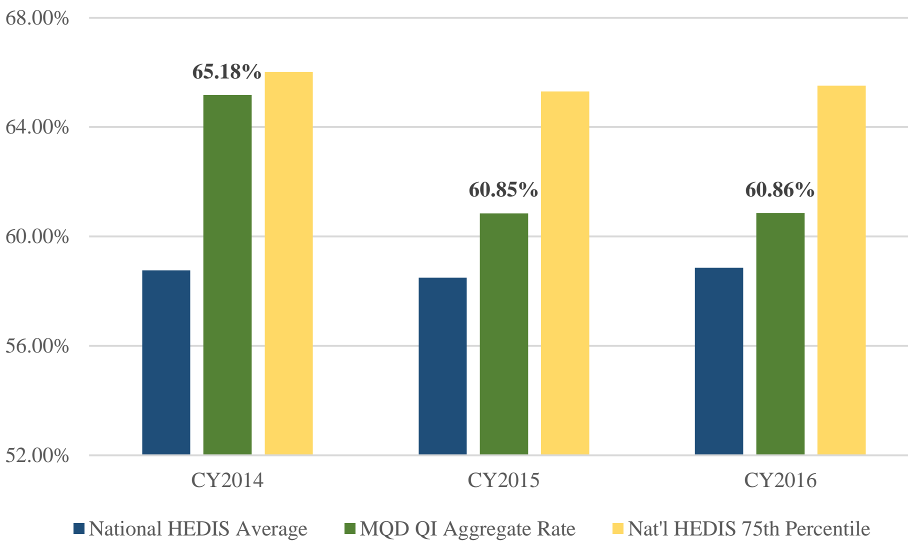
Figure 3: Chlamydia Screening in Women - 21 to 24 Years of Age



Breast Cancer Screening

The QI program experienced a decline in its performance on the “Breast Cancer Screening” measure. The measure assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. However, the QI program performed better than the national HEDIS average for all years measured. Performance decreased by approximately 4.25 percentage points between CY2014 and CY2016.

Figure 4: Breast Cancer Screening

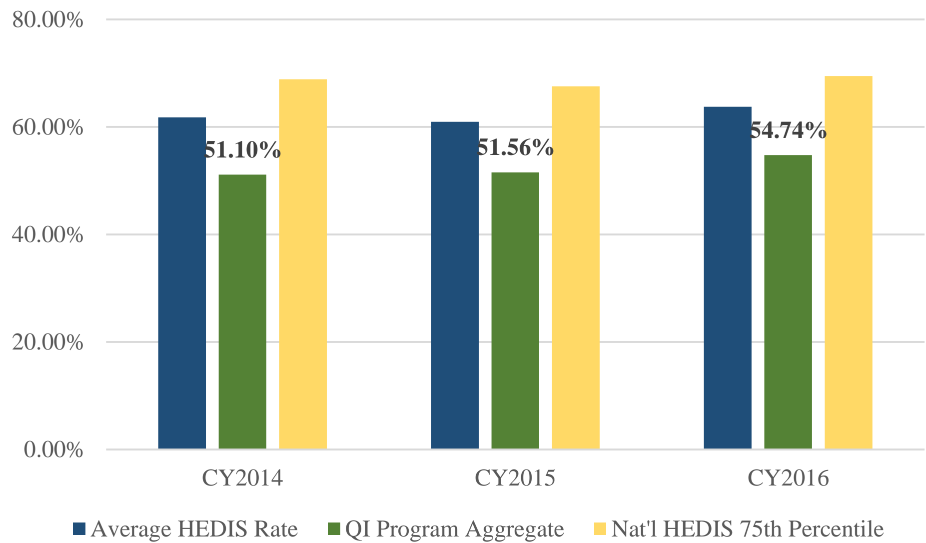


Adult Core Set - Maternal and Perinatal Health

Postpartum Care

"Postpartum Care" is defined as the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. The QI program improved performance on this measure by approximately .5 percentage points between CY2014 and CY2015, and about 3 percentage points between CY2015 and CY2016.

Figure 5: Prenatal and Postpartum Care - Postpartum Care

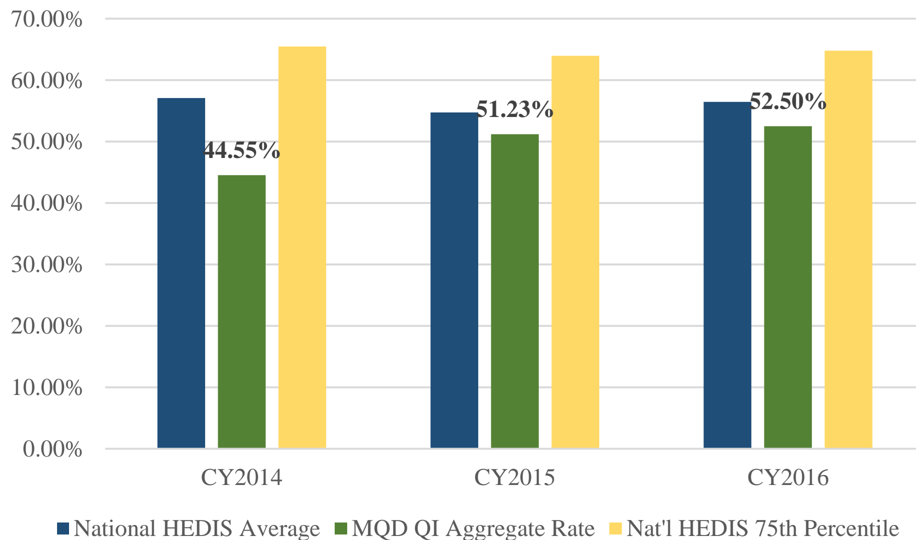


Adult Core Set - Care of Acute and Chronic Conditions

Controlling High Blood Pressure

The QI Program experienced improvement in the "Controlling High Blood Pressure" measure. The measure is defined as adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled based on the following criteria: adults 18-59 years of age whose blood pressure was <140/90 mm Hg; adults 60-85 years of age, with a diagnosis of diabetes, whose blood pressure was <140/90 mm Hg; and adults 60-85 years of age, without a diagnosis of diabetes, whose blood pressure was <150/90 mm Hg. Between CY2014 and CY2016, performance increased by about 8 percentage points.

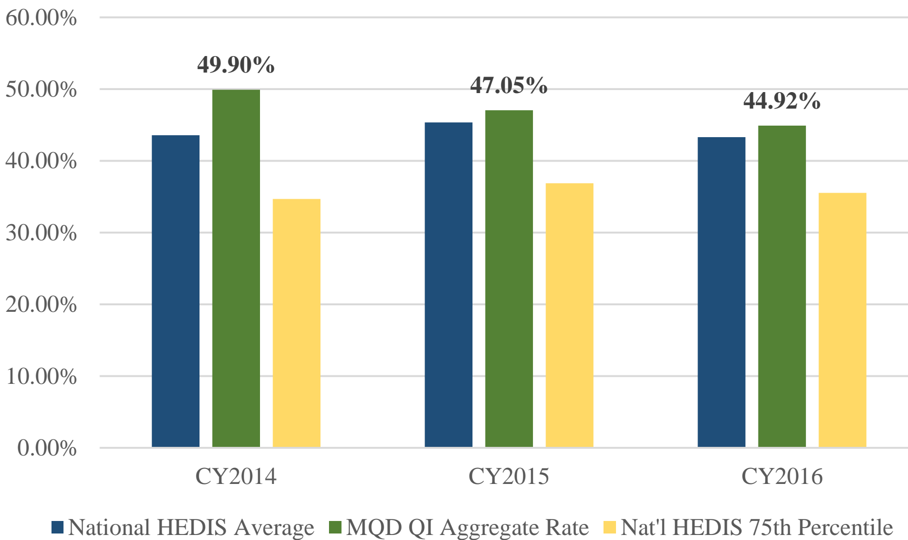
Figure 6: Controlling High Blood Pressure



Comprehensive Diabetes Care

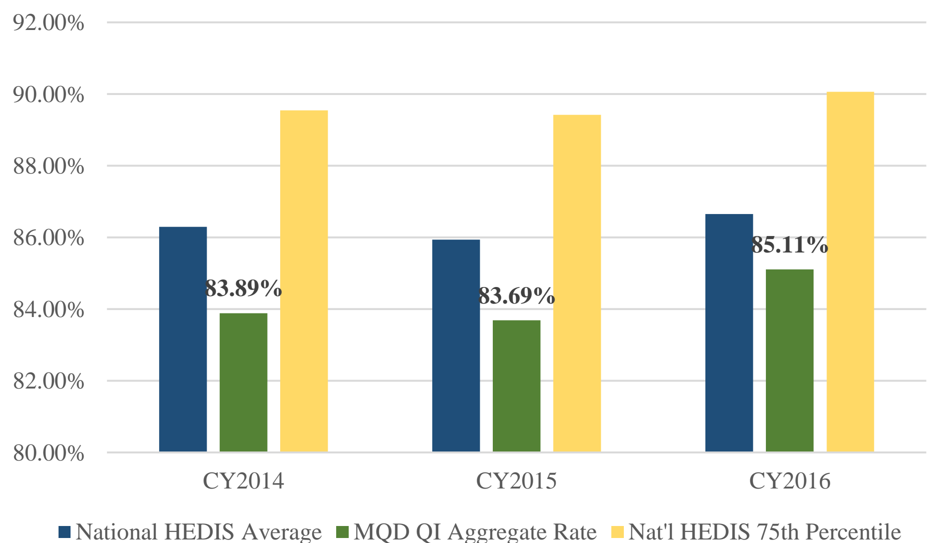
The QI experienced variation in the "Comprehensive Diabetes Care" measures during the waiver extension period. The "Hemoglobin A1c Poor Control" is defined as the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. A lower rate reflects better performance. The QI program improved its performance by 2.85 percentage points between CY2014 and CY2015, and then over 2 percentage points between CY2015 and CY2016.

Figure 7: Hemoglobin A1c Poor Control



The "Hemoglobin A1c Testing" measures the percentage of beneficiaries ages 18-75 with diabetes (type 1 and 2) who had a hemoglobin A1C test. The QI performance dipped by .2 percentage points between CY2014 and CY2015, but improved by nearly 1.5 percentage points between CY2015 and CY2016.

Figure 8: HbA1c Testing



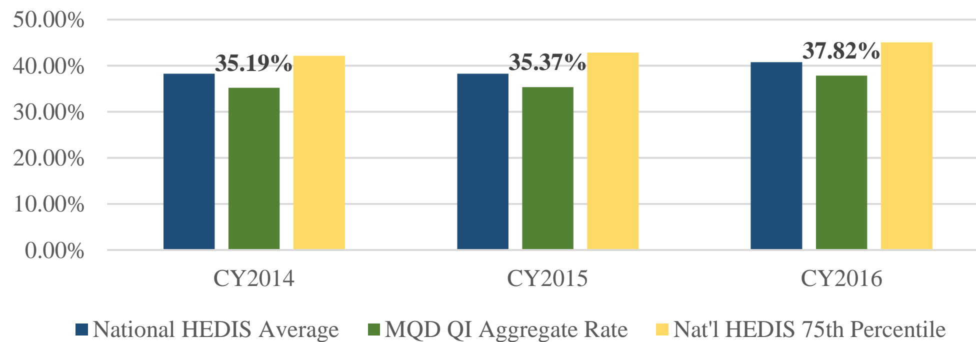
Adult Core Set – Behavioral Health Care

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

The QI program experienced variation with this measure. The measure assesses the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) dependence who received the following care. The QI program improved on Initiation over the extension period, and while the engagement results have varied, QI is still performing above the national HEDIS average.

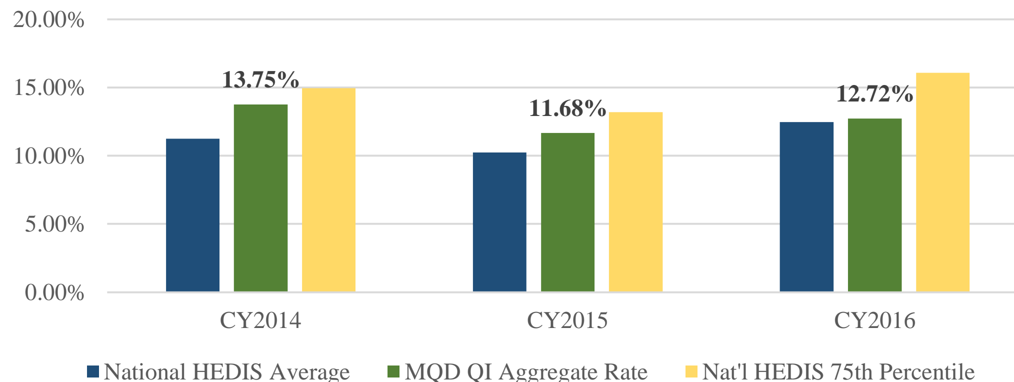
Initiation of AOD Treatment: Adolescents and adults who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Figure 9: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation of AOD Treatment



Engagement of AOD Treatment: Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Figure 10: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement of AOD Treatment



Antidepressant Medication Management

The QI program experienced variation with this measure. The measure assesses adults 18 years of age and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on their antidepressant medications.

Two rates are reported:

- Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months)

Figure 11: Antidepressant Medication Management - Effective Acute Phase Treatment

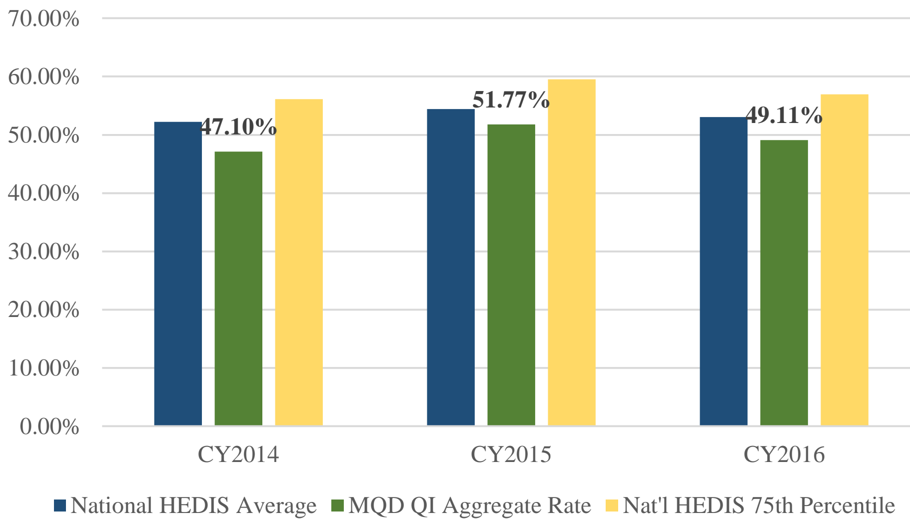
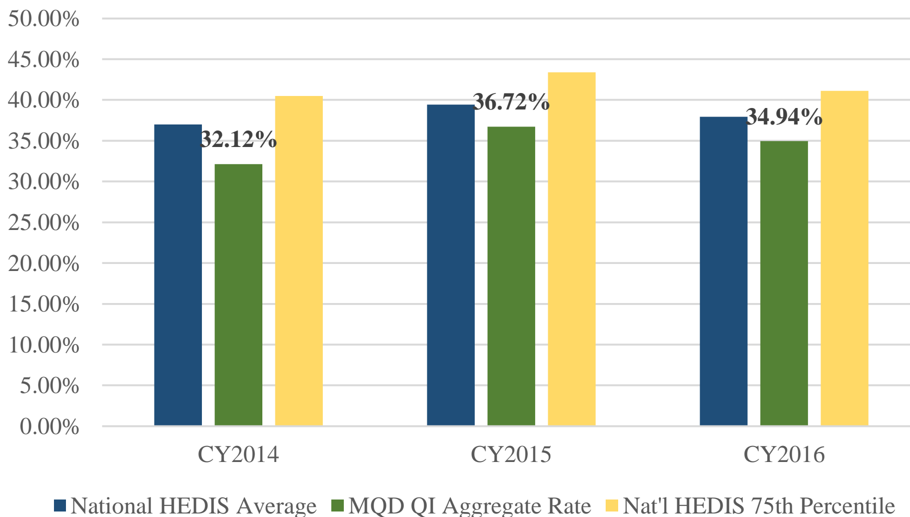


Figure 12: Antidepressant Medication Management - Effective Continuation Phase Treatment

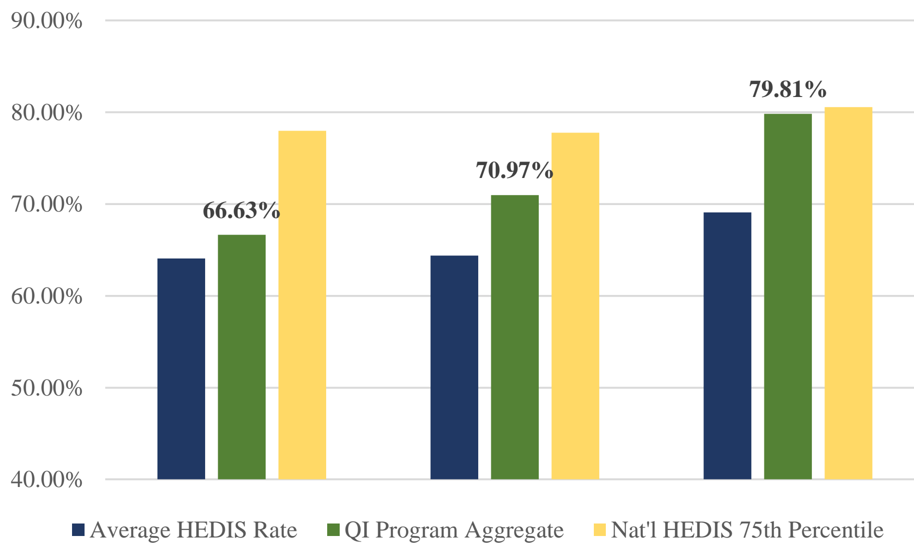


Child Core Set – Primary Care Access and Preventive Care

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile

The QI program experienced improvement in the "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile" measure. The measure is the percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of patients with documentation for height, weight, and body mass index (BMI) percentile. Performance increased by about 13 percentage points between CY2014 and CY2016.

Figure 13: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile



Children and Adolescents’ Access to Primary Care Practitioners

The QI program experienced variation in the “Children and Adolescents’ Access to Primary Care Practitioners” measure. The measure assesses children and young adults 12 months–19 years of age who had a visit with a primary care practitioner (PCP). The measure reports on four separate percentages:

- Children 12–24 months who had a visit with a PCP during the measurement year.
- Children 25 months–6 years who had a visit with a PCP during the measure year.
- Children 7–11 years who had a visit with a PCP during the measure year or the year prior to the measurement year.
- Adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Figure 14: Children and Adolescents’ Access to Primary Care Practitioners - 12-24 Months of Age

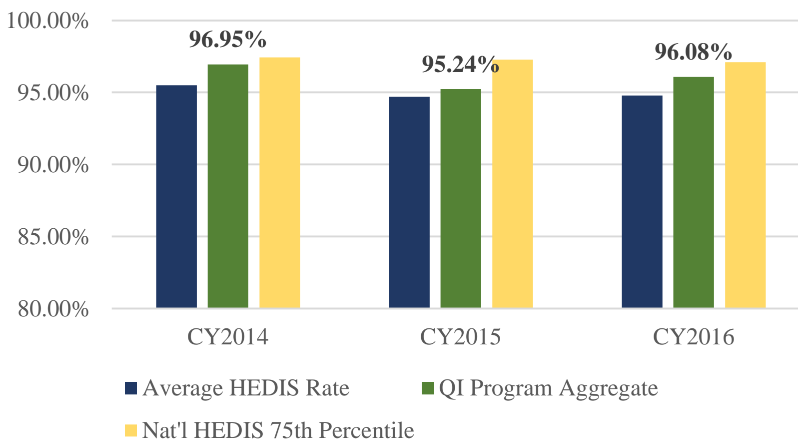


Figure 15: Children and Adolescents' Access to Primary Care Practitioners - 25 months to 6 years

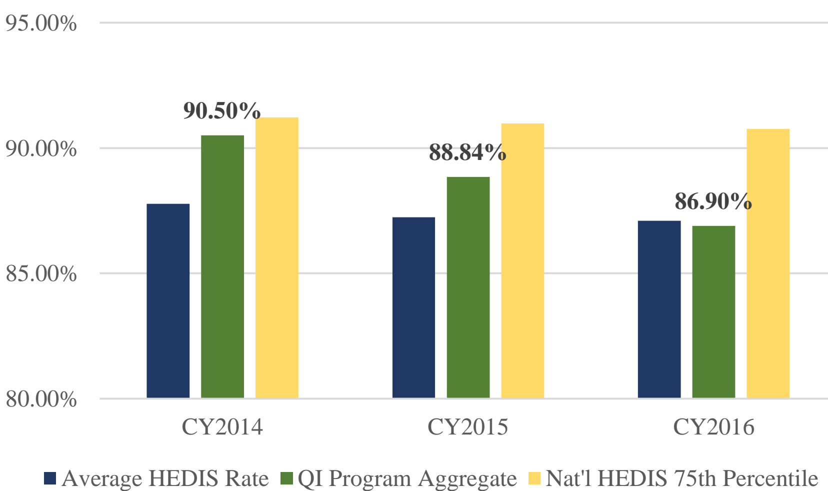


Figure 16: Children and Adolescents' Access to Primary Care Practitioners - 7 to 11 years

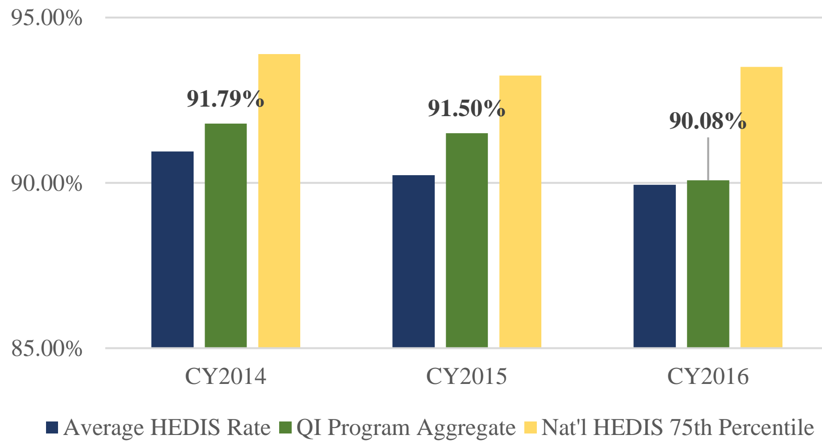
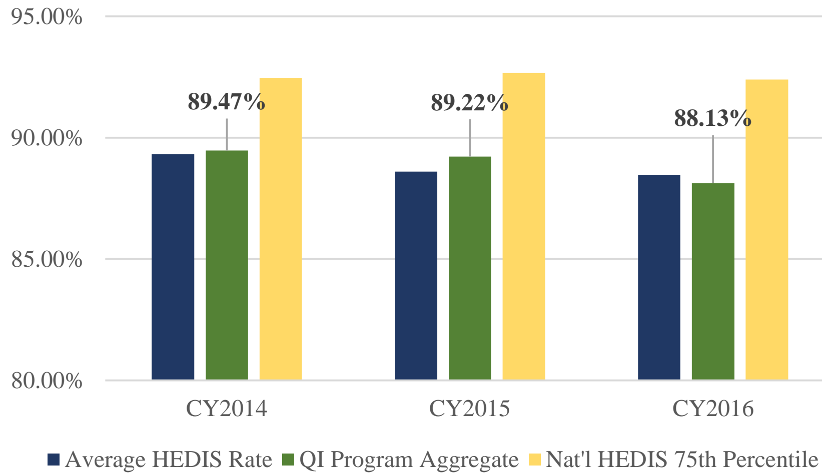


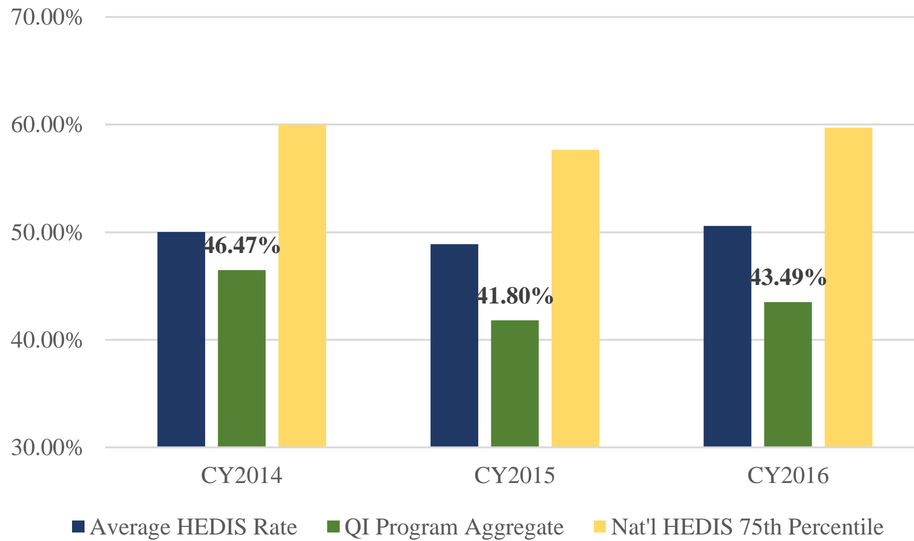
Figure 17: Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years of Age



Adolescent Well-Care Visits

The QI program experienced variation with the “Adolescent Well-Care Visits” measure. The measure assesses adolescents and young adults 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Overall, performance decreased from CY2014 and CY2016 by about 3 percentage points.

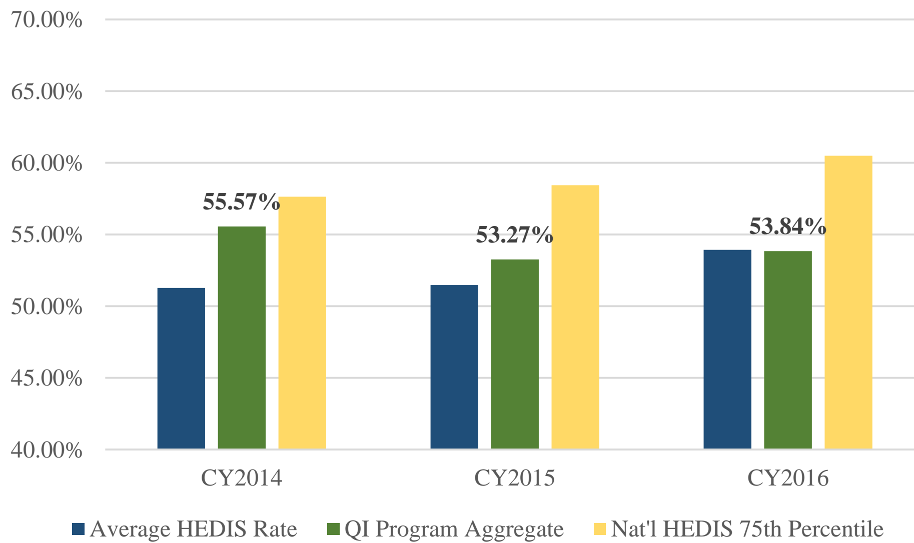
Figure 18: Adolescent Well-Care Visits



Chlamydia Screening in Women

The QI program experienced variation in the "Chlamydia Screening in Women" measure. Assesses women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. MQD reported on two age breakouts – 16-20 years of age and 21-24 years of age. Overall, there was about a decrease of 2 percentage points between CY2014 and CY2016.

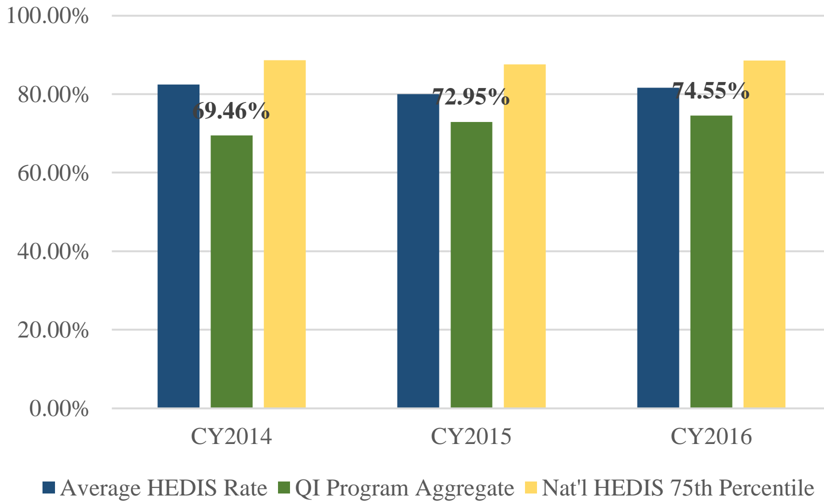
Figure 19: Chlamydia Screening in Women - 16 to 20 Years of Age



Child Core Set – Maternal and Perinatal Health

"Timeliness of Prenatal Care" is defined as the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. The QI program improved its performance by nearly 3.5 percentage points from CY2014 to CY2015 and approximately 1.5 percentage points from CY2015 to CY2016.

Figure 20: Prenatal and Postpartum Care - Timeliness of Prenatal Care

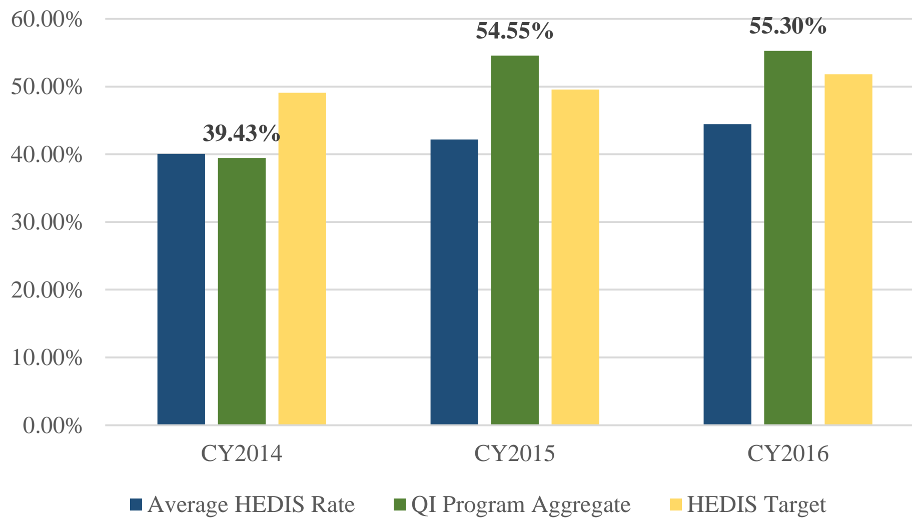


Child Core Set – Behavioral Health Care

Follow-Up Care for Children Prescribed ADHD Medication

The QI program experienced progress in the HEDIS "Follow-Up Care for Children Prescribed ADHD Medication" measure. The measure is defined as the percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care.

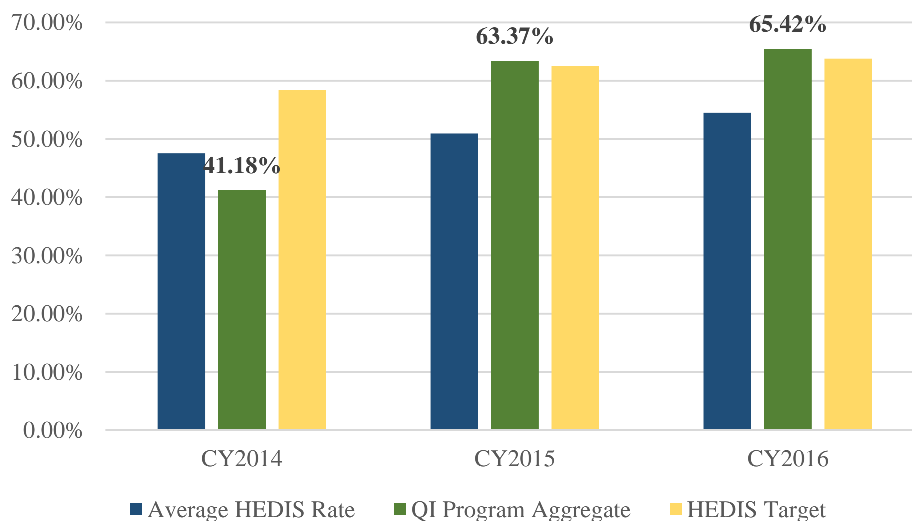
Figure 21: Follow-Up Care for Children Prescribed ADHD Medication - Initiation



Two rates are reported: the percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase; and the percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

For both components of the measure, the QI program rate was below the average HEDIS rate in calendar year 2014, but was above the national HEDIS 75th percentile in calendar years 2015 and 2016.

Figure 22: Follow-Up Care for Children Prescribed ADHD Medication - Continuation Phase



Pay for Performance Results

During this waiver term, beginning in CY2015 and continuing into CY2016, the QI health plans had a withhold of $2.00 PMPM for the non-ABD population and $1.00 PMPM for the ABD population. These entire withhold amounts were available for both the CY 2015 and CY 2016 Pay for Performance (P4P) Program. The MQD generally improved its P4P Program in the QI program, but there were also decreases in performance on some measures.

The following were improvements made to the QI P4P Program beginning CY 2015:

- Expanded measure set – increased number of measures from six (6) to nine (9)
- Recognized both improvement and goal achievement of individual measure scores – added incremental achievement targets to the current excellence target, with corresponding additional percentage incentives
- Weighted the measures differently based on the percentage of ABD enrollment each health plan served during the time period

The result of these P4P changes has been broader participation achievement of intermediate goals by a broader spectrum of the QI health plans. Whereas in past years a maximum of only two QI health plans in any year achieved any P4P payout, in the first two years of the new P4P Program, each and every QI health plan participated in the P4P payout. The intent was to keep each QI health plan engaged in the quality improvement process no matter where they are on the performance spectrum.

The QI program improved performance on seven of the nine measures included in the P4P Program, but only met two of its HEDIS targets. In addition to this longitudinal improvement, the QI program also narrowed the distance between the Hawai‘i rate and the national HEDIS target rate for the seven measures. However, Med-QUEST also saw decreases in performance in measures on well-child visits and immunizations.

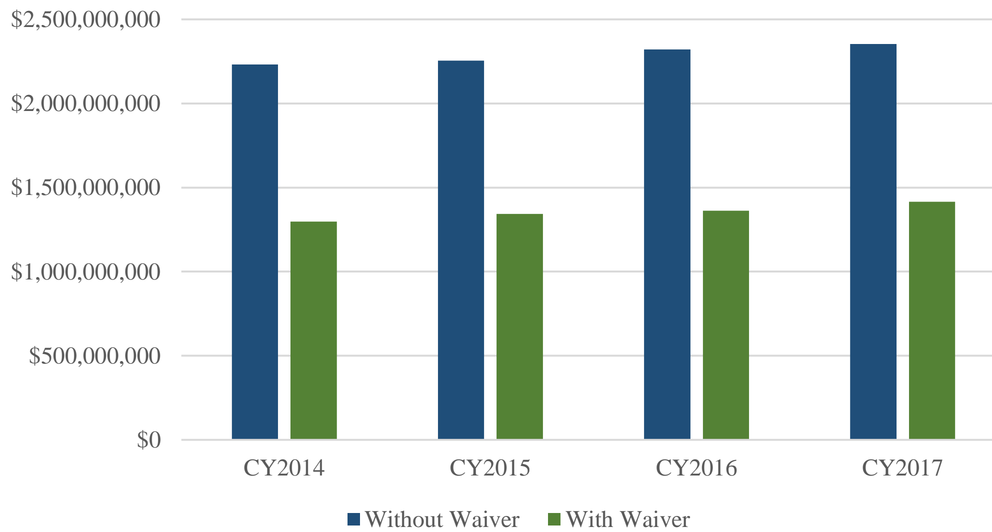
Table 4: P4P Results CY2014-CY2016

		CY2014			CY2015			CY2016		
		Hawai'i Rate	**Target Percent**	**Difference Between Rates**	**Hawai'i Rate**	**Target Percent**	**Difference Between Rates**	**Hawai'i Rate**	**Target Percent**	**Difference Between Rates**
Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	58.57%	63.23%	-4.66%	58.48%	61.50%	-3.02%	61.72%	63.33%	-1.61%
Comprehensive Diabetes Care	HbA1c Control (<8.0%)	40.37%	54.01%	-13.64%	43.59%	52.55%	-8.96%	45.80%	53.65%	-7.85%
Childhood Immunization Status	Combination 3	57.81%	76.50%	-18.69%	64.63%	75.60%	-10.97%	57.92%	75.91%	-17.99%
Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up	29.69%	56.78%	-27.09%	34.89%	55.34%	-20.45%	38.63%	56.22%	-17.59%
Plan All-Cause Readmissions*	Total	12.15%		12.15%	13.76%	13.17%	-.49%	13.14%	13.55%	.41%
Prenatal and Postpartum Care	Postpartum Care	51.10%	68.85%	-17.75%	51.56%	67.53%	-15.97%	54.74%	69.44%	-14.70%
Prenatal and Postpartum Care	Timeliness of Prenatal Care	69.46%	88.66%	-19.20%	72.95%	87.56%	-14.61%	74.55%	88.59%	-14.04%
Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	72.91%	66.24%	6.67%	67.59%	67.76%	-0.17%	71.32%	68.66%	2.66%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	75.80%	78.46%	-2.66%	72.39%	77.57%	-5.18%	71.51%	78.51%	-7.00%

The source for data contained in the table above is Quality Compass® 2015, 2016, and 2017 and is used with the permission of NCQA. Quality Compass 2015, 2016, and 2017 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Financial Performance

One of the goals of the demonstration is to "[c]ontinue the predictable and slower rate of expenditure growth associated with managed care." One measure for that goal is the budget neutrality test the waiver must meet under waiver rules. Budget neutrality savings is a reflection of the fiscal performance of the waiver. Specifically, it compares the expenditures with the waiver in place – inclusive of all the demonstration group costs -- against the hypothetical expenditures if the waiver were not in place at all. If the "With Waiver" expenditures are less than the "Without Waiver" expenditures, then Budget Neutrality Savings will result. Over the waiver term, Hawai'i continued its historical performance under the budget neutrality cap.



	CY2014	CY2015	CY2016	CY2017
Without Waiver	$2,232,453,994	$2,253,542,582	$2,321,791,532	$2,353,515,633
With Waiver	$1,298,373,371	$1,343,314,944	$1,361,491,708	$1,415,242,078

The numbers above do not include the Group VIII population as those numbers are not part of the savings calculation under budget neutrality. The table below illustrates expenditures if those numbers were to be included.

	CY2014	CY2015	CY2016	CY2017
Without Waiver	$2,865,706,000	$3,125,921,334	$3,372,492,772	$3,506,857,163
With Waiver	$1,707,340,410	$1,846,705,244	$1,961,265,188	$2,091,241,239

Provider and Health Plan Accountability

One of the hypotheses tested in the QUEST 1115 waiver renewal is “[e]stablish contracted accountability among the contracted health plans and health care providers” and “[m]aintain a managed care delivery system that assures access to high- quality, cost-effective care that is provided, whenever possible, in the members’ community, for all covered populations.” MQD has attempted to realize this goal through a number of vehicles. A good proxy measure for performance is provider opinion on how QI programs are able to support providers in their work to serve QI beneficiaries. The tables below describe provider attitudes toward health plan accountability, by QI plan.

It should be noted again that the response rate for the non-Kaiser sample was considerably lower than the Kaiser sample (18.0 percent and 28.2 percent, respectively). The low response rates increased potential for non-response bias and likelihood that provider responses are not reflective of all providers serving QI members. Furthermore, FQHC providers did make up 17 percent of the non-Kaiser sample, but were not included in the Kaiser sample.

General Positions

Providers were asked to rate their satisfaction with the rate of reimbursement or compensation they receive from their contracted QI health plans. In 4 of 5 plans, at least one-third of providers reported being very dissatisfied/dissatisfied with the reimbursement rate or compensation received.

Table 5: Provider Survey - General Positions

	Very Dissatisfied/Dissatisfied	Neutral	Very Satisfied/Satisfied	N
AlohaCare	41.9%	37.1%	21.0%	186
HMSA	30.0%	34.3%	35.7%	207
Kaiser	12.2%	24.4%	63.4%	41
‘Ohana	57.1%	30.2%	12.6%	182
UHC	54.3%	30.1%	15.6%	186

Providing Quality Care

Providers were also asked two questions focusing on the impact QI health plans have on their ability to provide quality care. Areas rated included: prior authorization process and formulary. Responses for the prior authorization process are described below:

Table 6: Provider Survey - Providing Quality Care

	Negative Impact	Neutral Impact	Positive Impact	N
AlohaCare	55.0%	32.8%	12.2%	186
HMSA	46.7%	36.5%	16.8%	207
Kaiser	8.8%	58.8%	32.4%	41
‘Ohana	65.0%	26.6%	12.6%	182
UHC	61.1%	30.3%	15.6%	186

Service Coordinators

Providers were asked to rate the adequacy of the help provided by the QI health plans' service coordinators. In 4 of 5 plans, more than one-third of providers reported dissatisfaction with the adequacy of help provided by service coordinators.

Table 7: Provider Survey - Service Coordinators

	Very Dissatisfied/Dissatisfied	Neutral	Very Satisfied/Satisfied	N
AlohaCare	41.0%	42.3%	16.7%	156
HMSA	31.3%	47.3%	21.4%	182
Kaiser	0%	25.0%	75.0%	48
'Ohana	54.2%	36.6%	9.2%	153
UHC	49.0%	40.6%	10.3%	155

Specialists

A majority of providers were dissatisfied with the adequacy of the number of specialists for three QUEST plans; were neutral in one plan; and were satisfied in the fifth plan.

Table 8: Provider Survey - Specialists

	Dissatisfied	Neutral	Satisfied	N
AlohaCare	60.8%	32.5%	6.6%	166
HMSA	34.2%	44.2%	21.6%	190
Kaiser	2%	18.0%	80.0%	50
'Ohana	72.5%	22.5%	5.0%	160
UHC	60.7%	35.6%	3.7%	163

In regard to the plans' behavioral health networks, approximately two-thirds of providers surveyed reported dissatisfaction with the availability of behavioral health providers in three plans. For the two other plans, close to 50 percent of providers surveyed reported being dissatisfied with the availability of behavioral health providers.

Table 9: Provider Survey - Behavioral Health Specialists

	Dissatisfied	Neutral	Satisfied	N
AlohaCare	66.7%	27.5%	5.8%	138
HMSA	49.7%	38.8%	11.5%	165
Kaiser	47.8%	28.3%	23.9%	46
'Ohana	69.9%	24.8%	5.3%	133
UHC	66.2%	30.1%	3.7%	136

Findings, Conclusions & Recommendations

The QUEST Integration is the continuation of a mature managed care program that serves approximately 99 percent of Medicaid beneficiaries in Hawai‘i. The information presented in this evaluation demonstrates that the QI program achieved success on the goals outlined in the STCs, but there may be room for improvement.

MQD grouped the following goals under Access to Care and Beneficiary Engagement:

- Align the demonstration with Affordable Care Act;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system; and
- Expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS.

The QI program demonstrated success in meeting these goals. The demonstration was aligned with the Affordable Care Act. Data from the CAHPS survey showed improved ratings for all composite measures and individual item measures for the adult population. The program also improved on the child CAHPS composite measures, however declines in performance on the global ratings and individual items suggest that more attention may be needed on the provision of services to children, such as care coordination and health education.

Service utilization data for nursing home, HCBS, and at-risk services show fewer people received nursing home services and HCBS in 2018 than 2014 if they qualified for those services by meeting the nursing home level of care in Hawai‘i – a high standard. If at-risk services are added to the analysis, the percentage of individuals receiving HCBS rather than nursing home services increases from 65 percent to 77 percent.

MQD grouped the next three goals into Improving Health, Ensuring High-Quality Care, and Managing Costs

- Improve the health care status of the member population;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP); and
- Continue the predictable and slower rate of expenditure growth associated with managed care.

The evaluation shows mixed results as it pertains to improving health care outcomes and quality of care in the QI program. In looking at the Adult Core Set measures, screenings for cervical cancer, breast cancer, and chlamydia decreased in the QI program during the measurement period, but breast and cervical cancer screening rates exceeded the national Medicaid average. For postpartum care, the QI program saw an increase in performance the measure, but fell below the national average. The QI program's performance for acute and chronic care conditions and behavioral health was mixed, but rates on three of the four behavioral health measures below the national HEDIS average which may suggest a need for improvement in the quality of care for adults in the QI program with behavioral health diagnoses.

For the Child Core Set measures, the QI program experienced variation across the domains. The program notably experienced strong performance on the Follow-Up Care for Children Prescribed ADHD Medication measure.

QI performance in the measures in the P4P Program similarly showed mixed results. While the state aggregate score improved on 7 out of 9 measures, the State only met the target for 2 out of 9 measures from CY2014 through CY2016.

MQD grouped the following goals into Provider and Health Plan Accountability:

- Maintain a managed care delivery system that assures access to high- quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations; and
- Establish contractual accountability among the contracted health plans and health care providers.

The provider survey shows evidence that providers believe there is a shortage of mental health providers in the QI program. This reflects workforce shortages that affect other payers and health systems in Hawai'i. As noted above, however, performance on behavioral health HEDIS measures for adults and children were mixed. QI plan performance on service coordination also had mixed results according to providers.

The QI program will continue to monitor performance on the measures found in this evaluation and in other quality monitoring activities and use them to inform policy and operations. MQD does not recommend particular policy changes at this time as it is presently embarking on a major evolution of the QUEST waiver.

In the next 1115 renewal period, MQD will continue the current QUEST program, but will adopt policies to invest in primary care, prevention, and health promotion, improve outcomes for high-need, high-cost individuals, engage in payment reform and alignment, and support community driven initiatives to improve population health in line with the Hawai‘i ‘Ohana Nui Project Expansion (HOPE) initiative. MQD will use the evaluation report findings to help inform the direction and the design of the HOPE initiative in the next renewal. In particular, findings related to primary care and prevention, chronic care management, behavioral health, and value-based purchasing will be useful in program design under the HOPE initiative.

QUEST Integration
Evaluation Design

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

December 18, 2014
Revised: June 16, 2017
Approved February 23, 2018

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Overview and Brief History of the Demonstration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current Enrollment and Delivery System

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

QUEST Integration has five (5) health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, ʻOhana Health Plan, and UnitedHealthcare Community Plan. See information in Table 1 that includes populations by eligibility groups, health plan enrollment, and eligibility by island.

Summary of QUEST Expanded Demonstration Evaluation-January 2014

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendations of QUEST Expanded Demonstration Evaluation-January 2014

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

1. Improve process for gathering information from providers

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

   Some recommendations for the future are:

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

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

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

3. Increase the Pay for Performance withhold from health plans

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

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

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

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

Goals and Objectives

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

1. Improve the health care status of the member population;
2. Continue the predictable and slower rate of expenditure growth associated with managed care;
3. Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations, with a focus on preventative care;
4. Improve care coordination and decrease provider administrative burden by establishing a Patient Centered Medical Home (PCMH); and
5. Expand access to home and community based services (HCBS) and allow LTSS individuals to have a choice between institutional services and HCBS.

Hypotheses

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

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

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

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

Population Groups Impacted

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

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

Outcome Measures

Current Measures

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

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

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

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

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

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

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

- Comprehensive Diabetes Care (CDC):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Future Measures

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

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

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

- Decreasing the percentage of discharges from the Hawaii State Hospital (HSH) and/or Department of Public Safety (DPS) that have Medicaid ineligible days post-discharge.
- Expanding the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in both the physician office and hospital settings.
- Expanding the use of One Key Question during the delivery of professional maternity services.
- Expanding access to Long Acting Reversible Contraceptives (LARC) for our maternity population by requiring separate and distinct reimbursement in the inpatient setting for LARC devices.
- Expanding the provision of Intensive Behavioral Therapy (IBT) services to populations with an Autism Spectrum Disorder (ABA) diagnosis.
- Expanding the settings that nursing services can be delivered to Medicaid clients, to include the Department of Education (DOE) school system.
- Expanding the use of tele-medicine.

Evaluation Design

Management and Coordination of Evaluation

Organization Conducting the Evaluation

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

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

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

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

Evaluation Timeline

Summary of Timeline for Annual Quality Activities

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

Summary of Timeline for Biennial Quality Activities

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

Summary of Timeline for Annual Deliverables

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

Summary of Timeline for Compilation of Demonstration Evaluation Report

July to November 2013	Analyze data from previous demonstration years

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

<u>Process</u>

Data Sources

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

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

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

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

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

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

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

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

Integration of the State Quality Improvement Strategy
MQD's goal continues to ensure that our beneficiaries receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. We have adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. MQD identified an initial set of ambulatory care measures based on this framework. MQD reviews and updates HEDIS measures annually that the health plans report to us.

MQD continues to update its quality oversight of home and community based services, which will affect mostly our QI health plans, the DDID program, and the Going Home Plus program. MQD uses quality grid based upon the HCSB Quality Framework for monitoring the DDID program. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. We have also updated behavioral health monitoring and quality improvement.

Our quality approach aspires to 1) have collaborative partnerships among the MQD, health plans, and state departments; 2) advance the patient-centered medical home; 3) increase transparency- including making information (such as quality measures) readily available to the public; 4) being data driven; and 5) use quality-based purchasing- including exploring a framework and process for financial and non-financial incentives.

MQD updated its quality strategy and submitted a draft version to CMS on December 18, 2014. MQD received feedback from CMS on July 16, 2015. An updated version of the quality strategy was submitted to CMS on September 30, 2015. MQD received final approval for this quality strategy on July 8, 2016. The revised quality strategy is consistent with the previously approved 2010 version.

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

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

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

related to the measure calculation.

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

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

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

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

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

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

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

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

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

Table 1: QUEST Integration Enrollment

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

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

Figure 1

Measurement Table

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

Figure 1

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

Figure 1

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

Figure 1

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

Commented [FJ1]: Addresses asthma measure questions in 4.f of 3/9/2017 letter.

Figure 1

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

Figure 1

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

Figure 1

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

Figure 1

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

Figure 1

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