QUEST Integration (QI)
Managed Care to Cover Medicaid
and Other Eligible Individuals

Request for Information Responses
No. RFI-MQD-2021-008

Department of Human Services
Med-QUEST Division

QUEST Integration RFI Update

Nearly 370,000 Hawaii residents count on Medicaid for their health care services, and more than 40% of them are children. Nearly 40,000 Hawaii residents have become QUEST Integration health plan members in the past six months as a result of the pandemic. Ensuring families have access to quality care and experience positive health outcomes takes collaboration from everyone in the community.

Med-QUEST invited the community to share their input on how to improve care for Medicaid beneficiaries through a Request for Information (RFI) from July 21 to Aug. 14. Med-QUEST is reviewing the responses to prepare a Request for Proposals (RFP) that will be issued later this month. Nearly 40 organizations, associations, and community leaders submitted responses. Their verbatim comments have been consolidated into this 160-page document for your convenience; every effort was made to accurately convey the information from the individual responses, but please allow for the possibility of errors.

July 21, 2020

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QUESTIONS FOR RESPONDENTS

QI Administration

(Limit response to 2 pages)

Question 1 – Based on considerations such as the number of Medicaid members and QI health plans administrative requirements of providers, what is the optimal number of QI health plans to operate in Hawai‘i? Should the number of QI health plans vary on a regional versus statewide basis?

Lana’i Community Health Center:

It is critical for patient access to **not** limit the number of plans — especially on neighbor islands. MQD must ensure to provide beneficiaries with access to a large network of providers, accepting Medicaid patients, particularly specialty care and behavioral health providers, across the state of Hawai‘i.

UHC

UnitedHealthcare Community Plan Hawai ʼi recognizes and appreciates MQD’s focus on efficiency and administrative simplification as it contemplates the optimal number of MCOs in the QI program. We recommend a statewide procurement that would result in four MCOs being awarded contracts, which would preserve member choice while simultaneously fostering competition and innovation amongst the MCOs. Due to relatively small populations, we recommend only two to three QI health plans be awarded for Molokai and Lanai, selection of which should be determined by RFP scoring of the awarded contracts.

Kaiser Permanente:

As we respond to this RFI, there is no relief in sight from the COVID-19 pandemic. In light of the pandemic, MQD has the opportunity to minimize disruption to members and maintain a program that ensures continuity of care and optimizes the health and well-being of QUEST Integration (QI) beneficiaries. Allowing incumbent health plans to continue offering the choice and access currently in place throughout the State is more important than ever. In order to properly serve QI members, QI health plans must understand the culture and unique island geography of Hawai‘i. This is particularly important during the COVID-19 pandemic as our communities experience high unemployment, intensified social needs, and unique challenges accessing care. We recommend MQD not reduce or otherwise disrupt the number of health plans participating in the QI program. We also recommend MQD simplify the procurement process, such as through issuing a Request for Applications (RFA) rather than an RFP and limiting applicants to MCOs with an existing QI contract and a strong community presence. If MQD proceeds with issuing an RFP, we ask MQD to consider postponing the release to not disrupt the collaborative work underway amongst QI health plans.

Each island is unique in its struggle to provide optimal access to a robust provider network. Thus, we recommend MQD allow QI health plans the option of operating in a defined service area where they have demonstrated experience. This approach ensures QI health plans will be assessed on provider capacity and performance within that particular service area to assure that quality care, appropriate access to services, and necessary supports are available. Many states, including Washington, Oregon, and Texas, allow plans to bid on a specific service area. For instance, in Oregon, a health plan may request an exemption if they aren't equipped to serve an entire region or county, as long as the health plan can demonstrate they can achieve the State's priorities and goals.

Maintaining the number of plans operating in each service area is also important to avoid disruption and confusion for QI beneficiaries in an already complicated time. If a member is forced to change health plans, while their provider(s) may participate in multiple plans, the member is still forced to navigate new technologies, policies, processes, ID cards, etc. that come with enrolling in a new health plan. For example, if a member is receiving prescriptions through a mail order pharmacy, they would be forced to change this arrangement, risking disruption to their medication regimen. This confusion would be further intensified for members receiving care and/or service coordination. For members with the highest needs, their relationship with health plan staff is often as important to them as their relationship with their providers. Not only would they need to reestablish these relationships, but as large numbers of new members are "onboarded" during a new health plan implementation, there is a risk of delay in initiating these services and reestablishing a service plan that meets the member's needs.

In Hawai'i, Kaiser Permanente (KP) operates an integrated healthcare delivery system that consists of a robust network inclusive of over 700 providers. The participation of KP providers in the Hawai'i health system greatly increases access to care for residents of Hawai'i. KP currently serves over 250,000 members across all lines of business in Hawai'i. Many of our members that were insured under our Commercial plan have lost their jobs due to COVID-19, and we have been able to ensure continuity of care is maintained without causing a disruption for members as they transitioned to Medicaid. During these difficult times, members can't afford a disruption that will terminate their longstanding relationships with their providers. While unique to KP, a reduction in the number of health plans could potentially not only disrupt continuity of care, but also substantially impact provider access for Medicaid beneficiaries.

Kokua Kalihi Valley:

As part of a network of statewide FQHC CHC's, KKV strongly believes that Neighbor Island MedQuest patients need access to more than 2 health plans, and that AlohaCare should be one of these plans….(enter AlohaCare talking points here and reference CB opinion piece by Kimo Almeda) https://www.civilbeat.org/2020/05/we-need-more-medicaid-health-plans-not-less/

Hawai`i Primary Care Association:

Due to Hawaii's geographic isolation, relatively small population base, and the limited number of health insurers conducting business here, the complexity of ensuring consistent, high-quality services to both rural and urban communities is greatly increased. While in a perfect world, fewer health plans would likely better promote efficiencies of scale, fewer health plans in a captive marketplace could result in higher costs, disruptions in service with inadequate provider networks, more bureaucracy, and ultimately the provision of lower-quality health care to recipients. Competition in the marketplace will drive innovation, efficiencies, and enhanced benefits to recipients. An example of this has been the provision of limited dental benefits to adult recipients by AlohaCare and OHANA Health. These extra benefits were provided to members at no additional cost to Medicaid. However, when MQD considered eliminating both plans from the next round of contracts on the neighbor islands, recipients on the neighbor islands would have undoubtedly lost those benefits if the new contractor did not agree to continue those services at no cost to Medicaid. The State of Hawaii has long held that the provision of essential government services should be equal across all of the islands. This public policy was established because the majority of the tax base resides on a single island. Varying the number of QI health plans by region could potentially create disparate levels of service for the neighbor islands -- areas of the State that are already dealing with challenges in recruitment and retention of health care providers.

Ohana

Based on twelve years of experience as a local Hawai'i Medicaid health plan and national experience operating government sponsored health plans in all 50 states, we believe that a straightforward statewide program with no more than four plans is optimal. Four statewide plans will allow a greater number of lives to be assigned to each health plan, increasing each health plan's ability to impact population health. Additionally, balanced risk distribution amongst four statewide health plans helps ensure financial resources to develop targeted programming for members receiving LTSS. Increased competition drives better service delivery and outcomes, and limiting the number of statewide health plans to four ensures a viable claims pool for the health plans and reduced administrative burden for providers and DHS.

Acumen Fiscal Agent:

In our experience it is important to have more than one health plan. Choice is extraordinarily important to the people we serve and competition generally leads to better providers, better services, and better quality of life for the people being supported, as well as the agencies providing service. That being said it is difficult for vendors to operate in environments with oversaturated provider networks and not enough client demand to reach economies of scale. Hawaii specifically faces very unique and dynamic logistical and geographic challenges. We have seen models that provide choice in health plans, but also impose caps on how many plans are active at one time base on population, demographics, and location. This might be something to consider for Hawaii.

Community First:

Given Hawaii's size, we believe two plans would be optimal. Two reduces complexity and administrative costs but preserves competition. On Oahu the size of the market may justify having more. On the neighbor islands, only two.

Healthcare Association of Hawaii:

A key standard that should be met is that the MCO is either based in Hawaii or makes a commitment to maintain a robust local presence to ensure that issues can be resolved expediently, efficiently, and with a strong understanding of the landscape of Hawaii providers. Contracts should be awarded to entities that have the best interest of beneficiaries in mind and we believe that having a locally based MCO is a key standard in that goal.

In general, the fewer the number of plans the better, especially given the fact there are only 360,000 QI members in the state. It is important to remember that physicians and provider organizations must do business with dozens of plans because they care not only for Medicaid patients, but also seniors on Medicare, and individuals or families with commercial insurance. Each of these plans have their own set of rules, forms, policies, procedures, and payment models. Complying with these many requirements creates administrative burden for providers and adds to the cost of healthcare.

Another standard that should be met is the payment of clean claims in a timely and accurate fashion with quarterly reports to MQD that include key plan metrics. Providers do not have a health plan's financial resources and long, unreasonable delays in payment can be very difficult to manage for small and large providers alike. Timely and accurate payment for services is critical to the sustainability of the health system in Hawaii, and some plans have performed consistently better than others. However, if and when there are issues, there should be commensurate sanctions and enforcement mechanisms to ensure compliance. Plans should also be able to explain any deficiencies in their performance throughout the contract period.

We appreciate some of the scoring criteria used in the previous RFP methodology and encourage MQD to include and build on them. Some of the scoring criteria we feel are useful are:

- Ensure payments do not destabilize the provider network by significantly impacting provider cash flow;
- Ensure prompt payment to providers who serve a large proportion of Medicaid enrollees, including dual eligible and Medicare enrollees;
- Include mechanisms used to assure and evaluate the MCO's performance related to timely and accurate payments;

- Provide a description of how the MCO ensures timely and accurate payments for cost sharing;
- Describe how well a plan meets provider service standards, including call center performance and payment timeliness; and
- Disclose information on current or past lawsuits to which the company is party.

CMCH:

Currently there are 5 total QI health plan (HMSA, KAISER, OHANA, UHC and AlohaCare). We think 4 QI health plans is an optimal number of plans to operate in Hawaii statewide. Excluding Kaiser for QI plan because it is difficult to deal with an HMO plan especially if getting a service outside their network. Most of the time the providers eat up the cost of providing the service to Kaiser client. Exception targeted case management since this service is carve out and we bill DHS directly. Given four QI plans to choose from for patients is good. The four health plans are been in business in Hawaii and most of the members already knows the plan and a lot of times they don't want to change plan. Access for members services will be easier since we already know the benefits that QI plans provide, and we do not need to request an authorization for basic medical/office visit services or behavioral health services. This is one of the best things that the QI plans have done to the behavioral health providers to not require authorization. Made it easier to provide the service as soon as the patient needs it.

Should the number of QI health plans vary on a regional versus statewide basis? NO, due to movement of people it would make it more cumbersome. Statewide is best for the patients in case they move to different islands, they will still get the same service they are getting from each island. There should be no break in service and the members should be able to keep their same QI plan rather than selecting a different one since they are already used to the plan they have for years.

AlohaCare:

AlohaCare recommends that Med-QUEST (MQD) limit bidders to health plans with Hawai‘i Medicaid experience and maintain the current number of QUEST Integration (QI) health plans to support continuity in the QI program. Following the COVID-19 pandemic that began in early March 2020, MQD enrolled over 38,000 additional beneficiaries, an increase of over 11 percent in less than four months. We believe the current number of plans will best support anticipated increases in QI enrollment as unemployment continues to grow.

A statewide award promotes beneficiary choice and allows QI health plans to operate a sustainable, viable QI program which is essential to achieve MQD's Hawai‘i ‘Ohana Nui Project Expansion (HOPE) initiative vision and goals of healthy families and healthy communities. Statewide participation by all QI health plans will allow the QI program to scale as needed to support achievement of HOPE goals and initiatives, offering the following advantages:

☐ Foster greater collaboration among all QI health plans statewide and MQD to successfully implement statewide population health initiatives that factor in the unique, regional needs of our communities.

- Greater opportunity to effectively scale programs, partnerships, and initiatives across the entire state.
- Increase access and continuity of care with seamless beneficiary choice and access to care within the state regardless of where the beneficiary resides.
- Reduces beneficiary and provider confusion giving all beneficiaries access to similar health plan community investments, provider partnerships and innovations, regardless of the beneficiary’s home island.
- Reduces MQD administrative burden by offering MQD the opportunity to collaborate with experienced QI health plans and invest in communities through innovative, statewide partnerships in areas such as value-based purchasing, infrastructure, and workforce development.

Hawaii Health Information Exchange:

Having experience working with the five “MCOs” that are currently servicing the Med-QUEST beneficiaries in the past few years, HHIE recognizes that each has their strength and unique relation with Medicaid Providers and Med-QUEST members. Because of the impact of the COVID-19 pandemic, it is likely that Med-QUEST will have increased enrollment in the foreseeable future. HHIE recommends that Med-QUEST identify the needs of their target population and use this to determine the type and level of services that are required. Ideally this would be done geographically, segmented by island. Med-QUEST can then solicit input from the responding QI health plans to narrate their strength, the uniqueness that differentiate them from other respondents, whether it’s based on geography or subset of population, and then determine the optimal number of QI health plans based on the need of the Med-QUEST beneficiaries.

HMSA:

Due to the challenges presented by COVID-19, HMSA recommends that decisions regarding the number of health plans in Hawaii ensure access to all members and minimize member disruption to services. The Department of Human Services (DHS) should safeguard the sustainability of health plans that service QUEST Integration (QI) members by distributing the risk associated with this population across all health plans. Therefore, HMSA recommends that the number of health plans stays consistent with the current QI contract.

In a post-COVID-19 environment, when members health care needs are less volatile, we believe that a smaller number of health plans would support many of the goals that DHS is trying to achieve. These include supporting DHS in achieving the Hawaiʻi ʻOhana Nui Project Expansion (HOPE) initiative and standardization of operational areas across health plans. However, the benefits of standardization need to be balanced against member choice. For these reasons, we believe that the optimal number of statewide health plans is three. Three statewide health plans will allow for collaboration surrounding the HOPE initiative and easier standardization while still providing QI members with options of choice in the marketplace.

Ohana Pacific Management Company:

From a provider perspective, one of the challenges to numerous QI health plans is the lack of consistent interpretation and implementation of administrative requirements. Often times, providers must establish separate processes and work/lows for each QI health plan. Accordingly, either there needs to be a reduction in the number of QI health plans or there must be consistent standards used by all the QI health plans for processing claims and administering benefits (i.e., authorizations).
From a beneficiary perspective, it is important to ensure choice is incorporated into the design of the QI system. Therefore, it would be prudent to include at least two QI health plans for beneficiaries to select.
Ideally, the creation of a unified program that focuses on continuity of care that is administered consistently throughout Hawai'i. This would necessitate that the QI plans service the entire state, versus segregating between Oahu and the outer islands. However, it is understood that QI health plans should be accountable for building out minimum network access standards as are common with Managed Medicaid programs and ensure adequacy standards are maintained to ensure access to quality care.

Pacific Medical Administrative Group:

From the providers' and patients' point of view, the number of optimal QI health plans is unimportant, AS LONG AS the existing plans 1) cover all existing Medicaid members, 2) provide excellent support for patients and providers, 3) ensure excellent care from providers for patients, and 4) are financially efficient and responsible.
During this SARS CoV-2 pandemic and Covid-19 disaster, existing QI health plan stability and function should be emphasized. Expansion of the QI program will depend on the number of new Medicaid enrollees, but a reasonable expectation is that working with existing plans to accommodate expansion is easier, faster, and more patient friendly, than transitioning new QI health plans.
PMAG is not aware of the details of the State's challenges in administering the QI health plans but would not hesitate to collaborate with the State in providing boots-on-the-ground perspective from providers and patients. Competition is still essential to ensure continuous improvement and excellence, which points to at least three to five QI health plans. The estimated number of plans is less important than the reality of how many plans are necessary. Regarding regional or statewide variation in number of plans, this would again depend on the capability of plans in those regions, not in the number of plans.
While stability for now is recommended, the changing conditions of the pandemic will dictate changes in QI health plan strategies. The pervasiveness and overwhelming impact of the current crisis in Hawaii and the projected recovery time indicate at least a two year need for a conservative approach to plan change.

Waikiki Health Center:

QI health plans should not vary by region and we should keep the current plans we have. If an individual moves to a different region and unable to find a PCP due to insurance plan/region restrictions, this will inconvenience the patient. This delay in getting the patient connected to care can cause increased costs.

Waianae Coast Comprehensive Health Center:

Resource Allocation Standards - Please consider establishing guidelines for health plans that specify what percentage of their Medical "loss", or resource allocation, should be budgeted for primary care, prevention, and wellness services. Regular reporting by health plans should detail expenditures by defined categories. Please consider benchmarks for hospital expenditures as a percentage of total costs.

Queens's:

Comments from President of Molokai General Hospital:

Currently, MQD has five major plans; AlohaCare, HMSA, Kaiser, Ohana, and United Healthcare. These Health Plans also offer Medicare managed care plans. From the perspective of a provider, even if the number of QI health plans were reduced, it would make very little difference from the standpoint of credentialing, authorization, and billing, because Providers will still need to work with these plans for other lines of businesses.

Hawaii Pacific Health:

The optimal number of state plans would be no more than three (3) plans that have a minimum nexus with the State of Hawaiʻi demonstrated through a minimum number of resources committed locally would be ideal. Preferably no for-profit insurers.

As a statewide provider, we strongly recommend statewide versus a regional basis. Greater consistency and administrative efficiencies would be achieved with through a statewide contract structure.

Question 2 – MQD supports increased standardization and reduced administrative burden in key areas such as quality assurance, quality improvement, billing, credentialing, prior authorization processes and tools, and other areas. What recommendations should MQD consider adopting that would increase standardization, reduce administrative burden, and maintain program integrity?

Lana`i Community Health Center:

Ideas include:

- Establish a centralized credentialing process that all managed care organizations (MCOs)use with prioritized and expedited credentialing or providers who will work in underserved communities (HPSA, MUA, MUP designated areas);
- Facilitate centralized or streamlined prior authorizations including reduced and efficient processing with the MCO and reconsideration of what requires prior authorization particularly forhigh-cost, high need patients;
- Establish a single (MQD level) formulary adopted by all MCOs;

- Implement timely processing of claims & streamlined mechanism to address discrepancies;
- Clearly express service coordination roles to providers so that the responsibilities of service coordinators and CHC care coordinators & care managers are delineated. (This is further detailed in the next section.).

UHC:

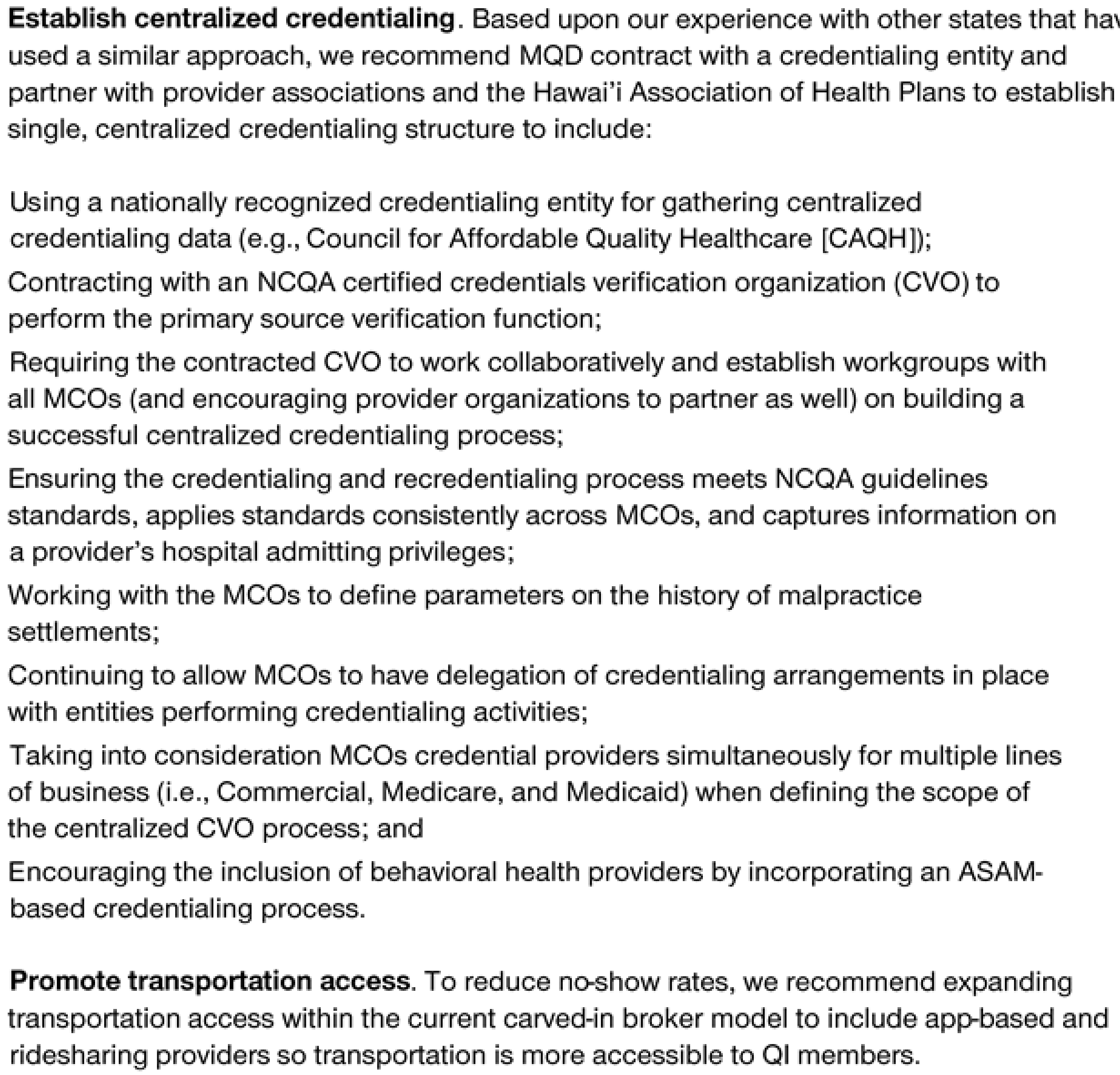
UnitedHealthcare supports MQD's interest in reducing the burden and complexity of the program for QI members and providers. There are opportunities for MQD, members, MCOs and providers to work together to find common solutions in areas affecting member experience, quality, program integrity, and administrative simplification such as:

Align quality and performance measures. MQD can ensure MCOs and providers are aligned with shared priorities by identifying the most critical quality and performance metrics - including member experience measures. We recommend MQD convene members, providers, MCOs, BHOs, and community-based organizations (CBOs) to identify and align priority measures to support system change. While MQD holds the MCOs accountable for the same measures, there are variations in which measures providers can or are willing to focus on. In addition, this is an opportunity to incorporate aligned measures on activities to address social determinants of health (SDOH) such as housing, transportation and nutrition.

Improve data sharing. With appropriate privacy and security safeguards, increased bidirectional data access between MCOs and providers will reduce time consuming and error prone manual work such as in the collection of quality data for HEDIS. This could be accomplished through collaborative workgroups and should include, at a minimum, MQD, Healthcare Association of Hawai'i, HHIE, and the MCOs.

Reduce prior authorization discrepancies. UnitedHealthcare acknowledges variances may exist between MCOs as part of their operating strategies related to the determination of services requiring prior authorization. As demonstrated during the current public health emergency, MCOs could further collaborate on standardized authorization requirements, forms, process and requirements including minimally necessary information to be submitted by providers. By removing discrepancies in the prior authorization process, MQD and the MCOs will be able to more clearly communicate clinical best practices and reduce administrative challenges while protecting the program against waste, fraud, and abuse. This will further support high quality outcomes by allowing providers to prioritize member care versus focusing on administrative challenges.

Clarify claim denial reasons. UnitedHealthcare has long supported the use of nationally recognized standards and recommend all MCOs use reason codes approved by the American National Standards Institute (ANSI) Insurance Subcommittee to communicate consistent explanations on denials of service. This will clarify claim denials, allowing providers to avoid administrative effort in understanding a denial and determining what steps are necessary for resubmission.



Establish centralized credentialing. Based upon our experience with other states that have used a similar approach, we recommend MQD contract with a credentialing entity and partner with provider associations and the Hawai'i Association of Health Plans to establish a single, centralized credentialing structure to include:

Using a nationally recognized credentialing entity for gathering centralized credentialing data (e.g., Council for Affordable Quality Healthcare [CAQH]);

Contracting with an NCQA certified credentials verification organization (CVO) to perform the primary source verification function;

Requiring the contracted CVO to work collaboratively and establish workgroups with all MCOs (and encouraging provider organizations to partner as well) on building a successful centralized credentialing process;

Ensuring the credentialing and recredentialing process meets NCQA guidelines standards, applies standards consistently across MCOs, and captures information on a provider's hospital admitting privileges;

Working with the MCOs to define parameters on the history of malpractice settlements;

Continuing to allow MCOs to have delegation of credentialing arrangements in place with entities performing credentialing activities;

Taking into consideration MCOs credential providers simultaneously for multiple lines of business (i.e., Commercial, Medicare, and Medicaid) when defining the scope of the centralized CVO process; and

Encouraging the inclusion of behavioral health providers by incorporating an ASAM-based credentialing process.

Promote transportation access. To reduce no-show rates, we recommend expanding transportation access within the current carved-in broker model to include app-based and ridesharing providers so transportation is more accessible to QI members.

Kaiser Permanente:

KP shares MQD's desire to reduce administrative burdens. This is more important now, during this global pandemic, when providers, health plans and the State are forced to do more with fewer resources. Rather than changing or reducing the number of health plans serving QI members, disrupting the health care delivery system for our most vulnerable members, standardizing processes would minimize the impact of interacting with multiple plans and creates an ideal scenario for MQD, providers and their Medicaid patients.

We recommend MQD continue to convene workgroups comprised of MQD and QI health plan staff to collaborate on recommendations for automating and streamlining new and existing processes to reduce unnecessary work and build a cohesive process to ensure program integrity.

We recommend outreaching to partners and counterparts in other states or Medicaid partners in other regions to identify work already underway that may be used to comply with federally mandated requirements to improve timely responses to meet federal and state requirements. Improving communication will help reduce both administrative burden and redundant work. Specific areas for consideration include:

- Update report templates to allow files to be uploaded into a database instead of embedding documents. This change would increase efficiency for both the state and health plans by reducing manual work. This allows access to view data quickly and see trends in data over a period of time for each health plan and across health plans.
- Increase collaboration with health plan workgroups before memos and contract changes are released to improve consistency and decrease health plan questions.
- Review mandated reports and ensure there is no redundancy and validate that the data is being analyzed or utilized for a practical purpose.
- Continue to use databases (i.e. CMS, other federal and state agencies) to minimize multiple entries and maintenance for provider data. This reduces data entry errors, improves review processes, and increases the verification of provider credentials and billing information (i.e. HOKU).

Kokua Kalihi Valley:

In the experience of KKV, some of the 5 MCO health plans increase the administrative burden on our staff and providers more than others. Of the 4 covering KKV patients, HMSA and AlohaCare present the fewest barriers to timely care and most support to our organization. Ohana and UHC present the most administrative barriers to timely care and the least support.

One example is in the area of perinatal care. KKV Perinatal Case Managers (trained as specialized Medical Assistants or nurses in country of origin) spend approximately half of their FTE on administrative duties assisting, arranging, coordinating and documenting services for patients, including health insurance issues, specialists and referrals, and health plan requirements. PCM’s report more steps and administrative barrier to accessing pre-term prevention medication prescribed by provider for patients on Ohana and UHC. They report the same experience with breast pump authorizations. In both cases a week, or even a few days, of delay can have negative consequences for mothers to be and new mothers, respectively.

It is recommended that MQD actively survey and solicit input from plan providers re: their experiences with disparities in administrative burdens posed and support services provided by the 5 health plans in a manner than assures their confidentiality. These responses should be weighted in alongside the cost of the bids, to assure the state is not saving money in a manner that will cost the system in the mid-term.

Hawai`i Primary Care Association

HPCA recommends that MQD consider the following to increase standardization and the reduction of administrative burdens:

- Establish a centralized credentialing process that all managed care organizations (MCOs) use with prioritized and expedited credentialing or providers who will work in underserved communities (HPSA, MUA, MUP designated areas);
- Facilitate centralized or streamlined prior authorizations including reduced and efficient processing with the MCO and reconsideration

of what requires prior authorization particularly for high-cost, highneed patients;

- Establish a single (MQD level) formulary adopted by all MCOs;
- Promote data transparency and timeliness & efficiency of data exchange (See HPCA Data Transparency Attachment);
- Implement timely processing of claims & streamlined mechanism to address discrepancies;
- Urge MCO support of information technology infrastructure for QI and population management, HEDIS and grant reporting, bidirectional sharing of data; and
- Clearly express service coordination roles to providers so that the responsibilities of service coordinators and CHC care coordinators & care managers are delineated. (This is further detailed in the next section.).

Difficulties in navigating insurance is time consuming which exacerbate problems experienced by high-needs, high-cost patients. We request that MQD invest the time necessary to work with contracted MCOs to develop common processes and shared infrastructures to reduce fragmentation in the system and redundancies across MCOs. (See HPCA High Needs High Cost Attachment.) This will be in alignment with CMS' Patients over Paperwork Initiative to reduce provider and clinician burden and improve patient outcomes and allow for a focus on patient care.

Ohana

'Ohana supports MQD's pursuit of increased standardization of quality assurance, credentialing, and other key functions to reduce administrative burden placed on providers resulting from health plans' varying processes. Our recommendations for simplification include:

- Require plans to collaborate and conduct concurrent audits of community care management agencies (CCMAs) using the same audit tools to ease the burden of multiple health plans separately auditing.
- Consider developing an NCQA-certified credentialing process using a centralized provider credentialing organization.
- Continue convening the Prior Authorization Simplification Initiative to develop a solution to simplify the prior authorization process without impeding health plans' program integrity efforts to monitor appropriate use of services.
- Require health plans to collaborate and agree on standard quality measures tor relieve providers from trying to meet various performance measures across different plans.
- To decrease the burden of providers sending charts to health plans to document quality measures, support development of a common member consent among all healthcare providers in the community so that hospitals, PCPs and behavioral health providers can effectively share physical and behavioral data through a common, legally compliant and secure exchange platform.

Collective Medical:

One way to reduce administrative burden in a managed care system is to ensure that patient data is not siloed by program. Payers and providers need the tools to access critical data at the right point in time (in compliance with federal and state privacy laws) to gain a holistic view of the patient, assess their needs and risks, understand who is on the patient's care team, and reduce duplication of services. Collective Medical recommends implementing healthcare interoperability technology solutions to achieve these objectives, and to reduce administrative burden as well as unnecessary costs.

For example, the community-based palliative care team Housecall Providers in Portland, Oregon, works with Medicaid and Medicare recipients, and relies on the Collective Platform's real-time alerts, customized to their needs, to reduce administrative burden. Housecall, a CareOregon provider, provides advanced care for patients at home. Their Medicare Independence at Home (IAH) program ensures quality care in the home by establishing six standards for home healthcare, including patient follow-up after hospital discharge, medication collaboration, and managing patient preferences for care.

Historically, case managers at Housecall Providers would spend hours a day trying to meet these benchmarks by calling around to different hospitals and facilities, looking for their patients. Using the Collective Platform, Housecall Providers was able to not only meet these standards but have more time to help more patients. Within the first year, Housecall Providers met all six key metrics, saving Medicare $1.8 million in care costs. Housecall Providers received 80 percent of those savings, totaling $1.2 million. Their practice has continually met these metrics, leading to $500K-$1.2 million in reimbursements each year.

Collective urges MQD to include a requirement or incentive for plans to implement an interoperable care coordination solution that enables data sharing among hospitals, ambulatory providers, and other post-acute care settings across the spectrum of services for the purpose of improved standardization and a more seamless experience for patients. The broad, deep data flowing from these providers and plans should be delivered promptly and cleanly to bring attention to true needs without bogging down workflow. Collective would welcome the opportunity to talk further with MQD about additional technology-driven strategies to reduce administrative burden that could be applied to the QI program.

Additionally, to the extent that MQD can generally align CCS and QI contract requirements, we expect that this would streamline administrative and compliance processes. This includes ensuring that providers of basic behavioral health services that are participating in both CCS and QI have the same or similar contractual requirements.

Acumen Fiscal Agent:

For individuals choosing self-direction, we recommend leveraging qualified and experienced financial management services / fiscal intermediary companies to partner with MCOs to ensure effective, efficient and compliant processes. Specifically, FMS providers can standardize the handling of authorizations and program rules, timely payroll for independent providers, effective billing and credentialing of independent providers and proper handling of taxes and required deductions, garnishments, etc.

Self-direction is a complex LTSS offering that requires experience, knowledge, processes and effective technology solutions. We know that a well-designed MLTSS MCO / FMS solution can result in a better experience for individuals and independent providers, efficiency and quality gains for MCOs and States, improved program integrity and a reduction in administrative burden.

Qualified and experienced FMS providers offer the opportunity for Managed Care Organizations to focus on what they do best, while leveraging a partner to effectively manage a highly specialized function that includes in depth knowledge and experience with:

- Labor Laws

- Federal, State and Local Tax Laws
- Compliance with the Electronic Visit Verification mandate
- Unique program rules
- Unique billing requirements

Acumen's MCO service offering also offers MCO's effective solutions to further decrease risk and costs, by providing real time insights into various participant risk factors (see responses to #7 for more information).

Community First:

All key areas mentioned, quality improvement, billing, credentialing, and prior authorizations, should be standardized. Health plans should compete on their administrative efficiencies, customer service, and provider service.

Whatever the number, MQD should build a common data platform with community portals and analytic capability that would enable a community to answer such questions as, "Which medical homes have the lowest rate of avoidable ED visits and inpatient admissions?" MQD and its health plans should enable the community to be accountable for the quality and cost of healthcare in their community by providing access to clear, actionable data.

MQD in partnership with the health plans also need to develop standard community systems and processes such as for referrals across providers and agencies or for transportation requests. These systems and process cannot be healthplan-centric with the expectation that community providers and agencies accommodate the variations. The community is the customer, and health plans have more organizational capacity than the providers in the community, in particular rural communities.

Healthcare Association of Hawaii:

We also suggest that MQD consider requiring standardization of processes that are often difficult for providers to manage and create barriers to patient care. This includes items like prior authorization, improper payment, and claim reconsideration procedures. It is especially critical during the COVID-19 pandemic that processes be uniform to minimize any disruption in the delivery of medical care. This same need for standardization applies to quality program metrics. Efforts to reduce reporting burden on providers will not only decrease time spent on administrative tasks, but can encourage better coordination among MQD, QI plans, and providers where quality efforts should be most focused.

While we understand the need for some flexibility, we feel that stronger standardized language from DHS on issues that create roadblocks would benefit providers large and small while further increasing beneficiaries' access to medical care.

CMCH:

Having one health plan which includes medical and behavioral health combined would help achieve these goals rather than having the behavioral health portion of the service provide by another health plan. Also, not allowing the health plan to off load their QM/QA on to the service providers would help with the administrative burden, this refers to Ohana CCS Celltrax. Combine the QI plans and CCS as one not two separate entities. The amount of prep is very laborious, and it is confusing when different entities have quality concerns to the service staff.

QI and CCS should not be allowed to influence service provider policies. Billing two separate entities/health plan is another burden for the providers. There are different rules in billing not just one rule. One plan requires us to have authorization and the other plan does not. You can still maintain the program integrity by combining the medical and behavioral health services into one plan rather than separately. It will be much easier to manage the health plan requirements rather than dealing with two different contractual requirements. It is a lot of work for everyone. As a user, I feel the program – mainly the case managers are bearing much of the administrative burden regarding data collection. As a pilot our program was copying the 18-page CCS recovery plan to our EMR and had to abort because it was taking too much space in the EMR. Credentialing on two different entities/health plan is also a burden. If medical and behavioral health is combined with one health plan then providers don't have to credential two times. Too much paper work and very tedious and time consuming process.

AlohaCare:

The COVID-19 pandemic has created challenges, especially for providers and community organizations who were struggling prior to the spread of the virus. AlohaCare recommends that MQD continue its current efforts to facilitate QI health plan collaboration in support of standardization and reduced administrative burden.

AlohaCare offers the following specific recommendations in support of standardization, reduced administrative burden and program integrity:

☐ Centralize provider credentialing by establishing a QI health plan collaborative responsible for creating a single source of provider information. Examples of this recommendation implemented nationally include:

o Tennessee and New Mexico partnered with CAQH (Council for Affordable Quality HealthCare) to centralize provider information. Providers and MCOs (Managed Care Organizations) are required to participate (Jan 2020).

o North Carolina's provider data contractor is responsible for obtaining primary source-verified credentialing data.

o Illinois's IMPACT program centralizes Medicaid provider credentialing into a single uniform NCQA acknowledged model. The state and MCOs collaborated to create a uniform provider roster (2018).

o California and other states are developing statewide databases for provider directory management. CAQH maintains provider directory data.

☐ Standardize authorization forms, guidelines, and processes among QI health plans. For instance,

o Develop Long-Term Services and Supports (LTSS) and behavioral health (BH) policy manuals to establish clear expectations for QI health plans.

o Standardize a prior authorization (PA) tool for medical services.

o Develop and implement a standardized social determinants of health (SDOH) assessment tool across all QI health plans to provide consistent information across QI health plans regarding beneficiary and family needs.

☐ Develop common metrics and integrated goals to align value-based payment arrangements and quality improvement initiatives statewide. We suggest MQD and QI health plans apply consistent and aligned approaches for targeted clinical domains, measures and VBP definitions while allowing for regional variations, starting with current QI health plan collaborations with community partners.

☐ Centralize transition of care data collection and distribution between QI health plans to support timely, collaborative, and secure beneficiary healthcare information sharing for

seamless continuity of care. For example, a system like Hawai‘i Level of Care Evaluation (HILOC) could facilitate efficient year-round information sharing rather than only during annual QI health plan change periods.
 MQD and QI health plans jointly develop and promote a Medicaid Managed Care provider learning forum to be administered by the University of Hawai‘i School of Medicine to provide continuing education credits to providers.

Berry Dunn:

Operational Readiness Reviews

Comprehensive operational readiness reviews of MCOs are a critical component of implementation activities prior to program go-live. BerryDunn has completed operational readiness reviews supporting the specialized MCO serving the foster care, adoption assistance, and select waiver populations, as well as a state’s Children’s Health Insurance Program (CHIP) managed care program. Our team leverages the principles and best practices put forth by the Centers for Medicare & Medicaid Services (CMS) and develops standardized auditing tools that align and reflect key contractual and federal requirements to assess health plan readiness for program launch. We perform these activities in collaboration with key stakeholders from the SMA to help ensure that programmatic goals are assessed in addition to standard managed care regulatory requirements. BerryDunn utilizes a robust evidence review process upon receipt of the MCOs’ policies and procedures and other supporting documentation, and assesses the health plan’s compliance with each respective standard and requirement to understand their operational and administrative processes prior to the launch of the program. Findings and determinations are reviewed and discussed with state leadership, which might or might not inform decisions for membership assignment and other key provisions for go-live. We also review Corrective Action Plans (CAPs) in collaboration with state leadership to assess the viability and timeliness of remediation plans should an MCO does not meet certain requirements.

Contract Oversight and Compliance Monitoring

A thoroughly developed and vetted MCO contract is a critical component to the success of any managed care implementation. The first step is to understand the goals and objectives of MQD to develop requirements and service-level agreement (SLA) expectations, in alignment with CMS guidance and federal and state regulatory requirements. We believe that well written SLAs in the contract help ensure that MQD has the mechanisms in place for appropriate contract oversight and is protected from poor service, while also helping to ensure excellent service delivery to Medicaid and CHIP beneficiaries. Our services can include providing technical support and analysis of contract language; proposing revisions to the contract language to help ensure the contract addresses identified goals and considers uncertainties identified through the solicitation process; and assisting with negotiating the contract with the MCO. These services can also include assisting with compiling the documentation package for MQD to submit to CMS for approval of the selected vendor proposals. We have helped government clients negotiate hundreds of complex vendor contracts over a 25-year period, and we have collaborated with SMAs and CMS on the development and refinement of managed care contract vehicles.

Provider and Member Outreach Services

An important part of a successful MCO program for a SMA is provider and member outreach. Provider outreach involves communication to both previously enrolled and prospective providers, soliciting their feedback and input regarding upcoming programmatic changes, and helping to ensure that feedback from stakeholder engagement activities is considered for incorporation into programmatic activities. Outreach to the provider community can include emails, facsimiles, website postings, paper mailings, telephone calls, public services announcements, articles, newsletters, blogs, and roadshows (virtual or in-person). BerryDunn has performed provider outreach services for state clients as part of their provider management. These outreach services help to not only enroll/disenroll providers but also handle such activities as grievances and appeals. Member outreach activities are similar in their purpose; however, modalities for communication might differ due to population distribution and access to information. BerryDunn has assisted clients with development of collateral for Medicaid and CHIP beneficiaries, as well as planning for the distribution of these materials via website updates, postcard and pamphlet mailings, newsletters, and roadshows.

Hawaii Health Information Exchange:

The COVID-19 pandemic has pointed out that Hawaii needs additional resources to keep our residents safe. Standardizing nomenclature and data set has always been the goal of HHIE. Based on what we have learned working with health plans, health systems and providers, achieving reduced administrative burden through standardization will require clearly articulated policies, through discussions and planning administered by a neutral convener. Hawaiʻi HIE recommends that the following criteria be placed in the RFP for QI HEALTH PLANs:
- QI HEALTH PLAN shall encourage hospitals, clinics and providers to share data supporting clinical quality and outcome improvement based on data exchange standards accepted by CMS, meeting the consensus among data users in the community. Standards include HL7 and IHE Profile.
- QI HEALTH PLANs shall encourage hospitals, clinics and providers to share data that are complete, and adhere to standardized data sets to support measurement of clinical quality and outcome improvement.
- QI HEALTH PLANs and their contracted network participants shall exchange data through Hawaiʻi Health Information Exchange, the State-designated entity to facilitate health information exchange in Hawaiʻi. Data exchange shall be permissible by all parties to the full extent of the law (HIPAA treatment, payment and healthcare operations; CURES Act regulations and CARES Act requirements) and shall be compliant with HHIE data quality and interface standards.

HMSA:

HMSA supports increased standardization of QI processes in key areas, as standardization would reduce the administrative burden for all stakeholders while maintaining program integrity.

One large opportunity to reduce administrative burden would be to implement a centralized statewide credentialing function, managed by DHS (or an DHS-approved delegate) for QI providers. This would greatly reduce the overall work for providers as well as health plans. Newly practicing providers would benefit most from this change in process.

In this centralized credentialing model, providers would begin the credentialing effort with DHS via the 1139 enrollment process. Once approved, DHS would share the information (using HOKU or the Provider Master Registry) with each participating health plan to update their systems. With centralized credentialing, consistency and timeliness will improve, which benefits all parties including QI members and providers.

Health plans, state agencies, and communities would also benefit from standardizing mechanisms for communicating, tracking, and reporting their activities. If DHS developed IT systems, defined processes, and provided communication materials and then shared those with the health plans, it would greatly streamline the efforts to support the QI population. Instead of building their own, each health plan would simply adopt DHS's systems, processes, and deliverables, ensuring consistency across health plans.

Currently, each health plan must develop their own member handbook based on information that is predominantly consistent with member information requirements of the QI contract as well as state and federal laws. Standardization would increase the accuracy of handbook information and simplify the review and approval process.

Similarly, DHS, in collaboration with health plans, could develop standardized provider communications and materials.

Ohana Pacific Management Company:

Credentialing for providers and facilities should be done once for those participating in the state funded programs, not once per QI health plan. This would reduce duplicative documentation and reviews, which create waste within the process.

Quality programs should be developed as a minimum standard for QI health plans to utilize and set a floor for basics quality requirements. QI health plans may contract with providers to exceed the thresholds however, the state should require a basic set of consistent minimum standards.

Prior authorization processes and responses should be standardized to ensure timely and consistent delivery of care. In addition, QI health plans should be required to set prior authorization requirements upon award and prohibit changes during the contract period, unless regulatory changes require modification.

Additionally, provider manuals and policies for QI health plans should not mandate or require providers to comply with more stringent requirements than are outlined in the contract with the state Medicaid program.

Pacific Medical Administrative Group

Intent is minimally impactful without implementation. Providers have heard many concerns that recognize excessive administrative burden. In the last PMAG PCP and Specialists survey of over 100 respondents, administrative burden ranks in the top five most important causes for physician burnout. All need action that is effective, efficient, and initiated as soon as possible given the current crisis.

It is essential that those who are impacted by inefficient and less effective forms and processes be allowed to guide appropriate changes. Skilled facilitation by clinicians who understand the issues on all sides will be necessary to maintain a concerted effort until these solutions are reached.

Issues to tackle are well-known by providers in healthcare:

1. Prior Authorization Forms should be standardized for all plans
a. Individual plan variations should be discouraged and negotiated for all
b. Timely responses should be enforced
c. Barriers to simple PA for appropriate urgent care should be eliminated
2. MQD should maintain an easy to access, navigate, and search on-line formulary for all plans. The formulary grid should include side by side comparisons between plans, alternatives for brand medications, and cost information. The plans should update the site as often as they implement changes, but not less than monthly.
3. Simple, clinically relevant, and data available Quality Improvement measures should be determined in collaboration with providers for plans. These measures would be calculated on a quarterly or semi-annual (e.g. March and September) basis and posted for plans and providers to review.

4. Credentialing should be revised to allow for disaster coverage of the anticipated large number of members moving from commercial to Quest plans.
5. EPSDT and other required forms should restrict the number of redundant, administrative, and research elements.
6. Using clinical strategies to facilitate state-wide collaboration of all stakeholders and mandated agreement for administrative reduction measures will help to ensure relief in this critical area.

Waikiki Health Center:

Quality improvement programs should be the standardized for each payer. The quality measures and submission process (ie. coding vs faxing) should be the same.

a. Could QI health plans also obtain some of their quality data via Hawaii Health Information Exchange? This would help with closing gaps/decrease outreach to FQHCs. (reduce administrative burden)

Waianae Coast Comprehensive Health Center:

Data - It has been the Health Center's experience that the ability to manage costs, and produce other favorable outcomes, is dependent on the capability, and willingness, of health plans to share accurate data. The Health Center has worked with AHARO Hawaii, a Hawaii nonprofit corporation consortium of five Hawaii federally qualified health centers, to establish standardized data agreements we hope to use as the framework for data sharing with the health plans. These standards are available on request and if followed would allow accountable care driven health centers to implement the objectives detailed in your RFI. Data sharing by health plans is currently incomplete and varies with each managed care organization.

Queens's:

Providers are currently required to submit enrollment applications for credentialing purposes to Department of Health MedQuest Division as well as each QI plan. Standardization could be achieved if the MQD would credential each provider then forward enrollment status and credentialing information to each of the plans instead of providers having to submit a separate applications to each QI Health Plan. Adopting a single application process (universal application) for credentialing for all MQD plans would increase standardization, reduce administrative burden, and maintain program integrity.

Reimbursements from the health plans to the providers for the same services varies which is confusing. Adopting and implementing a standardized template for contracts as well as standardized reimbursements for services would help to maintain the program's integrity.

Hawaii Pacific Health:

Establish minimum standards around (1) Local infrastructure & Decision Making Authority (2) Timely payment/claims performance; (3) Administrative Simplification; and (4) Enrollee support; (5) Service Transparency as follows:

Evidence of Local Infrastructure & Decision Making Authority

- Establish minimum standards indicating evidence of local infrastructure to process claims and track attribution of members.
- Establish minimum standards indicating evidence of local decision making authority to resolve issues.

Clean Claims performance

- Require acceptance of clean claim definition as claims with no material defect based on data contained in the claim. Clean claims do not require additional information beyond clearly documented billing requirements.
- Require 99% of clean claims paid within 15 days for electronic claims and within 30 days for paper claims.
- Calculate paid percentage by both claim count and claim dollar amount.
- Require 100% billing requirements published online and 95% electronic claim submission, including attachments.
- Require complete documentation published online of all billing and claim edits, including regulatory or policy basis for those edits.

- Require complete documentation published online of bill auditing methodology and criteria for review, including reference to regulatory basis.
- Require presumption of coding accuracy on a clean claim.
- Limit additional documentation requests and pre-payment review to < 5% of IP claims, 2% of OP claims.
- Require all audits to be performed post-payment.
- Accept claims for all covered services inclusive of subcontracted services. Forwarding claims to subcontractors is the responsibility of plan.
- Require 100% of grievances to be resolved within 90 days, with 95% resolved in 60 days.
- Require payor to allow provider escalation to IRO provided for continued provider disagreement.
- Establish standards on provider services call center – average speed to answer <= 1 minutes.
- Require 0% denial rate for undocumented billing requirements.
- Require 100% of code set updates documented and implemented in claims system as of effective date of the update.

Administrative Simplification:

- Require managed care authorization requests provided within 3 business days of submission. Authorizations not required for emergency or urgent services. 95% processed via HIPAA standard 278 transaction.

- Establish Gold card/waiver program coverage for 95% of high volume referring providers.

- Require 100% of State of Hawaiʻi 1147s accepted as authorization for QI payer services with no additional approval requirements.

- Complete concurrent review within 48 hours of records submittal. Provide 24 hour response time for peer to peer review with the ability to schedule the review if requested by the provider. Allow escalation to IRO for disputes. Recognize provider criteria and policies.

Enrollee Support

- Require 100% service coordinator assignment for hospital waitlist patient. Waitlist days is the measure of effectiveness.

HHAeXchange:

QI Administration

Industry experience and best practices have shown that instilling an environment of choice and ownership of tools at each stakeholder level is critical to a successful ecosystem. While on paper it can make sense to require one tool or system for all stakeholders; unfortunately, this often leads to abrasion and pushback. Each entity will have business goals as well as existing systems and tools that if not taken into consideration will create more administrative burden to meet a standardization requirement. One such example of this is the MCO choice with Provider choice model for EVV. Given choice to both groups results in the greatest chance of success as it takes into consideration the unique business needs of each stakeholder group. It is a best practice and critical to the project success to work with and include the State's MCOs as often as possible in the project, while also directing the MCOs to procure their own system that meets each MCO's unique business needs. If MCOs simply rely on the State's chosen solution, payment integrity can be lost, leading to more fraud, waste, and abuse.

Another crucial element to the success of EVV is to have the State agency clearly define EVV related contractual requirements for the Med-QUEST MCOs at the contract onset.

Open Model EVV System with MCO and Provider Choice

When a state requires or takes on the added cost to allow the MCOs to only use the contracted Aggregator's System, the MCOs often become a gap in the process, as the data is generally coming from the providers straight to the aggregator, without any pre-bill claims scrubbing or verification of the visit data from the MCO. The State Aggregator has a contract that focuses on the State's needs vs. the MCOs business needs. Each MCO has different needs and challenges, such as improved efficiency or real time data in the home to achieve Value-Based Payment (VBP) arrangements. Some MCOs may simply need visit compliance, while other MCOs do not have a way to match authorizations and Plan of Care (POC) to visit scheduling. If the State mandates the EVV Aggregator to the MCOs, it may harm the MCOs' abilities to serve members and achieve their specific goals and business needs. While the initial benefit of rolling the MCO system costs into the State's FMAP reimbursement may be positive, the long-term impact may drive increased fraud, waste, and abuse, billing issues, and a lack of claim adjudication. In addition, any aggregator solution chosen by the state will inflate costs if they intend to supply MCOs with EVV under the contract with the State. This additional cost is not only unnecessary, but it is not in the best interest of the State or the MCOs.

Pennsylvania Success Story

Pennsylvania utilized the above processes and models with all three MCOs in the state independently evaluating and then selecting their vendor of choice. The MCOs ultimately chose to work with the same vendor, but the State allowed for the option to evaluate and determine the best solution for their company needs and goals. The chosen EVV vendor then led all of the implementation efforts across the State from start-to-finish including provider registration and onboarding, in-person info sessions, live and recorded webinars, and the development of a hosted Support center for the State's providers. The results from this best practice include:

Reduction in Fraud, Waste, and Abuse (FWA) with Advanced Reporting - The MCOs in PA have reduced FWA across their provider networks by leveraging the EVV vendors advanced reporting and business intelligence tools, giving them actionable data at a 30,000-foot view, as well as on an individual provider level. The MCOs were able to reduce their audit workload with preventative compliance tools, rather than correcting them after-the-fact.

Streamlined Provider-Payer Operations - Under the open model approach, the State's providers were able to choose between using the MCO's platform, their existing EVV solution, or a quick-visit entry tool for providers transitioning off paper. By offering multiple forms of EVV, as well as integrations to other EVV solutions, the MCOs were able to strengthen the relationship between them and their provider networks, while also aggregating the data and simplifying submission and reporting to the State. Any industry-leading EVV vendor should also serve as a real-time communication platform with a full audit trail of all payer-provider communications, eliminating the need for phone calls, faxes, and emails.

Improved Member Care - With reporting on the utilization of the authorization as well as missed and short visits, the MCOs are now able to identify non-compliant or poor-performing providers immediately. Armed with this data, the MCOs work with individual providers on compliance and reward those that are providing services according to the member's authorization. Additionally, using a case broadcasting tool, they now broadcast open member cases to their entire provider network and match providers based on specific member requirements.

By allowing MCOs to evaluate and select an EVV vendor, MCOs can address their unique challenges that are often different from the challenges faced by the State. As EVV and the Medicaid industries evolve, MCOs will look to utilize the data collected through EVV to benefit members and improve care. Adding additional features and functionalities can be a challenge with a State selected vendor as each MCO may want different variations. Some MCOs have needs to track meals on wheels, wheelchair ramps, among other things depending on what the plan covers. MCOs must have choice in order to be successful in EVV deployment.

This setup is the only way to achieve a least burdensome approach for providers while also allowing MCOs the ability to have oversight of their provider networks and run their system. MCOs own the claim payment process and the provider network. Making the MCOs responsible for their provider networks is critical to a successful EVV implementation.

Open EDI Integration

To achieve successful interfacing with multiple EVV service providers and technology vendors in an open model, an MCO's EVV solution must deploy a self-service EDI Portal platform. Individual providers access the portal to upload confirmed visits and test the interface until it is correct for processing. At the completion of testing, files start to continuously flow from the third-party vendor systems to the MCO's vendor. As the portal receives data records and determines there are deficiencies, the system returns these records for correction to the provider, with the visit then re-sent when corrected; this ensures that the platform and the providers platform stay synchronized, an important benefit to the provider.

NCQA:

QI Administration & Care and Service Coordination.
Recommendation: Include LTSS Distinction to Hawaii’s current accreditation requirement.
Draft Contract Language: “Contracted QI plans are required to obtain NCQA Health Plan Accreditation, including NCQA Distinction for LTSS, no later than # years/months from contract start date.”
Hawaii currently uses NCQA Health Plan Accreditation to help plans demonstrate their commitment to quality. The state can enhance this current requirement by adding NCQA Long-Term Services and Supports (LTSS) Distinction to their oversight of Medicaid health plans. NCQA LTSS Distinction standards align to federal Medicaid requirements for LTSS and are designed to support NCQA Accredited health plans and managed behavioral health organizations, that provide medical/behavioral health benefits and coordinate LTSS. The program includes 3 areas of evaluation: a review of core features, such as person-centered assessments and implementation; measuring and improving performance; and care transitions. A fourth standard is for plans that delegate LTSS functions if applicable.
NCQA LTSS Distinction:

- Standardizes the model of care for plans and MBHO’s managing and coordinating LTSS.
- Serves as an extension to NCQA Health Plan Accreditation.
- Aligns with the LTSS provisions within the 2016 Medicaid Managed Care rule.
- Demonstrates commitment to integrate care and improve outcomes for this special population.

Five states currently require or recognize NCQA LTSS Distinction: Kansas, Tennessee, Virginia, North Carolina, and Pennsylvania. Adding this distinction and additional set of LTSS standards to the current Health Plan Accreditation align with the HOPE strategic area of improving outcomes for high-need, high-cost individuals. NCQA LTSS Distinction provides a standardized framework for holding plans accountable for effectively managing care for this vulnerable population.

Molokai Ohana Health Care:

QI Administration:
1. Successful Medicaid health plans need to have boots on the ground throughout the state and take time to listen to beneficiaries and providers about their needs and concems in order to be a true partner that supports all aspects of community health. MCHC's patient population is 57% Medicaid, whereas only 18% have commercial coverage. Our Medicaid

beneficiaries have been better served when decisions by health plans are made locally, not at corporate headquarters on the Mainland; where decisions can be made quickly and are informed by first-hand knowledge of the community. Given this critical time Hawaii is facing with an escalating rise and need to respond to COVID-19, while new applicants for Medicaid have simultaneously risen since March 2020 with new QI beneficiaries projected to increase by the end of the year, Medicaid must ensure that it remain the health safety net. Finally, access to providers, particularty speclalty care providers; timeliness of payments to providers. and consumer choice of healthcare plans for all Medicaid beneficiaries statewide are paramount for neighbor island residents as It is for our Oahu counterparts. For these reasons, MCHC is in support of maintaining the same number of QI health plans to operate in Hawaii.

2. MCHC supports MQD's interest and efforts for increased standardization and reduced administrative burden in key areas such as quality assurance, quality improvement, billing, credentialing, prior authorizations processes and tools, and other areas. It has been MCHC's experience that the ability manage costs and produce positive outcomes Is dependent on the capability and willingness to share and promote accurate data transparency. MCHC's work with AHARO Hawaii! is a demonstration to standardizing evidence based best practices and data agreements that have driven accountable care at the Provider level and may be a viable resource and strategy that could be shared as a framework with the Health Plans.

Crystal Costa:

Situation: Quality Assurance and Quality Improvement Measurement
Background:
Measuring what matters in quality, cost, and value is very challenging and requires finding the best balance between affordability and ease of measurement (which often uses process data to check boxes) with meaningful, patient-centered measurements which can effectively drive continuous improvement and supports the integrity of high quality palliative care.
Assessment & Recommendation:
We recommend that MedQuest learn how plans will achieve this balance by asking these questions:

- How will Plans measure performance and outcomes in a way to drive continuous improvement?
- How will Plans avoid requiring time consuming measures which are not linked with key patient outcomes?
- How will Plans work to provide care such that members are very satisfied?
- How will Plans use standardized and meaningful patient satisfaction tools to drive improvement of patient satisfaction?
- How will Plans collect, analyze, and act on basic standardized patient satisfaction tools such as:
  - Were you able to access the care you needed in a timely way?
  - Were your major concerns addressed to your satisfaction?
  - Would you recommend the plan to your family or friends?

- Will the plan expect better than 90% satisfied or very satisfied rating? (on a scale including not satisfied, somewhat satisfied, satisfied, very satisfied)

Situation: Importance of Shared-Decision Making
Background:
The well recognized foundation of palliative care is Patient-Centered care which puts patients' needs and wishes at the center of care, and empowering patients to determine the kind of care they want while avoiding unwanted care. Shared decision-making is the cornerstone of patient-centered care and requires special knowledge and skill and should be an expectation of our healthcare providers. However, reaching community-wide ability to practice shared decision-making will be challenging and will require state leadership to be clear and decisive in the need for it. **Assessment & Recommendation:**
We recommend that the following questions be addressed in any measurement plan proposed by the Plans:

- How will the Plan support and ensure improvement of *communication skills* of their in-network providers?
- How will the Plans' own case managers, service coordinators, medical management staff who interface with QUEST members and providers be included in efforts to improve communication skills and shared decision making?

● How will the Plan enable team members and providers to meet members *"where they are at"?*○ How will the plan include assessment of an individual's level of health literacy, and choice for how information is shared?

○ How are the member's values, beliefs, and wishes elicited and integrated into their plan of care? How are these responded to in an appropriate manner which leads to increased patient/family understanding, empowerment, and involvement in decision making?

● Approach Plan will use to evaluate how a member and their care team handle information? (How will the plan assess level of health literacy, language, culture, etc. to enhance a member and their caregivers' ability to actively engage in shared decision making?)

● How will the Plan develop policies and procedures to ensure that care is coordinated? ○ How will plans support the banking of, access to, and sharing of up-to-date patient care plans, treatment choices, and advance health care decisions across venues of care and between providers who care for the member?

○ What information system barriers will need to be overcome to achieve this ideal data sharing and how will that be done?

Situation: Responsiveness to member needs and changes in status

Background:

Responsiveness to members is essential because inadequate responsiveness can result in members not reaching out to the plan and instead waiting to seek care until the issue becomes emergent. At that point patients seeking care will escalate to emergency services (911 or ER).

Assessment & Recommendation:

We recommend that the following questions be considered by the Plans:

● How will the Plan hear from members and respond in a timely and efficient fashion when problems or issues arise?

● How will the Plan include processes which offer appropriate options for approaches which can flex depending on the member's conditions, severity of illness, health literacy, and acuity of issue(s)?

Care and Service Coordination

(Limit response to 5 pages)

Question 3 – What strategies or policies should DHS adopt that leverage care and service coordination at the community level? What care and service coordination services should remain at the QI health plan level? What is the best way to subcontract or delegate these responsibilities that results in shared accountability for whole patient care, while also improving outcomes?

Lana`i Community Health Center:

- Care coordination and care management should ideally be provided by the health center in conjunction with the primary care provider as a function of the care team.
- Resources that may be used to support health plan service coordination should be allocated to the health center to provide member and payor agnostic care with consideration to the level of complexity of the patient.
- The service coordinator should FIRST work through the primary care team to connect with a beneficiary that is established at a CHC. This can minimize duplication of

services and confusion for the beneficiary. This will also help to promote the relationship between the beneficiary and the primary care provider, ensure adequate support by the multidisciplinary care team, and improve the service coordinator's understanding of where they may help to coordinate services.

- Information gathered by the service coordinator to formulate service plans should be regularly shared with primary care teams.
- QUEST beneficiaries should not be burdened with potentially duplicative assessments from service coordinators nor should their efforts be completed in isolation of the care team. Health plans must define the role of service coordination/coordinator and delineate that role from health center care coordination and management. MCOs and health centers should have the option to craft the service/care coordination model that works best for their population.
- Community health workers, like care managers, can play a critical role in the success of a beneficiary's outcome as they serve as a trusted connector or liaison between health care and the community. CHWs should remain embedded in the community (in a community health center or community-based organization).

UHC:

We commend MQD on continuing to evolve as the health care system changes during these unprecedented times. Comprehensive and effective care coordination can mitigate the complexity and fragmentation of the health care system for individuals by promptly identifying needs and linking beneficiaries to timely, appropriate and effective services. The connection to community-based care, especially for individuals with complex health issues or SDOH needs, is critical to improve overall health outcomes and control costs. In thoughtfully improving the connection and coordination to community level care, MQD has an opportunity to transform the Medicaid delivery system in Hawai'i into a person- centered ecosystem by redefining the roles of MCOs as facilitators and connectors to enable and support providers (including medical, behavioral and community service providers) in delivering person-centered care.

The fragmentation of services across multiple programs can be complex and confusing to members, especially those with complex clinical and social conditions who require a significant number of services. Fragmentation undermines effective care coordination, especially without clear lines of authority or an inadequate governance structure. We recommend instituting clear lines of authority and governance, clearly delineating all roles and responsibilities for all involved programs and organizations. Any potential points of overlap should be eliminated to reduce member confusion and redundant service provision. A clear, effective pathway for communication across programs must be maintained and a collaborative and consistent approach across the MCOs, providers, agencies and other involved parties will be instrumental in ensuring these members with complex needs maintain the highest level of coordination.

We recommend MQD encourage MCOs and providers to work together to determine where care and service coordination sits best for members with complex health and social needs. MCOs and providers should identify how to best delegate care coordination services should it be determined these services are best suited at the provider level. In any model, we recommend a flexible team approach to care and service coordination leveraging predictive modeling, assessments, and comprehensive data to appropriately meet needs of both the total population and each individual member. Together, MCOs and providers can help close gaps and empower members to identify and achieve health and wellness goals.

Coordination and Delegation

Members identified for care coordination should have the choice to have coordination provided by a community-based organization that participates in and agrees to their coordination of care to the extent this is available in the member's geography. Care coordination should be delegated when a provider demonstrates the necessary competencies and the MCO retains oversight responsibilities. MCOs should provide standardized assessments and should conduct review of member assessments and documentation for quality and consistency. A mechanism to hold organizations accountable for the level of care they provide should be put in place. To be successful, a strong care model will need to be developed and clear expectations set. Monitoring, supervision, and staff support are critical to the success of care coordination. The challenge is to create a delegated model that supports members' goals, delivers a positive member experience, adds value, improves access and quality, and does not simply add additional costs to the overall QUEST Integration program. In this regard, the delegated provider will need to be more effective than the MCO in its care coordination program.

All long-term services and supports (LTSS) coordination should remain with the MCO to allow for optimal coordination of LTSS benefits and services to confirm member welfare and safety. HFA and 1147 LOC determinations should be conducted upon initial enrollment, annually and with change in condition. To the greatest extent possible the HFA and 1147 LOC determinations should be conducted face to face with the member. The COVID-19 experience has demonstrated the value of broadening the use of digital supports to meet member needs. We encourage MQD to continue permitting health plans to use telehealth and video conferencing platforms beyond the public health emergency based upon acuity and member preference to confirm safe and timely connection with members between annual assessments. This would allow for Service Plans to be reviewed quarterly and completed face to face or via an alternative platform based upon members needs and preferences. To better consider behavioral and social conditions in determining level of care, we recommend MQD work to enhance the 1147 form.

Care Team and Member Assessment

Care and service coordination best supports the member when it is based upon the needs of the member using a team approach. High cost, high need members may be stratified for increased touchpoints based upon member need and engagement. The team approach should consist of the following core members:

Registered Nurse/Licensed Practical Nurse;
Licensed Social Worker or other health care professional (CSAC, LMFT, CCM, PT);
Community Health Worker;
Assistant Service Coordinator;
Housing Coordinator; and
Behavioral Health Expert.

Care and service coordination at the community level should be optimized through the collaboration of the MCO and provider for all members who would benefit from care coordination at a SHCN/SHCN+ level. Assessments for this population should be flexible and allow for alternative, member centric settings and platforms including telehealth.

Assessment should be standardized and focused to allow portability from one program to the next as members' needs and goals change. Assessment frequency for this population should be done, at a minimum, on an annual basis and with any change in condition. Plan of care review should be reviewed semi-annually and with change in condition.

Statewide Approach

To achieve a comprehensive, coordinated system, we recommend MQD **create a statewide approach to SDOH** including the following components:

Creation of a standard screen where all providers and CBOs are focused on key state domains and priorities. MQD should work with members, providers, CBOs, and MCOs to develop a standardized screening tool to capture priority SDOH elements such housing, transportation, food insecurity and interpersonal safety in addition to member preferences including self-identified race and gender, primary language, prefer method for receiving communication, and other factors. The Accountable Health Communities Advisory Board could be used as a vehicle to build consensus and leverage existing investments. MQD can require all providers, MCOs, and CBOs to use this screening tool to enable a shared understanding of member's most critical social needs and individual care preferences. Improving SDOH data accessibility will allow for appropriate program coordination and linkages across an individual's whole experience. Targeting state resources to bring consistency to SDOH data collection and storage methods across social service programs and enabling the collection of sufficient information will afford the opportunity to test interventions and predictive analytics to target limited resources to individuals based upon combined need. Lessons learned from the Accountable Health Communities program, supported by the Center for Medicare and Medicaid Innovation grant, can be used during screening development to make sure it best suits the needs of Hawai'i residents.

Facilitate bidirectional transfer of meaningful, workable data. MQD has an essential role in ensuring the sharing of data across MCOs, providers, and CBOs that is necessary to support a person-centered experience. Greater connectivity has

NCCare360

NCCare360 is a statewide public-private partnership between the North Carolina Department of Health and Human Services and the Foundation for Health Leadership and Innovation that gives CBOs the ability to simplify communication, referral processes, and payment by centralizing all data sharing through a single source. NCCare360 uses a closed feedback loop to inform health plans, providers and CBOs that social services and supports have been provided to members. The platform also has the potential to allow for direct service payments to community-based organizations and creates the IT infrastructure for data collection to build new alternate payment/ value-based payment models for social services and supports.

the potential to enhance the maintenance transmission of accurate and comprehensive member data and allows the entire system to focus on member needs including accurate diagnoses, treatment decisions and options, and early identification of inconsistencies, duplications, and failures. These consequences of inadequate data sharing are felt acutely by members and their families, and the burden of untangling becomes an administrative and clinical distraction for providers and MCOs. We recommend MQD work to enhance the ability to share critical care coordination data (such as screenings, assessments, and care plans) and to track social determinants of health, like North Carolina's NCCare360. Through creating a platform like NCCare360 that allows providers and CBOs to use information from the screen to make connections to local community partners, MQD can enhance the ability to address or mitigate the identified social barriers. Any approach on data infrastructure development must have active and ongoing engagement from CBOs to be successful.

Analysis and Investment. The state and MCOs can use data collected from members and CBOs, and combined with clinical and utilization data, identify priority areas or domains to be addressed to support goals aimed at improving health and reducing disparities.

Unite US:

Social and economic factors have important effects on health and can be significant drivers of health inequities, in particular for patients with complex, overlapping health and social needs. Local communities play a critical role in providing social care services to these individuals, but this care is often not sufficiently connected to health plan care. DHS should promote strategies and policies for community care and service coordination that:

- Bring QI health plans and community service providers together within a common ecosystem - leveraging shared technology tools and standards for providing and communicating about care;
- Scale effectively to serve entire communities, in partnership with a broad array of community partners across service types and categories;
- Extend beyond simply providing basic resource information or referrals to individuals in need - to track and document the care provided by community partners in a manner that can drive shared visibility and accountability;
- Capture detailed outcomes metrics to determine the effectiveness of social care interventions, identify gaps in care, ensure follow-up, and learn about how social care can contribute to health outcomes - in particular for individuals with complex health and social needs who often have the highest costs to the Medicaid system

Unite Us is a technology company that builds coordinated care networks of health and social service providers. With Unite Us, providers across sectors use a common platform to send and receive secure electronic referrals, track every person's total health journey and the care they have received, and report on tangible outcomes across a full range of services in a centralized, cohesive, and collaborative ecosystem.

Health plan users are an important part of this kind of ecosystem. Health plan users are often responsible for developing comprehensive plans of care for their high-need beneficiaries, which can include identification of critical social needs. Within the Unite Us platform, these health plan users can conduct and record the results of screenings, document their plan of care, browse and select from community resources that meet identified needs, send secure referrals for social services, communicate with providers at community organizations who pick up the referral, and track the outcomes of care provided by partners in the community. Perhaps most importantly, however, referrals are not simply a oneway flow of information from health care to social care. Unite Us builds networks where referrals can be initiated by any health or social care users, all organizations are accountable to shared standards in providing care, and outcomes reporting is standardized across interventions.

Historically, programs in community service coordination were focused on creating broad consumer-facing directories of resources, or otherwise were extremely high-touch, hyper-local initiatives with a very small number of providers. Our experience has shown that these kinds of initiatives are not sufficient to improve care and outcomes at scale. Unite Us was created to address the personal pain points of our founders, who were both transitioning from active duty military service to the civilian sector and lived the difficulty in connecting with basic needs in their community. Unite Us initially built a consumer-facing tool for Veterans and Military Families. We felt if they could find resources in their community, we would solve all their problems. So we created a map, populated resources on the map with filters to help locate specific organizations, but quickly found out we were sending Veterans into a black hole. Because these resources in the community didn't know they were a part of our directory. There was no accountability for these organizations to assume a profile on Unite Us or engage on the platform at all.

Therefore, in early 2013 we redesigned our solution to address the root cause of the issue - making sure that individuals have access to an accountable social service provider in their community who provided quality services. Our platform was built for social service organizations to better coordinate with other social service organizations. The only organizations allowed on our system were those willing to sign service level agreements (SLAs). These SLAs include responding to referrals within a particular time frame, providing outcome data on services that have been rendered, and keeping their organization information up to date (as services, programs, and eligibility criteria changed, this also removed the need for duplicative work already happening in the community via United Ways and 211s). We were forced to take communities through a change management process, which allowed us to perfect our implementation curriculum, launching networks from 18 months in 2013 to 120 days in 2020. Starting in the community is an important distinction because we were forced to build a product that worked for the community and delivered a real solution to their problems. So as we transitioned to supporting the health care audience, our community-focused approached benefited them because now when they identify a member/patient/client who needs access to basic needs they can leverage a network of accountable social service organizations who have raised their hands and committed to the SLAs above and will care for that member/patient/client in a timely manner, providing the appropriate service with outcome data back to the health care audience via Unite Us. This is why Unite Us only builds communitywide care coordination networks because, without proper digital infrastructure and accountable organization's participation, we'll never be able to improve the health of our members/patients/clients or the communities with which they live. We're bringing social service organizations into the 21st Century and building a national supply chain of health, human, and social service organizations to reinvent the national healthcare delivery model, which is accountable, transparent, and focused on real outcomes for members/patients/clients.

Kaiser Permanente:

KP fully supports DHS' desire to make the process of navigating health plan care and service coordination (CSC) as easy as possible for providers. Members receiving CSC services are certainly those with the most complex medical, behavioral, and social needs and ensuring seamless, whole-person care is critical to improve health outcomes and quality of life. As an integrated health plan and delivery system, KP also understands the importance of ensuring that the role of the provider is an important one in care and service coordination.

Health care providers are now, more than ever, being stretched beyond their capacity to meet the current demands being placed on them. We recommend that DHS consider delaying expectations for transition of functions currently being performed by QI health plans to community providers. Instead, we believe DHS should continue to work with QI health plans to establish a model that allows both DHS and the plans to meet providers where they are in their readiness, capacity, and interest to take on additional care and service coordination responsibilities. Additionally, as part of this collaboration, QI plans should work to establish consistent tools and processes for working with providers, both before, during, and after transition of these activities. While we agree that the role of the provider is invaluable, we also believe that slowing the transition process will not only allow providers to focus their resources on providing care during this global pandemic, but also allow for a thoughtful, organized plan for community providers to accept a broader role in care and service coordination. We believe DHS should allow QI health plans to spend the first year of the new contract continuing to work together and engaging Medicaid providers in these discussions to prepare a comprehensive plan for provider delegation.

Similar to our discussions regarding state carve-out programs below, it will be important for community providers and QI health plans to establish clear lines of accountability for all responsibilities for care and service coordination. This includes assessments, care plans, services, member outreach and education, etc. It will be equally important to establish well-defined processes for communication between QI health plans and providers. This includes both mechanisms for data/information sharing and communication between those responsible for coordinating the member’s care. Both QI health plans and our providers must hold each other accountable. There should be mutually agreed upon mechanisms and measures for ensuring this occurs.

KP has the following recommendations for the redesign of the care and service coordination (CSC) model:

- Remove the bifurcation of care and service coordination proposed in the QUEST Integration RFP–MQD–2019-002. Instead, create a model, for populations that include the SHCN and SHCN+, that includes both care and service coordination, based on members’ needs.

Allow for this to occur through a team approach that includes a nurse (RN/LPN), licensed social worker or other similar health care professional (CSAC, LMFT,CCM, PT etc.), community health workers (CHW), housing coordinator, assistant service coordinator, and staff with behavioral health expertise.

Each member’s primary or “lead” coordinator would be based upon their highest individual needs (medical, behavioral, or social). The rest of the team is available to provide support and provide expertise as appropriate. For example, if a member has complex medical needs, their care would be coordinated by an RN. If the member’s needs are primarily related to their social needs, their care could be coordinated by the CHW or other team member as appropriate.

This team approach has multiple benefits. It allows for whole-person care, ensures that the team member with the expertise best aligned with the member’s need is coordinating care, and allows licensed health care professionals to work at the maximum capacity of their licensure.

- The focus for delegation to providers should be care coordination for SHCN and SHCN+ members, rather than service coordination for LTSS members. Successful service coordination requires appropriate assessment of each member’s home environment to fully understand the member’s ability to navigate their activities of daily living. Providers are caring for our members within the four walls of their clinics. It would require significant changes in their staffing and business/operating models to accomplish these assessments. To attempt to perform them within the provider offices could create risks for this vulnerable population. If DHS were to contemplate this delegation in the future, we recommend allowing time for QI health plans to work with interested providers and other community organizations to develop a plan for successful transition.

- As mentioned above, we recommend adding two roles to the CSC team not currently contemplated. CHWs are trusted members of the community and can serve to bridge the gap between our members and the health and social system, assist members with enrollment into support groups and other community programs, and help the CSC team with locating homeless members. We also recommend that DHS allow for the addition of an Assistant Service Coordinator (ASC). The ASC would provide administrative support to the team through activities, under the direction of the care or service coordinator, such as completing member mailings, scheduling appointments or transportation, and following up with members to ensure services are received. Both the CHW and ASC would allow clinicians to function at the top of their licenses while simultaneously creating additional interactions between the CSC team and the member.

Kokua Kalihi Valley:

Care coordinators hired by and integrated into Community Health Centers are more likely to be effective in engaging with patients and improving health outcomes. They are more likely to have community and cultural knowledge, language and communication skills, and a trusted relationship with patient and family. These are essential to planning and implementing effective care plans. While the situation may differ for private solo medical providers, MQD must consider funding and nesting this critical service in the most effective community settings.

For example: For at least the past decade, KKV Perinatal Case Managers (PCMs), working alongside medical providers, have cared for over 300 pregnant and post-partum women each year, and each year that care has resulted in birth outcomes at rates that are close to the US national average, despite the inherently high risk nature of this low income population. During that decade, KKV PCM's have referred to or called on health plan case managers (who tend to be at the RN/NP/MSW level) in only a handful of cases.

Hawai`i Primary Care Association

Care coordination and care management should ideally be provided by the health center in conjunction with the primary care provider as a function of the care team.
Resources that may be used to support health plan service coordination should be allocated to the health center to provide member and payor agnostic care with consideration to the level of complexity of the patient.
The service coordinator should FIRST work through the primary care team to connect with a beneficiary that is established at a CHC. This can minimize duplication of services and confusion for the beneficiary. This will also help to promote the relationship between the beneficiary and the primary care provider, ensure adequate support by the multidisciplinary care team, and improve the service coordinator's understanding of where they may help to coordinate services.
Care coordination and management of complex, high-needs, high-cost patients should not have to be terminated with QUEST plan changes.
Medicaid should consider additional state level partnerships and supports to assure continuity of care as complex patients cycle on and off coverage.

Information gathered by the service coordinator to formulate service plans should be regularly shared with primary care teams.

QUEST beneficiaries should not be burdened with potentially duplicative assessments from service coordinators nor should their efforts be completed in isolation of the care team. Health plans must define the role of service coordination/coordinator and delineate that role from health center care coordination and management. MCOs and health centers should have the option to craft the service/care coordination model that works best for their population.

Community health workers, like care managers, can play a critical role in the success of a beneficiary's outcome as they serve as a trusted connector or liaison between health care and the community. CHWs should remain embedded in the community (in a community health center or community based organization).

Service coordinators and support teams should work with the assigned but not attributed/established patients. There can be a greater responsibility on the plan to ensure this type of beneficiary is connected to a patient-centered healthcare home and understands the importance of primary care.

MCOs must provide timely data to health centers to support effective care coordination and management. (See the HPCA Addressing Data Transparency Attachment for types of data and use cases.)

MQD should consider the shared role and responsibility of social service and other community based organizations in addressing the needs of QUEST beneficiaries. The HPCA also recommends that MQD/MCOs explore supporting a means to streamline communication across clinical and community care. Some considerations include supporting case conferencing or an investment in a common technology platform that may integrate community case care information with EHRs and population management tools.

Transportation is a necessary service for patient engagement. There are transportation services coordinated or purchased by the MCOs and there are transportation services delivered by the FQHCs (transporting patients to and from their appointments). There are critical gaps in some communities and among members who reside in hard to reach areas of this State –- providing support to FQHCs to provide transportation improves access to care. The pandemic has made it challenging for members to seek care off-island. As such, sufficient network resources are needed to accommodate this during the public health emergency.

Ohana

‘Ohana has been working collaboratively with the other QI health plans to develop a plan to initiate the delegation of patient care activities to the provider community. We look forward to continuing this partnership and working with MQD to implement a community-based approach that supports whole person care and improves member outcomes. Based on our experience and informed by our discussions with the other QI health plans, we would like to offer following suggestions to MQD:

- Implement a team-based approach that leverages both clinical and non-clinical staff to support the member. This allows clinical staff to work at the top of their license while alleviating administrative burden through shared responsibility. It promotes timely access to services and allows the full team to serve more people.
- Encourage health plans and providers to leverage community health workers (CHWs) and peer support specialists as a critical component of the community-based care team. Health plans could contract with community-based organizations to use CHWs to identify members with complex medical and social needs and connect them to resources. CHWs' deep familiarity of social networks and community resources can bridge the cultural and socio-economic gaps between clinical professionals and the communities they serve.
- Support the development of a common informed consent model among all healthcare providers so that hospitals, PCPs and behavioral health providers can effectively share physical and behavioral data through common, legally compliant, and secure exchange protocols.
- Leverage multiple approaches for Service Plan approval and allow services to be delivered while pending signature return.
- Pay for services rendered by family caregivers or legally responsible individuals for PA Level I and Level II as an alternative to agency or independent and unrelated self-direct workers.
- Expand service settings for home care services to allow PA Level I, Level II and Private Duty Nursing services to be delivered in the home of a relative, hotel, or other community setting.

We recommend that QI health plans retain responsibility for overall program management to ensure access to care, quality, and efficient service delivery. Health plans should maintain responsibility for:

- Staffing – Determining their leadership structure and using staff in the most effective manner.
- Population health strategies – Analyzing data to assess community need and implementing programs to improve member health and reduce risks.
- Quality management – Conducting routine and ongoing monitoring activities to ensure that care is delivered in accordance with best practices and established standards.
- Service utilization monitoring – Collecting, analyzing, and reporting on service utilization at the provider, service, and member levels to assure that services are available, accessible and delivered at the right place and time to meet members' needs.
- Technology support – Bringing systems and processes to facilitate information-sharing across providers and systems involved in member care.
- Data reporting – Developing routine and ad hoc reports for use by internal staff, providers, and the Department to promote continuous quality improvement and demonstrate system effectiveness.

Additionally, health plans should provide service and care coordination for members at the highest risk levels, consistent with the CCS model, including all members receiving LTSS. As members with high risk levels often have complex needs that require close coordination with multiple providers and systems, health plans are best positioned to support these members.

Collective Medical:

A patient's journey through common behavioral health managed care networks can be fragmented and disconnected. Requiring all participating plans to implement an advanced, national, use-case-driven data sharing solution would powerfully leverage existing care and service coordination efforts in Hawai'ian communities and encourage the formation of new collaborative relationships to serve patients. Every person we speak with in the caring professions has entered their field to help and serve others. One of the most important things DHS can do is ensure that these professionals have the best possible tools to do the work they feel called to. We believe that kind of empowerment often helps individuals find at least part of their motivation intrinsically, as they see more positive results from their day-to-day efforts.

While we do not advise about where Hawai'i should place accountability for whole patient care, we emphasize that any data sharing platform chosen for use should demonstrate sufficient flexibility to be configured and implemented to support the structure Hawai'i chooses.

We have seen success stories at the community level, the health plan level, and even with statewide initiatives. Infrastructure that includes technology like ours is vital for the new era of whole-patient care, both for pushing toward goals with each patient or encounter, and for reporting and accountability. For example:

- Using Collective's real-time, ADT-based notifications, Aspire Health Alliance, a Medicaid health plan in Massachusetts with a dedicated Behavioral Health Community Partner program, has been able to raise patient engagement by 150 percent.

- Northwest Physicians Network (NPN)—an independent physician association in Tacoma, Washington, uses an advanced interoperability solution to collaborate with Pierce County's Mobile Community Intervention Response Team and emergency services to increase efficiency and improve outcomes for patients with substance use disorders, mental health conditions and other complicating factors. This strategy has generated a 44 percent reduction in 911 calls, a 47 percent decrease in EMS transport, a 36 percent reduction in ED visits, a 42 percent decrease in hospital admissions, and a 31 percent drop in observation stays.

Community First:

3. MQD should make a policy that care coordination is the responsibility of the medical home. The medical home should be the fundamental unit of healthcare delivery and care coordination should be its responsibility. In East Hawaii we discovered that different programs all had their own care coordinators which took care of patients within the scope of their program, e.g., hospital discharge, aging assistance or hospice care, but no one coordinated care across the continuum of care and across the community. In many cases care coordination is not needed, but when it is, such as for the impaired patient or the patient with many non-medical needs (the social determinants of health), the responsibility for care coordination across the continuum and the community should reside in the medical home.

Care and service coordination can refer to so many activities: case management by health plan nurses more to fulfill health plan and MQD requirements than engage with patients, referrals by social workers to agencies, patient relationship management by community health workers, or extreme care coordination by EMS paramedic firemen.

The services which should remain and be added at the QI health plan level are: facilitating off-island services or out-of-network services, assisting with non-medical enabling services provided by the plan, such as transportation, and assisting the medical home to navigate benefit and pre-authorization requirements of the plan. The health plan case managers should be a resource to the medical home.

The medical home should have community health workers who own the personal relationship with SHCN patients and ensure they receive the services and support from government programs and social service agencies which will improve their health outcome, for example, they would call the patient to remind them of an appointment and make sure there's transportation, or they would make sure the SNAP form and process is completed. They would care for the patient like they would an auntie, uncle, or close friend. MQD should provide additional funding to medical homes for them to have community health workers who own the personal relationship with complex patients.

Extreme care coordination, which we might call "jump over the fence" care coordination is typified by the EMS paramedics who have the skill set to outreach and care for patients under difficult conditions such as homelessness or locked gates. Extreme care coordination should be developed as a community resource that medical homes could access or a medical home capable of extreme care coordination should be developed as a center of excellence in the community for SCHCN+ patients who need this level of care.

Shared accountability for whole patient care should be operationalized with MQD having quality improvement meeting with the community, with medical and social service providers, business leaders, and community leaders all at the table on a quarterly basis.

Healthcare Association of Hawaii:

During the 2017 session, the legislature passed House Concurrent Resolution (HCR) 161, requesting that the MQD Administrator convene a working group "to evaluate the issue of complex patients who are waitlisted in hospitals because of medical or behavioral health issues and to consider solutions…" for the issue of waitlisted patients. The working group convened several times over 2017, issuing a report in December outlining its discussions and findings. One of the patient populations the task force focused on was patients with behavioral health or substance abuse issues.

The task force found that the inadequate size of the mental health workforce (particularly with psychiatrists) creates significant access issues for many patients. Access is further diminished by the fact that low reimbursement rates for mental health services have driven many providers of mental health care to a cash-only practice model. This can lead to undertreatment. It is extremely important to help primary care providers with better screening and treatment of mental disorders by creating payment models that encourage it.

There was also an acknowledgment from members that many high-need patients are unhoused. Until there are adequate foster or group homes for these beneficiaries to reside in, they will remain a high-need patient. Their wounds cannot heal adequately, their behavioral health and chemical dependency issues cannot be adequately addressed, and medication compliance cannot be ensured. MQD should seriously consider reimbursement strategies that house these individuals or provide needed wrap-around services, which will reduce medical costs and help move these patients out of the high-need, high-cost population. Further, adequate and appropriate behavioral health should be integrated into any payment model that MQD pursues. On this specific issue, our members shared some comments, which we support and reiterate. Those comments include:

- Support for a benefit to enable foster and care home operators to attend trainings on mental health to understand the diagnosis and treatment of mental health patients. This standard should not, however, reduce access to foster and care homes for patients;
- Re-assess the 1147 form to account for the needs of complex patients;
- Target reimbursements for this population so that providers will be more willing to take on these populations; and
- Support stabilization beds in the continuum of care – similar to what was discussed in the Involuntary Hospitalization Task Force – to help stand up these sites and maintain their financial viability.

CMCH:

The strategy should DHS adopt is integration of care for both medical and behavioral health service which can be a clinical and business priority for any organization.

The QI health plans should continue to provide all services both medical, dental, behavioral health, rep payee, housing, long term care and group home services. These should all be manage in QI plans to reduce any burdens on meeting contractual requirements.

You don't need to subcontract. Keep the services to QI plans to manage and control. One health plan providing all the benefits for the patients will be easier for providers to manage rather than remembering who is responsible for behavioral health or medical or even dental services.

AlohaCare:

AlohaCare recommends developing a shared LTSS platform and clear guidelines focused on eligibility and level of care determinations, and service and care plan development. We also recommend that QI health plans be given the responsibility to make LTSS eligibility determinations with proper supports from MQD to ensure program consistency. This would streamline administrative functions and better align health plan and community provider efforts. AlohaCare recommends that QI health plans maintain LTSS service coordination activities and overall service plan development responsibilities to avoid fragmentation and ensure medically necessary services identified on beneficiaries' person-centered service plan are authorized, delivered, coordinated, and documented. Maintaining LTSS service coordination activities at the QI health plan will benefit the beneficiary, LTSS providers, and QI health plans by ensuring streamlined communication related to under and over utilization of services, as well as identifying and quickly addressing missed visits and changes in beneficiaries' condition. AlohaCare supports Care and Service Coordination (CSC) teams in the community where beneficiaries live as MQD envisions through the HOPE Initiative. The team-based model allows for a more collaborative approach to care, as QI health plans coordinate medical, behavioral, long-term services, and social determinants of health needs in conjunction with each beneficiary's primary health plan providers, community resource agencies, and specialists. Having CSC teams partner with provider care teams will pave the way for more pooling of resources and reduce duplication of services, creating greater cost and programmatic efficiencies.

AlohaCare recommends delegation of care coordination activities to providers who demonstrate readiness to assume care coordination responsibilities. Delegation must be executed in a manner that ensures transparency of activities and results in improved communication between the QI health plan and provider. This requires the development of consistent tools and protocols across the delivery system to document responsibilities and progress for all involved parties. AlohaCare believes that QI health plans have a responsibility to support successful provider delegation of CSC activities.

AlohaCare offers the following in support of our recommendations above:

- Form a joint regional collaborative that consists of BH, PH, LTSS, CBOs, and other program providers along with representatives from each QI health plan who meet quarterly to discuss how community services may be provided effectively, efficiently, and in a timely way. This type of forum provides current information about community needs and capacity which will allow MQD and QI health plans to develop consistent training and policies ensuring continued process improvement in delegated care coordination.
- Develop a consumer advisory committee that includes advocates from underserved and other populations that face cultural and socioeconomic barriers. The consumer advisory committee can be tasked with providing insight and feedback on proposed policies and communications.
- Require QI health plans to hold interdisciplinary care team meetings between the primary care providers, the CSC teams, the beneficiary and the beneficiary's family to support shared responsibility, improved communication and collaboration in the assessment of beneficiaries' continuing needs, service availability, and issue resolution.
- Require the development of a shared care plan between the QI health plans and delegated providers using a shared platform for provider agencies, PCPs, QI health plans, and beneficiaries. Setting such a requirement should be applied across service delivery providers to help achieve the transparency needed to assist with delegation of activities and identify where QI health plans should target provider training activities.

Hawai'i Maternal and Infant Health Collaborative:

We are responding to the Care and Service Coordination section of the RFI (questions 3 and 4).

Care and Service Coordination

We applaud MQD's prioritization of care and service coordination, as well as their desire to better integrate community-based and QI health plan efforts. For this section, HMIHC offers four recommendations.

Recommendation 1 : Expand the definition of "care and service coordination" to reflect the breadth and depth of client needs, with an emphasis on social determinants of health.

MQD clearly recognizes that care and service coordination is important to ameliorating health disparities and optimizing health care resources. Therefore, its definition in MQD policies should be revised to ensure that beneficiaries are able to access the type of focus should be placed on the social determinants of health, and greater resources should be allocated to each qualified beneficiary to ensure appropriate “whole person care.”

“Care [and service] coordination” means different things to different people. In our experience, care coordination connotes more intensive assistance at the community-based level when compared to the QI health plan level. Currently, QI health plans assist with things such as finding a language interpreter, helping to select the right doctor specific to health needs, and making an appointment. While important and needed, these health plan/provider-focused tasks only help clients coordinate the medical system. In contrast, the desired “whole person care” requires helping clients coordinate the myriad aspects of their life that impact their well-being, i.e., address the social determinants of health. According to the National Academy of Medicine, medical care accounts for only 10-20% of health outcomes, while health-related behaviors, socioeconomic factors, and environmental factors account for the remaining 80-90% (https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/). Care coordination that identifies and helps to resolve issues such as housing, financial and food insecurity, intimate partner violence, legal and child welfare systems, etc., allows for more substantial and sustained improvements in beneficiaries’ health status, as well as population health disparities. While this more comprehensive care coordination requires greater investment of resources upfront, it should also yield greater return on investment, both in dollars and health outcomes.

A clear and standard MQD definition of “care coordination” that incorporates social determinants of health would facilitate the implementation of appropriate reimbursement strategies and models of integration across different systems, as in Recommendations 3 and 4 below. The definition itself should be informed by discussions with community-based partners, as in Recommendation 2 below.

Recommendation 2 : Gather input from community-based partners on beneficiaries’ care coordination needs, and assess existing models and tools.

As the question acknowledges, community-based care is currently “largely separate from or loosely connected to” QI health plans. These community-based providers have a wealth of knowledge and experience in care coordination and MQD beneficiary needs, which should inform the development and implementation of the MQD care coordination plan. This RFI should represent the first step toward a continuous process of engagement among MQD, QI health plans, and community-based providers. Designing and implementing effective care coordination for MQD beneficiaries depends upon seeking early input and authentic direction from providers and community members, including those from rural areas, neighbor islands, and underserved communities. The Hawaiʻi Maternal and Infant Health Collaborative (HMIHC)’s Perinatal Substance Use Workgroup has been meeting for the past year to assess and strategize care coordination needs for pregnant/parenting women with substance use disorder (SUD) and their families. Diverse, cross-sector partners have provided qualitative feedback on care coordination in their respective contexts, and we are in the process of collecting quantitative data from community-based partners as well. In the qualitative discussions, partners emphasized a few key points: 1) Care coordination looks at the whole person, meets them “where they’re at,” and is patient-centered to meet their goals; 2) Intensive coordination is what most clients need, including coaching, teaching, and frequent follow-up; and 3) Relationship and trust-building are absolutely essential, given that many clients have been judged or disenfranchised by the health care system previously. Numerous models and tools for care coordination incorporating social determinants of health are used among community-based agencies locally and nationally. As MQD gathers input from Hawaiʻi's providers, it should also assess these existing models. One example, which provides mobile midwifery care in addition to care coordination, is the Midwifery Integration Home Visitation Program (MI-Home) of University Health Partners (https://uhobgyn.org/mi-home-program-providing-prenatal-and-postpartum-care-in-yourhome-or-shelter/). An example of a tool used to assess social determinants of health in clinical settings is Well Rx, an 11-item questionnaire assessing needs in 4 domains (economic stability, education, neighborhood & physical environment, and food) (https://sdh-tools-review.kpwashingtonresearch.org/screening-tools/well-rx).

Recommendation 3 : Reimburse adequately for care coordination with a broadened workforce of transdisciplinary practitioners.

Although many community-based organizations have the desire and expertise to provide care coordination, as well as the vulnerable client population in need of it, insufficient funding is their main barrier to sustainability. MQD should reimburse for the care coordination, as defined per Recommendation 1 above, that these organizations can provide. Ideally, community-based providers should be contracted for care coordination at the MQD level, rather than at the QI health plan level. This way, a given community-based provider could serve any MQD beneficiary with whom they already have a relationship and rapport, regardless of their QI health plan selection, which will foster standardization and avoid logistical challenges.

Care coordination does not necessarily require specific advanced degrees. Rather, a variety of transdisciplinary practitioners can provide care coordination given a clear set of standards and trainings. By broadening the definition of workforce able to provide comprehensive care coordination, MQD can tap into underutilized resources for improving beneficiaries' health outcomes and their return on investment. Examples of potential reimbursable providers include: community health workers, community-based doulas, perinatal case managers, home visitors, and social workers. By reimbursing for care coordination provided by these vital team members with established professional competencies, beneficiaries will benefit from the connections they already have with resources and services to address social determinants of health available in their communities, which QI health plans may not know about.

Recommendation 4 : Institutionalize mechanisms of working together across systems of care.

To ensure that care administered by multiple programs and agencies is coordinated and not duplicative, MQD and other key partners (e.g., DOH) should design and implement a model of intentional, facilitated communications about care coordination. There are multiple approaches to this; one example is the Children and Recovering Mothers (CHARM) model from Vermont used for opioid-using pregnant women (https://dcf.vermont.gov/press-releases/CHARM). Relevant partners, including child welfare, medical care, substance use treatment, and community-based service providers, met monthly to discuss cases and coordinate their care. A process like CHARM would facilitate the delineation of responsibilities, and allow all partners to maintain a full picture of the client's situation.

Health Team Works:

A summary of our strategic advocacy related to these questions:

- Consideration for improving care and service coordination at the community level by funding practices to support their direct employment of care managers and other support resources at the practice or system level.
- Consideration for providing timely and actionable data as a key service that should remain at the QI health plan level. While coordinated, comprehensive care is a practice responsibility, success is predicated on strong health plan partnerships and resulting support.
- Consideration that care and service coordination delegated to the practices will require implementation support. We advocate for a 3rd party implementation support organization as a single source of accountability for statewide Practice Facilitation across health plans and provider networks.

We advocate strategic consideration for improving care and service coordination at the community level by funding practices to support their direct employment of care managers and other support resources at the practice or system level.

A higher probability of poor patient experience, confusion and distrust are outcomes of disjointed care efforts when service coordination is provided by multiple care managers and care coordinators from different entities including payer, practice, and hospital. Providing resources to practices and systems to hire care management resources fosters ownership and the ability to serve patients across payer populations.

The result is a streamlined and relationship-based approach. Patient experience improves and trusted relationships are fostered when continuity with a primary care team exists. Additionally, positive outcomes in a provider network include improved provider satisfaction and strengthening of primary care teams which leads to a corresponding reduction in provider burnout.

Delegating and funding at the practice or system level supports care management integrated with primary care, gives the care team autonomy to implement models (e.g. centralized, embedded in practices, or home/community-based) to best serve their patients, improve the patient experience and complement an interdisciplinary care team. Additionally, with funded resources, primary care practices have greater capability to identify social determinants of health and establish strong referral networks with community-based organizations.

We advocate strategic consideration for providing timely and actionable data as a key service that should remain at the QI health plan level. While coordinated, comprehensive care is a practice responsibility, success is predicated on strong health plan partnerships and resulting support.

Our position is the multi-payer collaborative approach (explained in page 3 as answer to question #8) is critical to the success of delegating care management to the practice or system level. Additionally, the QI health plans' participation in the multi-payer collaborative will lead to a standardized platform deployed statewide that connects healthcare delivery systems and practices with community organizations that address Social Determinants of Health.

We advocate strategic consideration that care and service coordination delegated to the practices will require implementation support. We advocate for a 3rd party implementation support organization as a single source of accountability for statewide Practice Facilitation across health plans and provider networks.

Often practices are provided facilitation services from systems, multiple payer teams, and other initiatives in which they may be participating. This disjointed support from multiple sources can be a significant source of administrative burden and even create barriers to meeting performance standards. Just as a payer's patient populations should not be siloed out or treated differently within a practice or system, implementation support should not be a fragmented approach. Ideally, the practice has a single trusted source for Practice Facilitation that is not tied to one entity but is well-informed and can speak to value propositions across stakeholders, even aligning initiatives to reduce competing priorities.

The 3rd party implementation support organization approach is addressed in the answers to questions 7, 8 and 9 related to Value-Based Purchasing (VBP) and Advanced Payment Models in pages 3, 4 and 5 of this response. Practice and provider network level workforce development is a part of Practice Facilitation that is essential to delegating care management. Training examples include those that build a culture of quality improvement, streamline processes and workflows, and role-specific training such as Care Manager Training to equip the current and future workforce for delivery in new models of care. For practices and healthcare organizations participating in APMs continuously improving team-based care, care management and coordination is imperative. Well-designed training offers comprehensive curriculum that accelerates the development of care teams in medical practices through a combination of online learning and experiential, activity-based learning delivered to cohorts of staff at a single medical practice or from multiple medical practices. Effective training is designed to develop skills and competencies that are essential for success in value-based care including care management competencies, team-based care fundamentals and healthcare quality improvement concepts. Specific skills and competencies to improve care management, patient engagement and team-based care include motivational interviewing, teach back technique, two-step risk stratification, empanelment, and fundamental quality improvement models and concepts. A cohort format for experiential learning creates engaging opportunities to practice new skills, improve care team communication and develop professional relationships to strengthen the peer support network of participants. The result is an empowered medical practice staff who work more effectively as part of an interdisciplinary care team to both improve outcomes and the patient experience. Derigo Health - Case Study provides an example of 6 small practices in Hawaii that benefited from a workforce development project with Care Manager/Team-Based Care Training.

HMSA:

What strategies or policies should DHS adopt that leverage care and service coordination at the community level? What care and service coordination services should remain at the QI health plan level?

DHS should adopt strategies and policies that encourage various health care professionals to work together in a cohesive, collaborative manner to 1) decide on an appropriate member-focused care plan, 2) support the member as they execute the care plan, and 3) adjust the care plan in collaboration with members as circumstances change.

Health care professionals can care for members to address physical and behavioral health challenges and leverage community-based services to assist members who are dealing with issues that they can best address (e.g., homelessness, food insecurity). This approach will enable the most qualified resources available to assist the member to improve their situation and put them on the path to physical, mental, and social well-being.

Primary care is essential to ensure members receive high-quality, personalized care and are supported as they navigate an often-confusing delivery system. Primary care is at the core of a collaborative and integrated model of a member's person-centered care. Primary Care Providers (PCPs) need to coordinate with other medical specialists and community resources to provide appropriate care for the member. Foundational to this integrated model is the technology that would support prompt bi-directional data and information exchange that all health care partners engaging and caring for the member can access.

HMSA believes that each member should receive the right care at the right time in the right setting. For some, this means care coordination is delegated to another party that is closer to the member and has resources to provide appropriate care. Some QI members with special health care needs (SHCN) are receiving their primary care at an organization that has the infrastructure to offer care coordination. These health care systems are best positioned to assume the responsibility, since they are in an environment that is closest to the PCP and the member. This change would assure that communication is streamlined to gain operational efficiencies. The health plan can support those delivery systems to navigate as needed within the health plan.

For the QI Long-Term Services and Supports (LTSS) population, or in situations where the PCP does not have resources to assume care coordination, optimal member care can be provided by utilizing the health plans' service coordination team to work with providers and members to connect them with the most beneficial resources.

Care coordination relies heavily on access to community services. The Community Health Worker (CHW) program provides frontline health care team members who have a strong understanding of the communities that they serve. The CHW acts as a key liaison between the communities that they service and various health resources to actively promote, maintain, and improve the health of members and their families. The CHW is enabled by the trusting relationships they can build with members and their families to understand, navigate, and access community services and other resources that meet their unique medical and social needs. The CHW supports providers and the HMSA service/care coordinators through an integrated approach to care management and community outreach.

Other community partners to which health plans could delegate care coordination would include homeless outreach agencies and Community Health Centers (CHCs). For members who meet qualifications for Nursing Facility Level of Care and live in nursing facilities, nursing facilities already have a care plan in place with member input. Service coordination from the health plan is unnecessary and would be duplicative. The health plan can support nursing facilities by meeting the discharge needs of the member to ensure that members are supported when the return to the community.

The health plan will need to coordinate with delegated entities to assure that QI members maintain (or improve) both their outcome and process measures. In addition, health plans need to meet all the delegation oversight requirements for National Committee for Quality Assurance (NCQA) accreditation. Delegation to community partners should be a thoughtful process that assures meeting member needs.

What is the best way to subcontract or delegate these responsibilities that results in shared accountability for whole patient care, while also improving outcomes?

Health plans should provide the delegated entities with a wide range of supportive tools, information, and training. Delegated entities and health plans would need to coordinate sharing of information for health plans to meet delegation oversight standards for NCQA accreditation. Health plans should invest in integrated technology tools that facilitate care management and information sharing. They should also use performance metrics based on evidence-based research and best practices that includes both outcome and process measures to monitor program outcomes.

In addition to the ongoing monitoring of metrics, a standard cadence of meetings and communications should be established for ongoing oversight, knowledge-sharing, accountability, training, and identifying supportive resources to help align best practices and consistency of care to delegated entities. Ongoing monitoring and continuous improvement of the program is the foundational step in strengthening population health. We will get higher engagement and improved outcomes with a care management program built into the provider network. We hope to improve member care and reduce provider administrative burden through this approach. Most importantly, we will be using partnerships within the community to create a single person-centered care plan, with one primary lead, to deliver the best care for the member.

Ohana Pacific Management Company:

Care Coordination for Chronic and Clinically Complex individuals should be a delegated function to local community providers who have sufficient geographic reach throughout the islands.

Programs should include a Care Managers who act as patient liaisons to assist in the management and coordination of care with PCP's, Specialists, and QI health Plans. Delegated care management services would also assist in coordinating care for other social service programs to include Meals on Wheels, Older Americans Act, etc. to ensure broad beneficiary wellness and management of care goes beyond physical health and adds psychosocial aspects, which frequently result in increasing the cost of healthcare. Sub-contracting or delegation either can occur directly with a local provider, or as a required component in any awards related to Medicaid procurement within the State.

Pacific Medical Administrative Group

Effective service coordination should be administered by trained service/care coordinators who have experience and education in healthcare service fields such as social work and psychology. Those with experience in these areas have demonstrated the ability to build effective communication and trust with patients. This has been identified as a crucial component of successful care coordination programs. Programs that train their service/care coordinators in evidence-based strategies and provide regular, ongoing, and consistent clinical supervision will ensure that accountability is shared for whole patient care. It is crucial to place emphasis on engaging patients by using evidence-based techniques such as Motivational Interviewing (MI) to improve patient outcomes and analyzing program data to conduct quality improvement and assurance activities.

Under current care and service coordination delivery models, workers are instructed attempt to contact a patient 3 times. If there is no response, 2 letters will be mailed 1 week apart, notifying the patient that the case will be closed if no contact is made. This type of protocol has proven to be ineffective at engaging patients and frequently results in patients not receiving necessary services. The State must take into consideration the changing technological landscape. Using defunct methods of communication and selecting an arbitrary number of calls before closing a case has long since been identified as a barrier in patient care resulting in poor program outcomes.

In order to effectively service the 350,000+ lives under MQD, the State should consider allowing community organizations and independent providers the opportunity to partner with MQD directly. An extensive vetting process is necessary to ensure these programs are utilizing evidence-based models and are driven by patient improvement measures that are quantifiable. Current service coordination models often measure outcomes based on “minutes served” or “patient engagement”, which is defined simply as speaking with the patient. These methods have no relevance or correlation to patient improvement or quality of care. Without an effective means to evaluate a patient's progress, it is impossible to hope for better program outcomes. Pacific Medical Administrative Group (PMAG) developed an Integrated Health Hawaii (IHH) Care Coordination Program aimed at addressing these gaps in care. Driven and developed by physician needs, the program is heavily engagement-focused, evidence-based, and data driven. Analysis of 2 years of program data suggests that it takes on average 10 attempts to contact a patient before they are willing to discuss their concerns and even longer to develop the rapport and trust that is necessary for patient engagement. We also found that patients stay in closer contact with a care coordinator if the means of communication are expanded to the convenience of text messaging, email, and encrypted messaging platforms. In addition, electronic medical records (EMR) have been crucial to creating standards of documentation and holding all staff accountable for their patients. Using a HIPAA compliant EMR streamlines the case review process and ensures that patients do not fall through the cracks. With the changing workplace landscape amidst the current pandemic, it has been crucial to patient continuity of care that documents can be accessed remotely and at any time. Integrated Health Hawaii's Engagement Focused Care Coordination model (EFCC) recognizes that the utilization of EMRs can be difficult as healthcare information systems are complex and can involve extensive changes in individual roles, relationships, and business processes. These socio-technical aspects of change may be difficult for many healthcare providers and service/care coordination programs. However, the importance of tracking program development, quantifiable patient outcomes, and holding staff accountable is crucial for any QI health plan to implement as part of their service delivery model.

The definition of "service coordination" varies between agencies. Sometimes terms such as case manager, care manager, patient navigator, and care coordinator are used interchangeably but describe very different activities and functions. It is crucial to clearly define what care coordination is, and the QI plan should ultimately take responsibility of either providing or subcontracting a care coordination program that takes 100% responsibility of initiating, establishing and coordinating ALL other coordinators in the community and/or government agencies in addition to being the designated leader in the collaborative care medical model (UW AIMS). In IHH's EFCC, we have seen the most effective service/care coordination for adults involve a behavioral health focus that addresses depression, anxiety, substance use, and trauma while measuring outcomes regarding symptom improvement over time. Severe mental health issues in adults also requires consistent service/care coordination that focuses on engagement and measures outcomes. Children require care coordination that involves a variety of programs and services that can focus not only on the child's healthcare needs, but educational and family centered as well.

Waikiki Health Center:

Service Coordination should include assistance with Housing and providing smart phones to the patients. If we are trying to treat patients on a holistic level, housing also needs to be addressed (ie. Maslow's Hierarchy of Needs). Without housing/shelter (social) needs beings addressed, it is difficult to address complex health needs of our patients. Furthermore, due to COVID, Service Coordinators can only complete their 'visits' via telehealth. Many eligible quest patients are unable to obtain services without access to a phone (and/or minutes).

a. Service Coordinators should have standing orders to assist with addressing quality measures (ie. provide/mail FOBT kit).

Waianae Coast Comprehensive Health Center:

Care and Service Coordination - Where the majority of patients are Hawaiian and Pacific Islanders, as it is at the Health Center, standard actuarially based risk adjustment is inadequate, especially if we seek to measure true value. Ahead of more precise risk adjustment we do see opportunity in the RFI's focus on high- cost/high-risk cohort management. The focus of coordinated care on an agreed upon group of high-risk patients neutralizes actuarial limitations and incentivizes us to pursue achievable performance goals.

Queens's:

Comments from Director of Care Coordination, UM & CDI and Director of Community & Post-Acute Care Services

Strategies and policies that DHS should implement need to focus on ensuring accountability of community providers and service coordinators. Our care coordination teams have identified the following gaps in care that should be filled through community based care coordination services:

- *When assessing the needs of a patient, case management agencies need to meet patients in the hospital to determine appropriate level of care and possible discharge to foster homes.*
- *Quality of home health, SNF, LTC, Care Home, Foster Home. Based on our experience, it has been difficult to get Quest patients in SNF d/t reimbursement, Home Health taking 7-10 days to get into the home when goal is 72hrs.*
- *Ensure DHS has the ability to prevent and discourage practices that negatively harm beneficiaries. Such as situations where a beneficiary could be transferred to a hospital for some acute care need. Then when the time has come for the resident to be discharged, the post-acute care facility refuses re-admittance.*
- *DHS should implement escalation policies to ensure that when challenges arrive in the coordination of services for Medicaid beneficiaries, they can be addressed in a timely and effective manner to ensure safety and quality of services for the beneficiary.*

Services that should remain with QI plans:

- *Benefits management*
- *Prior authorization*
- *Utilization management*
- *Determining services hours available for patients (PA1/PA2 services)*
- *Post-acute (SNF/Home Health) authorizations*
- *Transportation authorization*

Services they could delegate/contract:

- *Complex care management consults: home based physical/psychosocial assessments could be contracted with health systems to provide.*
- *Transitional case management: inpatient to next level of care*
- *PMPM with quality and outcome metrics*
- *Shared savings with the contracted system/agency*

Hawaii Pacific Health:

Decisions here need to be driven by outcomes data to support strategic objectives.
However, one area of improvement would be to allow a reimbursement framework to enable the expansion of the health care workforce that are most accessible and economical for community level settings.
This workforce would include: (1) Community Health Worker addition (2) Professionals to assist in Screening/Triage getting; (3) Social Workers.

- Provide Behavioral health for patients that are not part of the CCS continuum.
- For patients that require hospitalization there should be an automatic adjustment in
The individual's acuity level. If the assigned service coordinator at the QI health plan level is able to manage higher acuity individuals then it could remain at the health plan level, however if not then it should be handed off to someone (subcontract/delegate) that is able to make rapid contact with the individual during their hospitalization.

Question 4 – Members who meet the criteria for these programs have complex medical and social conditions, and often receive services from multiple programs administered by QI health plans (e.g. Special Health Care Needs (SHCN) and Community Integration Services (CIS)), and/or multiple programs and agencies separate from the QI health plans (e.g. CAMHD, CCS, etc.).

How should responsibilities be delineated when members are receiving care administered by QI health plans and/or outside programs that results in shared accountability for whole person care, while also improving outcomes?

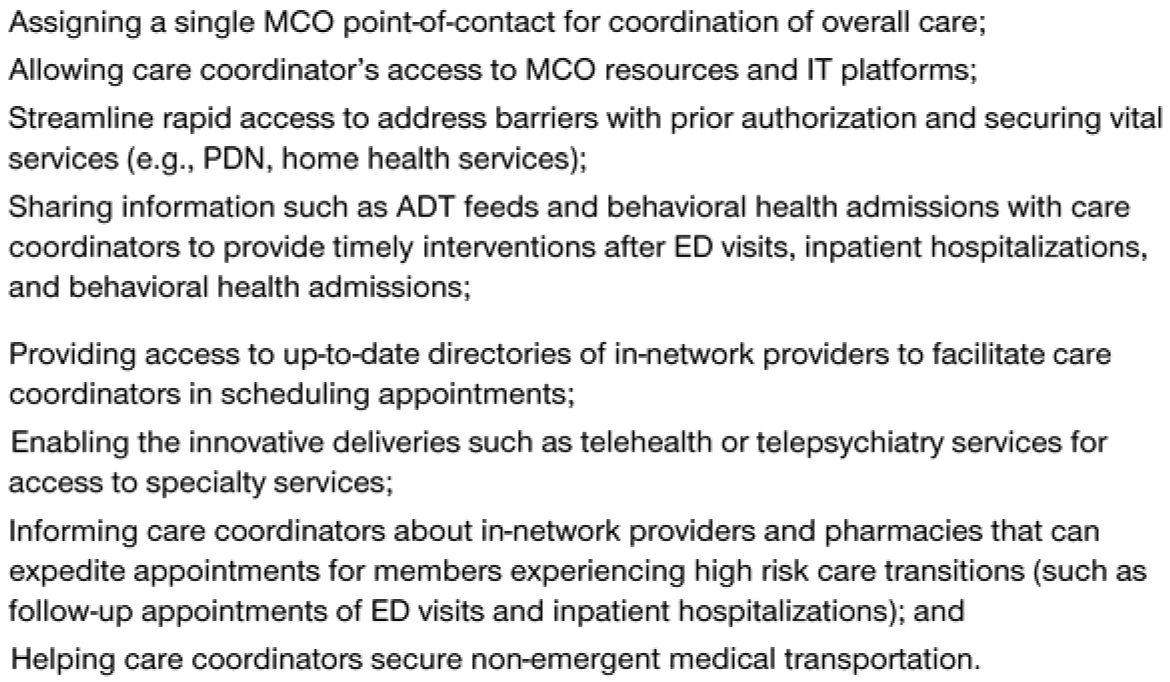
Lana`i Community Health Center:

- Results should continue to be shared and responsibilities should be delineated by the care team responsible for delivering these services. Each care team should always have a primary care or medical team member involved.
- A coordinated plan of care is essential, particularly for high need high cost patients as untreated behavioral and support issues affect patient success. Therefore, increased access to more behavioral supports is critical.
- There needs to be an efficient data sharing platform (payor agnostic) in order to coordinate care between all programs

UHC:

Members who choose to have their care coordinated at the local level and who qualify for, and are enrolled in, multiple programs need to have a PCP or service coordinator to support coordination of benefits without duplication. To the extent possible all assessments should be standardized and portable. MCOs could coordinate programs so each member has a primary coordinator who will collaborate with additional programs and coordinators to access additional benefits. The MCO's primary coordinator will be responsible to confirm all benefits and services are represented on the members individual care/service plan and this care/service plan will be shared with the additional programs.

MCOs should serve as collaborative partners and deploy a variety of strategies to support community-based care coordinators by addressing an individual's care needs and removing barriers to support timely delivery of services. These strategies can include:



Assigning a single MCO point-of-contact for coordination of overall care;

Allowing care coordinator's access to MCO resources and IT platforms;

Streamline rapid access to address barriers with prior authorization and securing vital services (e.g., PDN, home health services);

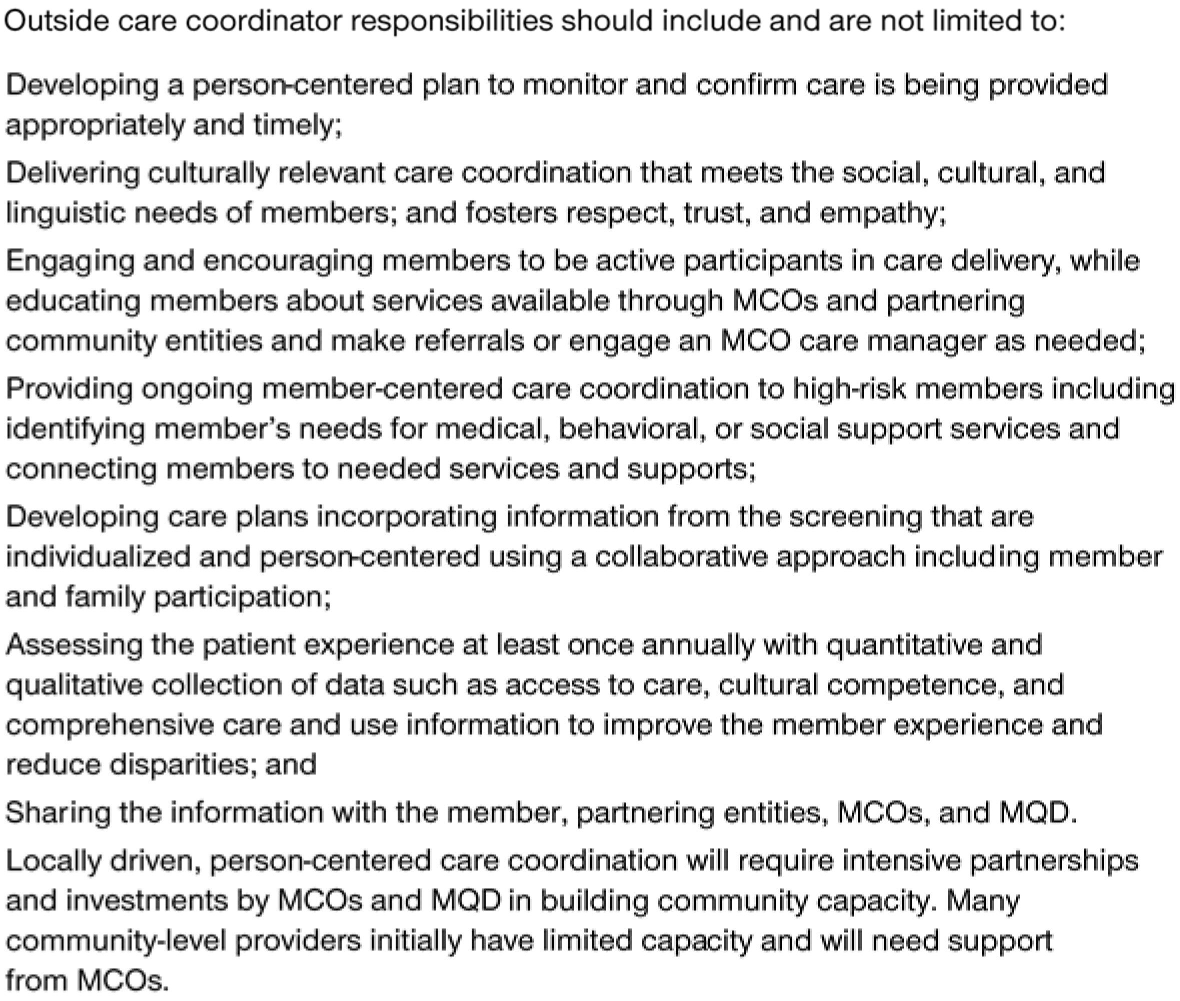
Sharing information such as ADT feeds and behavioral health admissions with care coordinators to provide timely interventions after ED visits, inpatient hospitalizations, and behavioral health admissions;

Providing access to up-to-date directories of in-network providers to facilitate care coordinators in scheduling appointments;

Enabling the innovative deliveries such as telehealth or telepsychiatry services for access to specialty services;

Informing care coordinators about in-network providers and pharmacies that can expedite appointments for members experiencing high risk care transitions (such as follow-up appointments of ED visits and inpatient hospitalizations); and

Helping care coordinators secure non-emergent medical transportation.



Outside care coordinator responsibilities should include and are not limited to:

Developing a person-centered plan to monitor and confirm care is being provided appropriately and timely;

Delivering culturally relevant care coordination that meets the social, cultural, and linguistic needs of members; and fosters respect, trust, and empathy;

Engaging and encouraging members to be active participants in care delivery, while educating members about services available through MCOs and partnering community entities and make referrals or engage an MCO care manager as needed;

Providing ongoing member-centered care coordination to high-risk members including identifying member's needs for medical, behavioral, or social support services and connecting members to needed services and supports;

Developing care plans incorporating information from the screening that are individualized and person-centered using a collaborative approach including member and family participation;

Assessing the patient experience at least once annually with quantitative and qualitative collection of data such as access to care, cultural competence, and comprehensive care and use information to improve the member experience and reduce disparities; and

Sharing the information with the member, partnering entities, MCOs, and MQD.

Locally driven, person-centered care coordination will require intensive partnerships and investments by MCOs and MQD in building community capacity. Many community-level providers initially have limited capacity and will need support from MCOs.

Unite US

Unite Us is a technology company that builds coordinated care networks of health and social service providers. The Unite Us has 200+ individuals across all departments, including a dedicated team of 85+ public health experts that build authentic, lasting community partnerships with network participants. This on-the ground approach ensures quality, accountability, and standardization of data sharing throughout all Unite Us networks and enables partners to use data-driven insights to improve care delivery. With Unite Us, providers across healthcare, government, and social service sectors coordinate in real time around shared clients, send and receive secure referrals, track every person's total health journey, and report on tangible outcomes across a full range of services in a centralized, cohesive, and collaborative ecosystem. This social infrastructure helps communities transform their ability to work together and measure impact at scale. This systematic and standardized approach to care and service delivery goes beyond referrals and closing the loop. This new model truly takes care of the whole person through uniquely designed networks of providers across the community who work together to ensure services are delivered and health is tracked and improved.

Kaiser Permanente:

While KP appreciates the value of these specialized “carve out” programs, we also understand that this specialization cannot come at the expense of the member’s experience receiving whole-person, person-centered care. Consistent and complete policies and processes for communication, data sharing, roles and responsibilities, and coverage policy are key to ensuring alignment between QI health plans and CCS, AMHD, CAMHD and CARES. We suggest that MQD convene workgroups with representation from each of the QI health plans and the state programs to establish policies and protocols that mutually benefit all involved parties.

Our Service Coordination team has already begun to see improvements and recommends ongoing work to improve structured avenues of communication. This includes communication at a leadership level to ensure that programmatic issues are being appropriately addressed as well as communication between case managers in state-administered programs and QI health plan care and service coordinators. These staff should have a consistent plan for sharing updated care plan information, changes in health or social status, medication changes, and any planned upcoming treatment, visits, or other interventions. It is also imperative that this includes plans for ensuring that all the member’s treating providers, including mental health providers, primary care providers, and other specialist providers are consistently aware of all changes in care plans, treatment, and medications.

In addition, there should be further clarity regarding roles and responsibilities. This is important not only to reduce duplicative work efforts for staff, but to avoid multiple redundant calls to members, which create both confusion and frustration. For example, for a member with comorbid medical and behavioral health conditions, who should be responsible for coordinating with hospital staff to ensure all services are in place at the time of discharge or for care transitions to a lower level of care? Similarly, if a member has a change is medications, who is responsible for communicating these changes to all providers involved in the member’s care?

Finally, it is important that responsibilities for coverage of services are clearly defined. This is not only important to understand financial responsibilities but allows staff to focus their energies on ensuring members are getting the care they require rather than questioning coverage responsibilities. For example, if a member calls into the CARES program and is recommended to receive a particular level of service, there should be clarity regarding the QI health plans’ role in determining the appropriateness of that level of service.

Hawai`i Primary Care Association

Responses to Question #3 are also relevant here.
Results should continue to be shared and responsibilities should be delineated by the care team responsible for delivering these services. Each care team should always have a primary care or medical home team member involved.
A coordinated plan of care is essential, particularly for high need high cost patients as untreated behavioral and support issues affect patient success. Therefore, increased access to more behavioral supports is critical.
There needs to be an efficient data sharing platform (payor agnostic) in

order to coordinate care between all programs.

A multidisciplinary care team along with a myriad of community-based social service providers may be involved in the care of a complex, highneeds, high-cost patient. MQD and MCOs should explore allocating resources for community level care management, where the health center, as the patient centered healthcare home, is central to this role.

Additional detail supporting these recommendations can be found in the HPCA High Needs High Cost attachment.

Ohana

‘Ohana supports a team-based approach to care that brings together all systems and providers involved in the member’s care to develop a fully integrated person-centered care plan. To foster accountability and facilitate close collaboration, we suggest that MQD collaborate with agencies that serve QI members to develop written protocols that outline the roles and responsibilities of each organization. Protocols could address topics such as:

- Expectations for participation in shared care planning
- Communication methods and points of contact
- Clinical support, such as case conferences, for members with complex needs
- Mechanisms for identifying and resolving problems
- Data and information-sharing
- Processes for referring members for services
- Cross-system training

Overall program effectiveness should be assessed through standard measures such as avoidable ED visits and inpatient admissions. MQD could consider executing shared savings contracts with these organizations to promote shared accountability for whole person care and improved outcomes.

Acumen Fiscal Agent:

When an MCO uses a Financial Management Services (FMS) company to run a participant-directed program, there is clear delineation of responsibilities to allow the FMS to assume complete accountability for the specific, complex back office aspects of self-direction. Qualified and experienced FMS’ are experts in these various processes and rules and can provide a cost effective, compliant solution to MCO partners and an easy to use, predictable service to participants and their employees. Self-direction is a highly cost effective model that allows individuals to have direct control over services with personal accountability for their care. This approach has been proven to improve outcomes for the people in supports as well as accountability of the program.

As an example, when a participant chooses to self-direct their services they commonly become an employer for their workers and their FMS becomes an Agent responsible for all withholding and filing of tax dollars associated with payroll. This requires expertise, processes and configurable technology that ensures all unique exemptions and exclusions are offered to employers and employees and the related “handling” of the related taxes. We recently encountered an example where an MCO was attempting to act as the FMS for a participant directed program and encountered a number of challenges as it related to State Unemployment Insurance filings and overlapping Tax ID numbers. These issues can be easily avoided by using an experienced FMS and will allow MCOs to focus on what they do best. Invariably, this will lead to a more cost effective solution and a better member / participant experience, overall.

Community First:

Whole person care requires a whole community caring with everyone being accountable, including the patient, health plans, and MQD as well as medical and social service providers. It requires a community coming together to develop effective care for the SHCN+. Medical and social service providers need to collaborate to create a system of care addressing both medical problems and the social determinants of health. Information and feedback systems should drive quality improvement and accountability across all entities. Let me illustrate with the work we’ve done in East Hawaii.

In East Hawaii we created the Community Action Network (CAN) and the Community QA Committee to formalize feedback, accountability, and improvement to develop effective care for these patients which we called the High Cost, High Need (HCHN). CAN was convened as a coalition of medical and social service providers with a focus on care coordination. These providers include organizations such as Hope Services, Hilo Medical Center, Community Paramedicine, Bay Clinic, Hui Malama Ola Na Oiwi, East Hawaii Independent Physicians Association, Big Island Substance Abuse Council, Hospice of Hilo, Legal Aid Society, and the County Office of Aging. CAN is led by Darryl Oliveira (manager at HPM and formerly fire chief and civil defense administrator of Hawaii County) and Randy Kurohara (small business owner and formerly managing director of Hawaii County). CAN participants are front line workers who understand the gaps in the system and between policy and reality.

We also created a Community QA Committee comprised of representatives from independent entities, such as medical and social service providers, and developed the legal structure to enable them to discuss patient cases and have their discussions protected. This grew out of animated discussions about cases which cut across providers and which could be discussed only a de-identified basis making it impossible to identify root causes of problems.

It is envisioned that systemic problems identified through case discussions would be referred to the CAN to address. To complement CAN, we are exploring creating a Regional Health Partnership with executive level participants who can more directly influence policy and make operational decisions. Alternatively, we may expand the Community First Board so that it can serve this function. As this example illustrates, creating community accountability and governance takes time. In East Hawaii despite five years of effort to organize the community around healthcare, achieving the potential of CAN and the Community QA Committee is still a work in progress.

Healthcare Association of Hawaii:

One of the main issues for coordinating services is that providers, by their nature, only see individuals for discrete issues and do not necessarily see or have control over the entire range of services, programs, or treatments of an individual receiving wrap-around services. It would be helpful to require QI plans to have more responsibility over managing the entire scope of care for an individual so that providers do not have to manage an individual's various conditions and services alone.

To this end, the service coordination role could be magnified to more effectively coordinate beneficiary services, programs, and treatments. If QI plans do not feel they are able to effectively coordinate this care, then it may be helpful to include requirements for plans to contract with providers who can or provide an enhanced rate to those providers who take on these roles. While we understand some of this may be underway with value-based initiatives and payment transformations, the responsibility of coordination should be more explicitly accounted for and described.

We also recommend that MQD contemplate ways to increase payment flexibilities, particularly as they relate to improving a patient's environment such as by addressing factors like social determinants of health. We understand that this would be a substantial undertaking that requires coordination with federal partners and other state Medicaid offices, but these efforts have the potential to generate substantial program savings and – most importantly – patient benefits.

CMCH:

This statement shows the high administrative burden and large number of programs that are created. As providers we do not want to have to work with different health plans for patients that has complex and social conditions. Streamlining these services would allow less confusion and redundancy. For each program there are administrators, supervisors and service providers along with charting and treatment plans. If the redundancy is decreased, then there will be more quality care for patients because the providers can focus on the patient rather than filling up all the forms that is required for patient treatment or continuity of care to another entity. Keep the medical and behavioral health services into one plan to reduce the burden of filling out paperwork for patient to receive other services. The patients can also get burden by going to transfer or receive services form different program. Yes, there will be times that they need special care or community integration but that can be done by having one health plan manage all the required services for the patient. As providers, we can be informed and aware of the plan for the patient.

AlohaCare:

AlohaCare supports and is committed to leveraging the expertise of various partners across the care continuum. We recommend MQD establish a multidisciplinary team to set expectations, requirements, and standardized technological solutions across the care continuum to improve shared accountability. If this is not addressed, duplication and fragmentation of efforts will continue, leading to increased program costs and suboptimal beneficiary outcomes.

AlohaCare offers the following specific recommendations to improve delineation of service delivery and improve beneficiary outcomes:

- Require interdisciplinary care team meetings as described above, between the primary care providers, the CSC teams, the beneficiary, and the beneficiary's family to support shared responsibility, improved communication, collaboration, and accountability in care and service delivery. Requirements for interdisciplinary care team meetings could be established through state-led forums or coordinated QI health plan regional and/or state-wide learning networks.

- Invest in a single shared platform to create a streamlined care plan and process for exchanging clinically relevant data and information between QI health plans CAMHD, CCS, clinicians, and community-based providers. A payer agnostic solution allows all entities role-based access to information such as Admit, Discharge, Transfer (ADTs), medical history, care plans, care gaps, and other beneficiary related details support information sharing across each beneficiary's care team.

- Establish consistent requirements and components for a joint inter-disciplinary care and services plan that identifies the lead agencies/individuals accountable for each area of a beneficiary's care plan including service provider, payer source for each identified service, timeframe for service initiation and renewals. This will help to document responsibilities and address accountabilities for shared beneficiary outcomes.

- Ensure transparency by reporting on how all responsible parties are performing against targeted measures. The availability of this information must be made available to stakeholders to ensure consistent outcome measurements are applied to all care and services providers for internal and external accountability.

- Expand MQD / QI health plan meetings to include clinical leaders such as pharmacy directors to discuss current trends and collaborate on best practice solutions.

Hawaii Health Information Exchange:

Based on the HHIE experience in assisting integrated physician networks and Medicare Quality Payment Programs, for questions 3 and 4, HHIE recommends that QI HEALTH PLANs be required to:

- Leverage HHIE's interoperability with hospitals', clinics' and providers' EHRs – current and in process – to route data to support QI HEALTH PLAN payment models. (Question 3)

- Incent the use of HHIE among the provider network as a common platform to share standardized data to enhance the value and data quality for population health analytics. (Question 3)

- Incent sharing of data to the fullest extent allowable by law and based on standards accepted by CMS, and as required by Med-QUEST policies. (Question 3)

- Provide education and tools to behavioral health and primary care providers and their staff so that they understand state and federal requirements to obtain patient consent so to allow the sharing information of information across providers for whole-patient care. (Question 4)

- In collaboration with Med-QUEST, identify an effective electronic Referral Platform, administered by a neutral entity like HHIE, and use the e-Referral Platform to securely deliver care and address the needs (medical and social determinants, like food insecurity, housing, etc.) of the Med-QUEST members. Metrics will be monitored and shared with the larger team to hold all parties accountable to the outcome and to promote the development of a Continuously Learning Healthcare system ((https://www.beckershospitalreview.com/quality/7-characteristics-of-continuously-learning-healthcare-systems.html) (Questions 3 and 4)

Heath Team Works:

Delegating and funding the care management of high and rising risk patients requires access to actionable data and standard workforce development training as described above. Not only is training essential to the workforce pipeline to ensure effective longitudinal and episodic support of high needs patients, it is important in addressing implicit bias and social determinants of health that can negatively impact individual and population health. Additionally, this flexibility afforded the practice allows for consideration of the right resource allocation based on a risk stratified empaneled population. For example, there may be a greater need for a nurse/clinical care manager providing additional support to high and rising risk patients, social work resources to support behavioral health and care coordination across clinical and community settings, and/or community health workers (CHW).

As patient risk and complexity rise, so too, does the need for coordination and communication across multiple settings and services. This is a continuing challenge in the absence of full HIT interoperability considering the many services (clinical and community-based) that impact a person's health. Solutions to reduce fragmented, disconnected, and at times, dangerous care must be multi-faceted and supported by technology, process, and people. Examples of people and process (human-centered design) approaches, supported by technology, may include the development and use of common care pathways, co-management protocols between providers and/or entities, full participation in the HHIE, integrated care models, collaborative care planning, interdisciplinary care conferencing, and enhanced clinical-community linkages. Patient-Centered Medical Neighborhood concepts certainly apply, but must reach beyond the walls of medicine to truly be effective.

Our recommendations for improving all aspects of whole person care and improving outcomes are the same as strategic considerations we advocate for in the response to question 3.

HMSA:

Members who are receiving services from multiple programs are often confused from their interaction with multiple caregivers. In addition, the current roles may be overlapping increasing the overall costs of the provision of services to QI members. Several suggestions for DHS to consider include:

- Systemwide clearly defined roles of the provider, community partners, and health plans.

- Single care plan to address complex member needs.

- Regular multi-disciplinary team meetings of all parties serving the member.

In addition, some level of centralized data and communication must be established before defining responsibilities and coordinating care. DHS should bring all entities (QI health plans, and their Care and Service Coordination (CSC) program leadership, CCS, CAMHD, AMHD, and CARES) together to collaborate and come to consensus on how to define responsibilities. The member should choose the entities that participate in delivering their care and how they interact with the member.

If the member qualifies for one of the waiver or carved-out programs (Developmental Disabilities/Intellectual Disabilities (DDID), CAMHD or CCS), the health plan can delegate care coordination, as they have expertise in caring for the particular needs of these types of members. This allows for prompt delivery of services and avoids the “back and forth” communication that would take place if the health plan were managing care. This process offers a better member experience by simplifying communication for the member. The health plan would continue to oversee activities and outcomes to see that medical needs are being met.

For members receiving CIS, the recommendation would be that health plans should allow the homeless community partners to provide care coordination to this population, as they have deep expertise in this area. The health plan will continue to oversee the delegation. For members with both Medicare and Medicaid (i.e., dual members) the recommendation is that DSNP members have the same QI plan to simplify the coordination of benefits.

Ohana Pacific Management Company:

Similar to the prior response, an delegated entity should manage and coordinate care for individuals assigned to a QI health plan as part of any Medicaid procurement and should require any QI health plans to actively coordinate an ensure continuity with programs as part of their contract.

Additionally, this coordination should be monitored to ensure a specific target or

measurable ranges of coordination are achieved or result in corrective action for any procurement award. These can be measured through quality indicators and QI health plan reporting or through a delegated entity if that option is selected.

Pacific Medical Administrative Group

Integrated Health Hawaii’s Care Coordination (IHHCC) model has encountered common issues regarding delineation of responsibilities amongst a variety of programs and has used evidence-based practices to help meet these challenges. Using models of best practices services at both at the educational and programmatic level is critical to ensure service/care coordination staff are fully aware and trained of the unique differences in health plans and challenges in healthcare delivery. Service/care coordinators should maintain ongoing communication with all entities of patients’ care to avoid delivery fragmentation resulting in gaps in care. When there are gaps needed care coordination such as during transitions between services and providers, it can be detrimental to the patient and expensive for the health care system. Ultimately, IHH CC’s take full responsibility of whole patient care often coordinating multiple community and health plan service coordinators and community-based case managers. IHH CC attend IEPs, court proceedings, arrange transportation, translators, set medical and psychiatric appointments, complete any and all applications with/for member, write appeals, conduct crisis intervention and suicide prevention when other community/health plan service coordinators cannot or will not. IHH CC's initiate regular monthly consult meetings with both medical and behavioral health service coordinators from the health plan to prevent confusion, establish accountability, and agree on specific tasks and responsibilities.

Documenting the outcomes of those receiving care coordination services is vital program proof-of-concept but more importantly to program sustainability. IHH CC's work with PMAG PCPs to administer monthly evidence-based screeners to members such as the PHQ-9, GAD-7, and SBIRT to evaluate and assess patient progress. IHH CC also developed an innovate tracking system to monitor all care coordination activities and conduct internal quality improvement activities to ensure patient engagement and provider satisfaction

Providing uniform standards of care, health plans, and payment schedules based on evidence by the patient's service/care coordination network can help avoid the undertreatment and overtreatment in healthcare (Kearney, 2017). National guidelines suggest that much of the rejection of services that can lead to undertreatment should focus on individual/patient centered care that balances risks and benefits (NIH, 2016). Care coordination services are optimally positioned to meet those guidelines and provide the necessary and accessible treatment while considering the whole patient and the variety of risks and benefits that are possible.

Waikiki Health Center:

Services through different programs can cause fragmentation in care. Regular meetings to coordinate care is essential. This will prevent duplication and also promote better outcomes.

Waianae Coast Comprehensive Health Center:

Care and Service Coordination - It is the Health Center's experience, that the active engagement of community members, including Medicaid consumers, increases the probability of achieving sustainable improvement in outcomes. Selected strategies and innovations that generate from the community will have a far greater chance of affecting change. This is particularly true where communities are low income and multi-generational. Health plans that can demonstrate strong evidence of active community engagement should be highly valued in the QUEST RFP process.

Queens's:

There needs to be a clear accountability structure to ensure shared accountability for whole person care and improved outcomes. Communicating the well-defined roles, workflows and care conferencing/IDT teams from the outset is critical for the management of care for beneficiaries.

Responsibilities could be delineated by:

- *Clearly defined ways to communicate information and data sharing*
- *Quality of Care, total cost of care data sharing (concurrent) ie: last quarter here is the total cost of care for the population, trends, etc.*
- *Clear Metrics: Total cost of care, quality, utilization, outcomes*

Hawaii Pacific Health:

The most difficult challenge is assignment of agency for the total health outcome of the Medicaid client that spans across the various agencies, program requirements, and payment requirements that the patient will encounter.
For example, as a pediatric services provider, we encounter this often in our pediatric cases involving Child Welfare Services (CWS) care coordination where significant barriers to finding a disposition or resource caregiver/foster home exist.
The current process is resolved through multiple individuals representing these different programs from each of the state departments – DHS, CWS, CAMHD etc. It is very helpful to have all the resources offered and the willingness to meet together to discuss a discharge plan is greatly appreciated. However too often the Provider based case manager is directed back and forth between each division and struggles with communication and decision making.
Delegation of a DHS level of coordination to work across the various programs to drive the process instead of Provider Case Manager/Social resources to work between these divisions to create a discharge pathway for these patients would be ideal.

HHAeXchange:

Care and Service Coordination

In working with many Managed Long Term Services Supports (MLTSS) plans, and seeing overpayments for claims that do not reconcile against the Cures Act, best practices dictate that the state require the MCOs to have a pre-billing review process that ensures Cures Act compliance with the necessary six data points. These pre-pay claim edits must include LTSS service codes. This will make certain that the State does not have to chase overpayments.

Industry-leading EVV vendors should provide a balance to the complexity found in adhering to the federal EVV mandate to reduce fraud and the overall goal of improving outcomes for the growing number of chronic members in need of homecare services. The selected EVV solution needs to provide payers with oversight and prevent fraud, waste, and abuse, while helping providers to better meet Medicaid requirements and stay within authorizations to ensure prompt delivery of payments.

MCOs can reduce FWA across their provider networks by leveraging an EVV vendor’s advanced reporting and business intelligence, giving them actionable data at a 30,000-foot view, as well as on an individual provider level. MCOs should also validate billed services according to the
individual’s authorization and the MCO’s required scope, duration, and frequency of service. This ability strengthens quality assurance for PCS and HHCS by improving health and welfare of individuals by validating delivery of services. The MCOs get real-time insights into the services provided to their members, including EVV compliance, underutilized authorizations,

missed & short visits, billing, and more.

These important activities and the resulting value are not “just” about mitigating fraud, waste, and abuse. Lowering the incidence of missed or truncated visits and deviations from service plans result in higher quality care. In addition, through the gathering and aggregation of clinical data through these processes, it is likely that the State will gain new insight into the care given and will be able to drive policy, set rates, and consider new value-based payment methodologies.

Crystal Costa:

Situation: Care Coordination is often disorganized and siloed
In our opinion, health plans often have a rigid, compartmentalized approach to care coordination and which limits their ability to effectively engage, coordinate, and manage, on a member-by-member, day-to-day basis, care of members who are medically complex, vulnerable, and who may have ineffective caregiving resources.

Background:
Health plans historically have had difficulty engaging QUEST members in case management and shared decision-making. Reaching highest need QUEST members by phone has been exceedingly challenging and health plans often close cases after a specified number of attempts to reach the member have failed. When members do engage, the care plan developed is often fragmented, ineffective, and inaccurate due to a lack of valuable input and collaboration from the core care team treating and supporting the member as well as the member themselves.

Assessment:
Health plans care managers and service coordinators face many barriers in the ability to effectively engage and coordinate care as there is a strong emphasis on telephonic versus in person assessment. Medically and socially complex individuals require robust care-coordination, and integration across all care venues. To accomplish this there needs to be much stronger partnerships with the providers and care managers who are part of the direct care team. In our community in general there is a lack of competence in the areas of active listening, eliciting patient viewpoints and preferences, skilled facilitation of goals of care discussions, care planning, and ability to advocate for coordinate care among all providers treating the member. There is often a lack of trust on the part of the member and direct care team in part due to a poorly defined role and purpose of the health plan team.

Recommendation:
Health Plan CM’s should partner with and provide extended care team support to the palliative care team involved in direct patient care. This team based approach puts the patient at the center and provides seamless integrated care. The aim of interventions should be the stabilization of the member, medically, socially, spiritually, psychologically, etc. as well as the maximization of outcomes of any therapies or interventions the member chooses to pursue. Each care team member should have a well-defined role that is communicated with the member and all care givers. Serious complex chronic conditions often follow a waxing and waning trajectory and it is not unusual for people to experience periods of relative stability punctuated by exacerbations or crises. Because member needs

can fluctuate it is important for health plans to build in flexibility and the ability to dial the intensity of services up or down depending on the needs of the member.

It is important that health plans include face to face visits with QUEST members deemed to be the most complex, vulnerable, or requiring highest levels of support. While this can be an intensive level of care, applied carefully, consistently, and for the most appropriate members, face to face encounters integrated with the core care team will provide these members with the time, space, and skilled facilitation to develop strong therapeutic relationships and improved health outcomes. It would serve health plans well to turn to providers in the community who already are engaged in such activities and show a high level of competence in the areas of active listening, eliciting patient viewpoints and preferences, skilled facilitation of goals of care discussions, care planning, and ability to coordinate care among all providers treating the member.

For these most vulnerable and needy members we would recommend that attention be paid to partnering with organizations and providers in the community who either currently are providing high quality palliative care or who are interested in and potentially capable of developing such capacity. This requires a clear definition of palliative care which would be applied as well as core elements/standards which is expected of any palliative care program to adhere to (Please see the attached CAPC definition and list of standards supported by the statewide palliative care summit conducted in April 2020, *Attachment 1*). Then a current environmental scan should be compiled and updated and a decision made about which programs would be allowed to provide palliative care services.

Situation:

How should responsibilities be delineated when members are receiving care administered by QI health plans and/or outside programs that results in shared accountability for whole person care, while also improving outcomes?

Background:

In our experience, health plan case managers should always be apprised of the member's situation and conditions and ultimately are responsible for recommending programs and services to fill member needs. However, at any point in time the case manager on the team *actively managing* day-to-day care of the member needs to assume first chair and should be responsible for keeping the health plan case manager up to date and informed about the status and care plan for the member. In the case of a medically complex and fragile QUEST member who meets criteria for palliative care, the palliative care team should have primary responsibility for ensuring that an appropriate care plan (in which the member, family, and providers have all shared in its creation) is created, updated, documented, and shared among all members of the team. In addition, this team should be clear that they are responsible for engaging providers who are actively treating the member to ensure that everyone is working from the same care plan.

In addition, it is our experience that palliative care is not well understood among community health care providers, leading to underutilization of palliative care services. Health plans can probe their data bases to identify members who potentially could be better managed in a palliative care program.

Assessment:

These community-based teams are highly valuable but may not be fully versed and informed about QUEST benefits and processes and the health plan must take responsibility for ensuring that services and benefits are applied in appropriate, compliant, and thoughtful ways as well as maintaining availability to answer community staff questions and explorations.

Recommendation:

Health plans should develop an evidence-based population health methodology for identifying those members who may be appropriate for palliative care services and report regularly to PCPs, specialists, and physician organizations about who among their patient panels might be considered for referral.
Health plan case managers and service coordinators should maintain a mutually respectful, close, and active partnership in the support of every QUEST member deemed to be appropriate for a higher level of service.

Promoting a Behavioral Health Continuum

(Limit response to 3 pages)

Question 5 – What opportunities should MQD be aware of to integrate behavioral health with physical health across the continuum for Medicaid beneficiaries? What is the role of primary care in integration? What strategies should MQD consider adopting that support integration at the provider level?

Lana`i Community Health Center:

- Primary care integration is embedded at various levels across health centers and many of the innovative programs are grant-supported.
- Embedded behavioral health providers in primary care promotes a whole person continuum. Warm handoffs to behavioral health would allow for immediate connection and support for a patient and primary care provider and facilitate follow through in a follow-up referral to behavioral health.
- Allowing for innovative programs (alternative healing programs) to address behavioral needs that are integrated in primary care provides opportunities for MQD.

UHC:

UnitedHealthcare supports MQD’s vision of the Hawai’i ‘Ohana Nui Project Expansion (HOPE) program and the focus on increasing access to primary care and behavioral health with the integration of physical health across the continuum of care.

Role of Primary Care in Integration

Many members do not experience physical and behavioral health issues separately and primary care providers (PCPs) are often the first point of contact for members who would benefit from behavioral health services. Engaging with PCPs (who typically already have an established relationship with the member) results in better member care. It can help to change the attitude about behavioral conditions, reduce stigma and increase the likelihood of an individual suffering from a mental health or substance use condition will receive timely and appropriate intervention and treatment. Recognizing the COVID-19 pandemic has had a serious impact on the behavioral health and wellness for many, MQD's focus on building capacity in the primary care setting will help Hawai'i respond to the lasting behavioral health effects of the public health emergency.

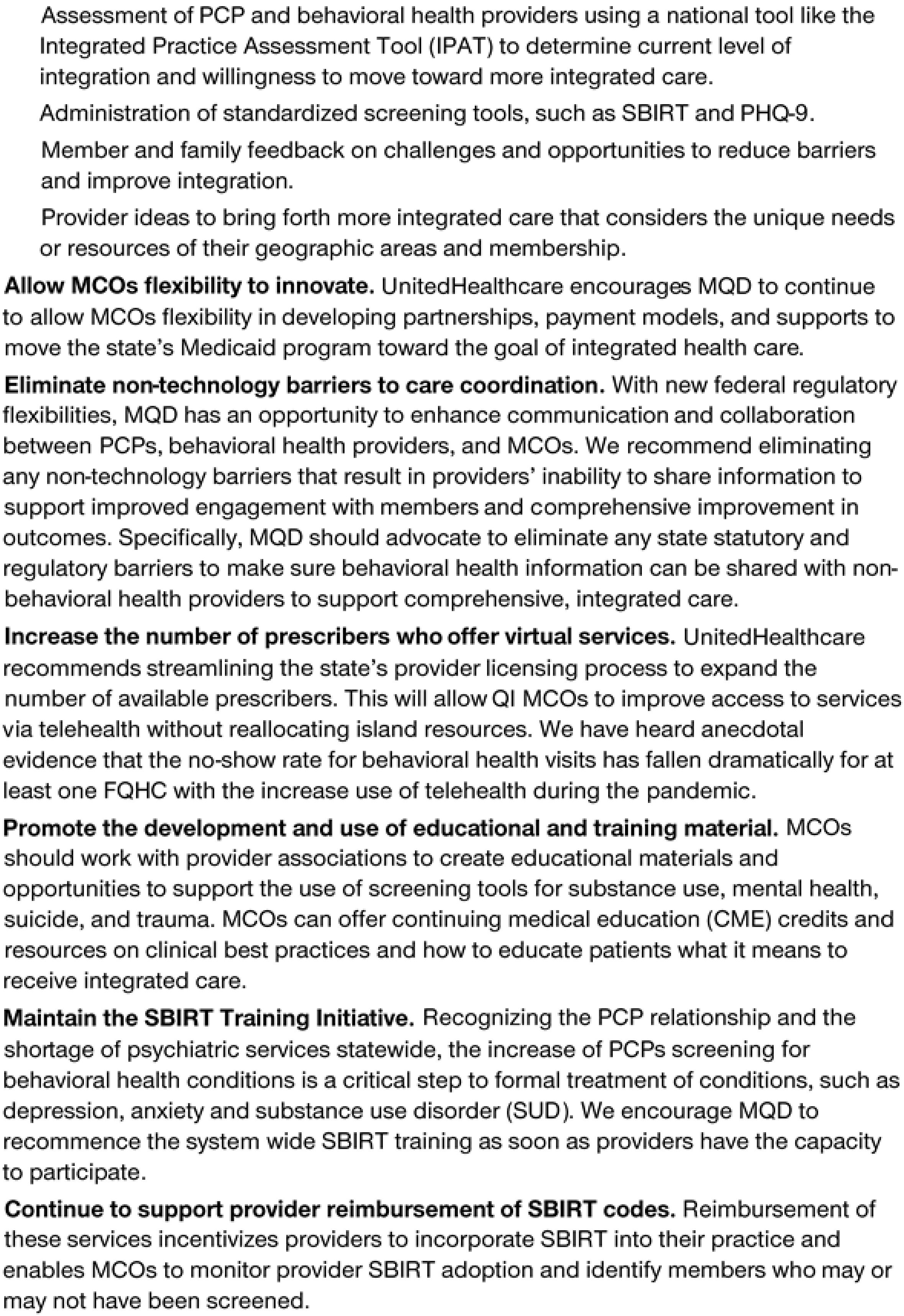
Additionally, individuals living with a serious mental illness (SMI) are at higher risk of experiencing chronic physical health conditions and dying earlier. Members with an SMI can benefit from more regular engagement with both their behavioral health and PCP and their increased coordination.

PCPs can be supported in their integration efforts with several tools and resources such as evidence-based screening tools (e.g., SBIRT), the facilitation of relationships with behavioral health providers, educational resources, integrated clinical tools, technical assistance and ongoing integration supports.

Opportunities to Advance Integration

To promote integrated care, UnitedHealthcare recommends the following strategies:
Facilitate solution-oriented collaboration. To support behavioral health integration, we recommend a cross-functional stakeholder work group across MQD, QI MCOs, BHOs, providers associations, stakeholders and other agencies to discuss strategies and identify solutions for addressing specific challenges and barriers in integrating care and accessing behavioral health services. Activities that could be discussed include:

- Development of tools focused on strengthening the knowledge and skills of PCPs to deploy more preventable approaches to mental health well-being such as motivational interviewing.



Assessment of PCP and behavioral health providers using a national tool like the Integrated Practice Assessment Tool (IPAT) to determine current level of integration and willingness to move toward more integrated care.

Administration of standardized screening tools, such as SBIRT and PHQ-9.

Member and family feedback on challenges and opportunities to reduce barriers and improve integration.

Provider ideas to bring forth more integrated care that considers the unique needs or resources of their geographic areas and membership.

Allow MCOs flexibility to innovate. UnitedHealthcare encourages MQD to continue to allow MCOs flexibility in developing partnerships, payment models, and supports to move the state's Medicaid program toward the goal of integrated health care.

Eliminate non-technology barriers to care coordination. With new federal regulatory flexibilities, MQD has an opportunity to enhance communication and collaboration between PCPs, behavioral health providers, and MCOs. We recommend eliminating any non-technology barriers that result in providers' inability to share information to support improved engagement with members and comprehensive improvement in outcomes. Specifically, MQD should advocate to eliminate any state statutory and regulatory barriers to make sure behavioral health information can be shared with non-behavioral health providers to support comprehensive, integrated care.

Increase the number of prescribers who offer virtual services. UnitedHealthcare recommends streamlining the state's provider licensing process to expand the number of available prescribers. This will allow QI MCOs to improve access to services via telehealth without reallocating island resources. We have heard anecdotal evidence that the no-show rate for behavioral health visits has fallen dramatically for at least one FQHC with the increase use of telehealth during the pandemic.

Promote the development and use of educational and training material. MCOs should work with provider associations to create educational materials and opportunities to support the use of screening tools for substance use, mental health, suicide, and trauma. MCOs can offer continuing medical education (CME) credits and resources on clinical best practices and how to educate patients what it means to receive integrated care.

Maintain the SBIRT Training Initiative. Recognizing the PCP relationship and the shortage of psychiatric services statewide, the increase of PCPs screening for behavioral health conditions is a critical step to formal treatment of conditions, such as depression, anxiety and substance use disorder (SUD). We encourage MQD to recommence the system wide SBIRT training as soon as providers have the capacity to participate.

Continue to support provider reimbursement of SBIRT codes. Reimbursement of these services incentivizes providers to incorporate SBIRT into their practice and enables MCOs to monitor provider SBIRT adoption and identify members who may or may not have been screened.

Build behavioral health capacity. Once a member is screened, there must be adequate treatment capacity to make a successful referral. We recommend MQD leverage opportunities to expand telehealth, such as the opportunities noted in Question 10, and encourage the MCOs to collaboratively engage in capacity building activities.

Kaiser Permanente:

Across the United States, behavioral health conditions, including mental health and substance use disorders, are often underdiagnosed and treatment is delayed.1 According to the National Institute for Mental Health, primary care settings provide approximately half of all mental health care for common psychiatric disorders. Ensuring primary care providers are appropriately incorporating behavioral health screening, identification, and treatment in their practices is paramount to addressing these concerns. Currently, integration of behavioral health with primary care/physical health spans a continuum, from minimal coordination to full integration with behavioral health care providers working directly with the primary care provider and using shared electronic health records (EHRs) to ensure Medicaid beneficiaries are receiving whole-person care.

In Hawaiʻi, primary care providers currently operate at varying levels across this continuum. QI health plans should be expected to offer their contracted providers education, training, and both financial and non-financial incentives to move along this continuum of behavioral health integration. QI health plans should also be expected to seamlessly incorporate behavioral health into their member outreach and education and their care and service coordination activities.

MQD should consider convening all participating QI health plans to address behavioral health integration in primary care to allow an opportunity for the health plans to come to consensus on the types of screening tools required and education offered for primary care providers. By simplifying the process, and creating consistency, MQD appropriately would be playing an important role in creating administrative simplification and driving improved integration of behavioral health in the primary care setting.

MQD should consider giving preference to those plans that are able to demonstrate a provider network that performs at the highest level of the behavioral health care continuum. Similarly, behavioral health integration should be incorporated into Value Based Payment (VBP) strategies to improve both physical and behavioral health outcomes.

Hawaiʻi is faced with a shortage of behavioral health providers. By appropriately arming primary care providers with the resources and incentives to improve their ability to provide behavioral health care, the State can improve access to specialized behavioral health providers. When primary care providers are providing behavioral health care for patients for common conditions, such as depression and anxiety, they are creating capacity for specialist behavioral health providers to treat patients with more severe behavioral health needs.

Hawai`i Primary Care Association

Primary care integration is embedded at various levels across health centers and many of the innovative programs are grant-supported. Embedded behavioral health providers in primary care promotes a whole person continuum. Warm handoffs to behavioral health would allow for immediate connection and support for a patient and primary care provider and facilitate follow through in a follow-up referral to behavioral health.

Allowing for innovative programs (alternative healing programs) to address behavioral needs that are integrated in primary care provides opportunities for MQD.

MQD should continue to value telehealth and telephonic access for members/communities that may not have access to a sufficient network of behavioral health providers onsite or on-island.

MQD should engage HPCA to understand health center primary care integration efforts (e.g., Primary Care Integration Initiative, Collaborative Care Model, SBIRT) and successes and lessons learned.

MQD, in conjunction with MCOs, should consider investing in innovative programming and working with HPCA to develop evaluations, gather best practices, analyze return on investment, and bring successful programs to scale. HPCA can provide more detail on the types of integration programming being implemented across health centers.

Ohana

As the only QI health plan that also serves the CCS program, we are uniquely qualified to provide perspective on the opportunities to integrate behavioral health and physical health for Medicaid beneficiaries. We fully support MQD’s goal to align services and suggest that MQD consider the following opportunities to integrate behavioral health with physical health services: ☐ Encourage providers to adopt a Collaborative Care Model, which has proven to be effective in terms of controlling costs, improving access, improving clinical outcomes, and increasing member satisfaction in a variety of primary care settings – rural, urban, and among veterans.

☐ Promote value-based payment models that incentivize providers to implement integrated care models, including coordinated care, co-location, and integration.

☐ Implement Behavioral Health Home models that allow behavioral health providers to serve as the member’s PCP.

☐ Align incentives for improved outcomes across the QI and CCS programs.

- Include non-traditional services that support the whole person, such as crisis, recovery coaches, employment and education support, food services, housing and family support as part of the benefit package for the QI program. Weave behavioral health-related performance measures and processes into MQD’s Quality framework.

‘Ohana’s affiliates have supported system transformation efforts in other states that have moved to integrated care models. We look forward to sharing lessons learned with MQD to inform implementation of effective approaches in Hawai’i.

PCPs play a crucial role in integration as they are most likely to see the member and are often the first provider to identify when a member has behavioral health needs. Specifically, they can perform the following activities in an integrated care model:

- Screening and assessing the members’ whole health needs.
- Coordinating care across all providers participating in the member’s care.
- Participating in care teams and care planning for members with complex needs.
- Managing referrals to specialty services.
- Maintaining the member's medical record, including receiving documentation of all services provided by specialty services.
- Providing health promotion services to support members and families in adopting healthy behaviors.
- Identifying members who are potentially high-cost, high-utilization, complex, or special needs cases.

SUPPORTING INTEGRATION AT THE PROVIDER LEVEL

MQD can further support a whole health approach that considers members’ social, physical, and behavioral health needs through the following activities:

- Assist in developing formal referral protocols between providers and local and state social services agencies to facilitate member access to these critical supports.
- Reimburse behavioral health providers for completing physical health screenings.
- Encourage the use of e-consults and clinical support to enhance providers’ capacity to serve members with complex needs.
- Reimburse providers for on-site care coordination.
- Incentivize providers to participate in data and information-sharing to deliver actionable data at the point of care.
- Design payment approaches that consider the total cost of care for appropriately serving and supporting members with complex needs.
- Support development of a common member consent among all healthcare providers in the community so that hospitals, PCPs and behavioral health providers can effectively share physical and behavioral data through common, legally compliant, and secure exchange protocols.

Collective Medical:

Too often, health plans isolate their mental health case managers from their physical health care managers. In states like Hawai’i that have carve-out behavioral health plans, the need for data sharing only intensifies. Opportunities for integration across the care continuum open up dramatically with increased opportunities for high-quality communication among providers and payers.

Emergency department overuse is one area many systems choose to target using a data sharing platform, and this can be a fruitful place to catch opportunities to improve efficiency, experiences and outcomes surrounding behavioral health patients Imagine the very common scenario of a patient in a behavioral health-related crisis presenting in the emergency department, needing care. With no background or communication, the ED staff has to fly blind with a patient in distress, with risks they don’t know about, likely unaware of diagnoses or care history. With a robust data sharing platform, however, the ED staff might have some or all of the following advantages:

- A one-page notification that surfaces the patient’s main diagnoses, including mental illness if applicable, COVID-19 testing status if applicable, history, and medications
- A warning if the patient has a history of security incidents
- A Care Insight (unique to Collective) from the patient’s primary care provider with personalized notes about the patient’s needs and preferences
- Information from Substance Use Disorder providers, depending on patient consent under 42 CFR Part 2 (Collective offers a Consent Module for this purpose)
- Information about the patient’s interaction with certain community supports, such as the patient being on a HUD assisted-housing voucher waiting list
- Alert sent to the patient’s behavioral health provider so that they can follow up--or even intervene immediately, in some cases
- Alert sent to the patient’s primary care provider so that they can follow up
- Alert sent to home health or skilled nursing, if applicable, so that they can collaborate to avoid unnecessary hospital admission or readmission
- Alert sent to the patient’s payment source so that they can ensure the patient is seeking care in-network and engage care management when needed

The alerts mentioned here are sent within minutes into the recipients’ chosen means of delivery—text, e-mail, or even directly into an EMR track board. When information is shared in real time with the care team, true collaboration becomes possible in a way that would normally require the entire team to be housed under one roof. The role of primary care becomes more equalized with the rest of the team—they have the same opportunities to send and receive information as hospital staff, behavioral health providers, or payers.

Collective therefore recommends that care integration rest upon a solid, national data-sharing platform with robust capabilities for communication among the entire care team. Our customers have seen significant success using this approach:

- The SUD program at Hardin Memorial Hospital (HMH) in Kentucky, has used the platform to connect to local SUD clinics such as Step works, a treatment and recovery center with five locations. The Step works care manager gets a real-time notification when one of their patients is in the HMH ED, which allows them to reach out to the ED social worker and meet the patient at the ED before opioids are given. Step works can intervene before the patient leaves the hospital, and in all but a few cases, these patients have chosen to re-engage in treatment.

- Virginia's Emergency Department Care Coordination (EDCC) program, launched in the summer of 2017, helps ED staff identify if a patient has been seen somewhere else, how they were treated, who their primary care provider is, and if they've had any controlled substances prescribed to them. Giving medical providers access to critical patient information in real time has helped decrease fatal opioid overdoses from 1,230 in 2017 to 1,213 in 2018. Additionally, all fatal drug overdoses in Virginia dropped from 1,536 in 2017 to 1,484 in 2018.
- Aspire Health Alliance runs a behavioral health program for Massachusetts' Medicaid program, MassHealth. The program is opt-in only, which meant traditionally participation rates were averaging 10 percent. With expanded data sharing capabilities, Aspire case managers receive real-time notifications and can follow-up with patients while in the ED, instead of contacting them down post-discharge, leading to a 50 percent opt-in rate for behavioral health programs when patients are engaged in the ED, and an overall 35 percent participation rate.

Community First:

In East Hawaii access to behavioral health services needs to be addressed before considering integration with primary care. There may not be a shortage of Masters level providers, but there is clearly a problem of access. Low Medicaid reimbursement is often cited as a reason providers are not taking new patients, but even more significant may be the unreliability of these patients to keep appointments. Perhaps rather than not enough behavioral health providers, there are not enough community health workers to ensure low no-show rates.

To improve access, MQD can shift from a FFS model to a PMPM model for behavioral health services. This would mitigate the low reimbursement rate and the high no show rate. One behavioral health provider (BHP) could support several medical homes, and as the partnership between them and PCPs mature, PCPs may become comfortable managing psychotropic medications in coordination with BHPs. This could alleviate the shortage of psychiatric resources.

Behavioral telehealth should be promoted. The COVID-19 pandemic has caused a dramatic increase in utilization generally but particularly in behavioral health. Many more physicians are trying it, and insurance regulations which were barriers were removed during this crisis. Getting BHPs onto a PMPM would ensure that insurance regulations do not once again become barriers.

CMCH:

MQD should act as a leader to initiate and finalize the coordination of mental health providers and primary care providers to come up with agreements to treat and to integrate the EMR systems so records can be shared amongst all providers, hospitals and clinics. The role of primary care in integration is to ensure that it can meet all patient’s health care needs in once setting across the continuum of care for Medicaid beneficiaries will be one of the best thing that any providers can wish for their patients. Services can also be delivered multiple ways depending who is providing the care and what type of care the Medicaid beneficiaries needs and the location where the service will be provided. Integration of care can take place in any behavioral health clinics with primary care also in the same clinic.

AlohaCare:

AlohaCare supports the Collaborative Care Model to integrate BH with PH across the continuum of care for Medicaid beneficiaries. Supporting primary care providers in meeting the BH needs of patients is critical to achieving coordinated, integrated whole person care. The Substance Abuse and Mental Health Services Administration (SAMHSA) identifies incorporating BH screenings in conjunction with collaborative care as one effective approach for integrating BH into primary care settings.

Investing in primary care and preventive care for all Hawaiʻi residents is one of the key strategies to meeting the HOPE initiative goals. As such, encouraging and supporting primary care clinicians to screen for BH needs and co-occurring PH conditions is critical to meeting the overall health needs of patients and increasing overall population health.

AlohaCare recommends that MQD allow QI health plans to provide care coordination/case management and support for current Levels I-IV CCS beneficiaries. This will provide greater opportunities to integrate physical and behavioral health care for beneficiaries with moderate BH needs. Having the QI health plan be responsible for beneficiary assessments and engagement, maintenance of a comprehensive provider network, and development of innovative payment incentives creates more opportunity to achieve integration at the provider level.

AlohaCare offers the following specific recommendations to promote the adoption and integration of BH at the provider level and within the care continuum:

- Support primary clinicians to adopt screening for BH needs using nationally recognized screening tools such as the PHQ-9, GAD 7, SBIRT or CAGE-AID through contractual requirements and/or incentives.
- Expand use of peer support and community health workers to assist primary care practices and other providers to support beneficiaries in their recovery process and meet their identified joint care plan needs.
- Continue support for BH telehealth e-consults to assist primary care providers with screening, identification, and initiation of beneficiary care and treatment within the primary care setting or through referrals to BH specialty care providers.
- Develop and promote a provider learning forum among MQD, CCS, AMHD, CAMHD, CARES and all QI health plans to provide PCPs with the training, tools, and processes necessary to support adoption of integrated screenings. This could be accomplished through web-based training platforms, regional forums, or virtual trainings such as Project ECHO with shorter modules to promote increased adoption within the primary care practice.

- Develop payment structures to promote integrated care that support alternative provider payment opportunities. If MQD continues to procure both QI health plans and the CCS program separately, MQD should consider a collaborative payment model and performance initiative across both programs that supports joint beneficiary stratification, care plan development and clinical outcome measures.
- Establish standards for interdisciplinary team structure for members receiving CCS, including the QI health plan pharmacist whose role would be to complete a medication review.

Hawai’i Integrated Early Childhood Behavioral Health Plan Advisory Team:

Promoting a Behavioral Health Continuum (MQD RFI Questions 5 and 6)

MedQUEST Division (MQD) can set the foundations for lifetime wellness by putting additional attention, support, and resources toward early and on track development and health as part of MQD’s strategy to integrate physical and behavioral health. Infant and early childhood mental health is a cross disciplinary field of study, research, and practice that focuses on the wellbeing of very young children within the context of their early relationships, family, community, and culture. Early relationships lay the foundation for a child’s lifelong health and wellbeing by supporting resilience as a young child learns to cope with stressors and environmental demands.

There are several existing efforts underway that can enhance MQD’s implementation of MCO contracts and a focus on the youngest children and their parents/caregivers.

1) The Advisory Team submitting this response is developing an integrated Early Childhood Behavioral Health Plan for release in December 2020 with feedback from stakeholders and consultation support from West Ed Center for Prevention and Early Intervention. The Plan enables Hawai‘i to create an integrated child and family serving system that promotes school readiness and family success by aligning child and family mental health, trauma-informed care, and health systems and services with early learning systems across public agencies, community-based providers, and other stakeholders.

2) Association of Infant Mental Health Hawai‘i (AIMH-Hi) houses an Infant Early Childhood Mental Health endorsement process for Hawai‘i. Currently, AIMH-Hi is offering community trainings as well as working with a select group of 15 clinicians through a Fellows Program with the goal of increasing the individual’s expertise on infant early childhood mental health and our community’s overall capacity for mental health consultant for early childhood providers giving Hawai‘i a pathway to multi-level professional endorsement.

3) Hawai‘i Community Foundation leads Promising Minds, an initiative to increase the healthy development of vulnerable children ages 0-5 and build resilience in those who have already experienced the negative effects of trauma in their short lives. Across five communities with at-risk families, 45 early childhood professionals across various settings have been trained on working with children and families with risk and creating trauma-informed care and early learning environments; another 30 professionals will finish their training by the end of 2020. Promising Minds also is working to increase the supply of transdisciplinary professionals with early childhood behavioral health expertise available for consultation in partnership with AIMH-Hi. The Promising Minds Initiative is

jointly financed by seven funders including two national foundations.
4) Hawaiʻi Maternal and Infant Health Collaborative is working to create an integrated perinatal care coordination model for substance using moms and their infants. The approach includes screening, referral, and treatment in the prenatal period, combined with ongoing support and treatment during the postpartum period.
5) Early Childhood Action Strategy in collaboration with the Department of Health's Early Intervention Section, is supporting the development and implementation of an integrated and comprehensive early childhood system of personnel development (CSPD) for disciplines serving infants and young children with disabilities. The CSPD project will help to improve recruitment and retention of transdisciplinary professionals that can fulfill screening, intervention, and treatment needs as covered by QUEST and other insurance plans.

1. Centering the young child in behavioral health integration with primary care

Recommendation 1.1. Separate out screening from bulk payment. *Rationale:* Developmental (e.g. ASQ or ASQ-SE) and other qualified EPSDT screenings are currently conducted in the Well Child Visit. Physicians should be financially incentivized to complete the developmental screenings separately from a regular Well Child visit because they are not getting reimbursed for the time to complete the screening. Additionally, the QUEST reimbursement rate for screening is low, which results in low physician compliance and is a potential barrier for physicians to consistently screen their patients.

Recommendation 1.2. Clarify a list of Infant Early Childhood Mental Health Diagnostic Guidelines eligible for QUEST reimbursement. *Rationale:* Hawaiʻi does not yet have a defined list of diagnostic guidelines that providers can reference to understand qualifying assessments, diagnosis, and treatments. Without guidelines, clinicians and practitioners are not providing reimbursable interventions and treatment for young children and their parents or provide the service without QUEST reimbursement.

Recommendation 1.3. Ensure payment standards (the range for the payment rate) for MCOs is competitive for Hawaiʻi's market. *Rationale:* Without competitive rates for screening, intervention, and treatment, it will be difficult to fully serve the QUEST plan participants especially with preventative and early detection that is needed for infants, toddlers, and preschoolers.

Recommendation 1.4. Expand the eligibility for diagnostic, intervention, and treatment to include children at imminent risk. *Rationale:* Currently QUEST provides services for children who meet the criteria of "medical necessity." The younger the child, the less likely they will meet the "medical necessity diagnostic criteria. It is imperative to adopt a framework for providing children QUEST reimbursable services if the child is determined to be at imminent risk for health threats and later dysfunction. MQD can incentivize MCOs adopting "imminent risk" as the standard for determining eligibility for services to children throughout its MCO contracts. Defining service eligibility by "imminent risk" would bring QUEST in line with other social services also housed at DHS like Child Welfare Services that acts ahead of a potential health and safety threat for a child that has future repercussions.

2. Build a stratified workforce to parcel out screenings and early intervention

Recommendation 2.1. Broaden the workforce that can provide QUEST reimbursable screenings and intervention to include transdisciplinary practitioners. *Rationale:* By broadening the definition of workforce and setting clear standards for screening and other services, MQD could tap into an underutilized resource to meet its goals around integrating behavioral health with primary care. MQD could set standards for transdisciplinary practitioners. For example, in California health professional complete an online training module to qualify them for ACEs screening reimbursement (see https://training.acesaware.org). MQD can use existing standards in IECMH for transdisciplinary practitioners. AIMH-Hi is building a broader IECMH-informed workforce including four potential pathways leading to certification and has done standard setting around a continuum of expertise that might qualify someone to screen, refer and provide various levels of intervention (a sample of the four pathways can be provided upon request). Practitioners are positioned to support parent-child relationships and complete services in a dyadic model.

Recommendation 2.2. Include community-based screeners as eligible practitioners for QUEST reimbursement. *Rationale:* Many community-based organizations with transdisciplinary practitioners (early intervention, home visitors, care coordinators, assessment specialist, ‘ohana advocates) already have training and complete developmental and other screenings. Those transdisciplinary practitioners are not reimbursed for those services through QUEST and it causes a lot of potential duplication of screening for children in community and clinical settings. Using a standard training or qualifying process like the one outlined in Recommendation 2.1, expands the screeners to include staff at community-based organizations once they have qualified.

3. Create a standard for EPSDT data and rebuild the EPSDT coordinator position

Recommendation 3.1. Re-establish an EPSDT coordinator position to share data, perform quality assurance, and implement a standard data system. *Rationale:* Historically, Hawai‘i used to collect and publish helpful reports from EPSDT data. Through an EPSDT coordinator position, MQD could restore insightful analysis ultimately leading to quality improvement and provide consistency in data collection and accountability. Second, clinicians and other practitioners are collecting and storing EPSDT data differently. For example, the developmental screener ASQ and ASQ-SE is conducted and stored in different systems and formats making it difficult for a medical practice or program to provide meaningful data for improvement to services to children and families. A sample of a comprehensive system of data gathering is Help Me Grow Orange County which developed a public-private partnership to increase screenings and referrals. The California Statewide Screening Collaborative is another model that integrates data in service of young children (http://www.cascreenbto5.org). Additional data capacity would allow MQD and partners to inform services, policies, and programs.

HMSA:

HMSA recognizes that both the physical and behavioral health care delivery systems in Hawaii have been discussing integration for some time. For integration to be successful, all parties involved (provider, health plan, DHS and Department of Health or DOH) need better alignment. Moving to integration without alignment may have adverse consequences for this high-risk population.

Mental health and substance use disorders are common. Both can have profound effects on physical and behavioral health well-being. The health delivery system sometimes has inadequate collaboration between primary and specialty care providers, including behavioral health. In specialty care settings, there is a need to better address the physical health needs of people with serious mental illness (SMI).

In general, the behavioral health provider community in Hawaii struggles to adequately support the QI population due to its high volume and strong demand. Telehealth can be used to broaden the pool of available behavioral health specialists who can participate in the care of QI members. Telehealth for these members includes care from behavioral health specialists with previous ties to Hawaii who are still licensed in Hawaii but may be living elsewhere. Also, telehealth can much more easily service members living in rural areas or who have issues with access to physical health care facilities.

HMSA supports moving toward alignment and addressing the issue of behavioral health specialists. If this is one of DHS's goals, there are many models and examples of integrated care. One model for integration is the "collaborative care model." This model requires organization around the following components that when applied collectively, improve health outcomes:

- Patient-centered team care.
- Population-based care.
- Measurement-based care.
- Evidence-based care.

For members experiencing a serious mental illness who are not optimally served by primary care, members would most benefit from a multidisciplinary team that integrates primary care expertise into outpatient mental health clinics, as these outpatient clinics are often where members receive regular care. The integration of a nurse practitioner and/or primary care provider into a specialist behavioral health care setting or vice versa supports provision of primary medical care.

Typically, in primary care, there are only two people involved: the PCP and the patient. The collaborative care model introduces more health professionals as needed to treat or manage the member's conditions.

Successful integration demands shared accountability among all involved parties − health plans, physical and mental health providers, and broader system stakeholders.

As DHS re-envisions the QI and CCS programs, we understand that behavioral health is a significant driver of total health care costs. To provide optimal care to those in our community with behavioral health needs, we propose finding alignment among community stakeholders and considering a collaborative care model.

Ohana Pacific Management Company:

One strategy that should be developed is a provider based "care management" program that will allow home visits to evaluate Social Determinants of Health. If structured properly with appropriate technology (i.e. tele-health}, and with proper training, "care managers" could identify psycho-social issues as well as physical health issues, and provide for outreach and access to appropriate "wrap around services" (i.e.

Value-based Payments (VBP) and Alternative Payment Models (APMs) (Limit response to 3 pages)

Pacific Medical Administrative Group

Internal assessment of the IHH's CC model has shown that primary care is essential for helping patients meet their whole person care needs. Independent primary care physicians often establish a long-term relationship with their patient that helps develop and promote behavioral health services. However, the coordination of care and services necessary to help meet their patients' needs can often be disorganized and overwhelming (Antonelli et al., 2008; Pham et al., 2009). To help maintain the necessary role of primary care physicians and to still ensure that patients are receiving high quality care, it is important to help connect physicians with the appropriate and best service/care coordination programs for both them and their patients. Additionally, ensuring that these programs have transparent and documented outcome measures can provide any necessary changes in service or care. Primary care physicians with the assistance of Service/Care coordination serves the most important role in integration of care for members.

MQD should consider adopting some of IHH's strategies that support integration utilizing an adaptation of University of Washington's AIMS (UW-AIMS, 2014) collaborative care model. There are five guiding principles of the UW-AIMS model:

1. Patient centered team care
2. Population based care
3. Measurement based treatment to target
4. Evidence based care
5. Accountable care

At IHH we fulfill each of these principles through consistent and routine training, data collection, and evidence-based implementation of program development and improvement. Aligned with these principles IHH's EFCC does the following:

1. Conducts monthly reports to PCP's and ongoing/regular communication with PCP via phone, email and even text messaging (Principles 1 & 2).
2. Regular co-attendance to member's primary care appointment especially when members are not engaging (Principles 1 & 2).
3. Monthly consult meetings with medical and behavioral health service coordinators of the health plan (Principles 2 & 3).
4. Weekly consults with Adult Psychiatrist (Principles 3 & 4)
5. Weekly consults with Pediatric Psychiatrist (Principles 3 & 4)
6. Twice weekly Clinical supervision by licensed mental health specialist for all CC's (Principles 3 & 4)
7. Vetting of all mental health community providers that we connect members to (Principle 5)
8. Regular and ongoing staff training regarding patient engagement, burnout prevention (for staff) and patient unconditional positive regard using evidence-based modalities

such as Motivational Interviewing, Crisis Intervention, Suicide Prevention & Psychological First Aid. (Principles 4 & 5)
9. Regular and ongoing training/education to physicians and staff regarding IHH services and referral processes. (Principles 4 & 5)
10. Use evidence-based recommendations by UW AIMS regarding caseload size. Typically, no more than 50 patients per care coordinator.(Principles 3, 4, & 5)

Waikiki Health Center:

Integrated care is essential for holistic care for the patient. This is something that is practiced at Waikiki Health.

Waianae Coast Comprehensive Health Center:

Promoting a Behavioral Health Continuum - ROI and Population Health/Care Coordination - The RFI proposes an investment in care coordination at the community level. The objective would integrate behavioral health with primary care, and address social contributors to health. We agree that in making such investment our State should expect a return in the form of reduced cost and improved quality. Best practices in population health requires a systematic assessment of perceived social needs of patients, development of coding and tracking social services, coding care enabling services that systematically reduce access barriers to care, the ability to risk stratify patients and, ultimately, the ability to measure the impact of this new integrated care model on agreed upon performance metrics. Health plans should be incentivized to launch pilot projects in these areas. Such system changes are complex and may be best updated through innovation grants in selected communities.

Hawaii Pacific Health:

- Patients with physical health problems may also have complex social situations that intersect with behavioral health. However, these patients may not recognize or accept behavior health services. This can result in a repeated cycle of frequent admissions and medical noncompliance. Utilizing community health workers that are assigned to a health plan can help build relationships that may eventually lead to accepting behavioral health services and reduce admissions. The stabilization of mental health and medical health would ideally take place at the same time for the most optimal outcome. If an individual could be connected to a community behavioral health service provider in a faster, more timely manner while receiving inpatient hospital care it would provide an opportunity for the individual and the service provider to start building rapport and identifying immediate post discharge needs that would help reduce the potential anxiety that people fear when leaving the hospital. If service providers could be assigned and come see the patient for a face to face interaction it gives the patient and the service provider a chance to start partnering with each other and patients care team to ensure that the patient/individual is set up for success as he/she reintegrates back into the community.

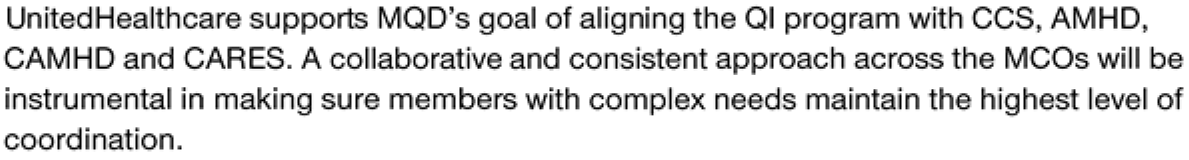
Primary care is the foundation for enhancing preventative care and assessing the needs of the patient. Expanding services for high risk populations can assist with medical compliance.

Question 6 – How can MQD align the QI program with CCS, AMHD, CAMHD and CARES?

Lana`i Community Health Center:

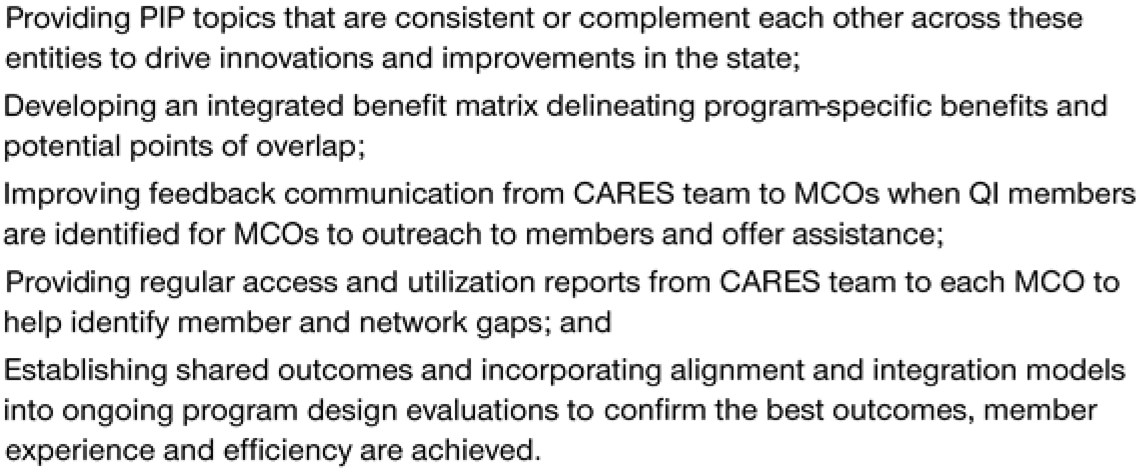
It is critical that CCS, AMHD, CAMHD, and CARES services and care plans are shared with health center care teams and that there is a clear understanding of each entities' roles.

UHC:



UnitedHealthcare supports MQD's goal of aligning the QI program with CCS, AMHD, CAMHD and CARES. A collaborative and consistent approach across the MCOs will be instrumental in making sure members with complex needs maintain the highest level of coordination.

To foster this member-centric focus, we would encourage MQD to Consider:



Providing PIP topics that are consistent or complement each other across these entities to drive innovations and improvements in the state;

Developing an integrated benefit matrix delineating program-specific benefits and potential points of overlap;

Improving feedback communication from CARES team to MCOs when QI members are identified for MCOs to outreach to members and offer assistance;

Providing regular access and utilization reports from CARES team to each MCO to help identify member and network gaps; and

Establishing shared outcomes and incorporating alignment and integration models into ongoing program design evaluations to confirm the best outcomes, member experience and efficiency are achieved.

Kaiser Permanente:

As described above in our response to question #4, while KP appreciates the value of these specialized "carve out" programs, we also understand that this specialization cannot come at the expense of the member's experience receiving whole-person, person-centered care. Consistent and complete policies and processes for communication, data sharing, roles and responsibilities and coverage policy are key to ensuring alignment between QI health plans and CCS, AMHD, CAMHD and CARES. We suggest that MQD convene workgroups with representation from each of the QI health plans and the state programs to establish policies and protocols that mutually benefit all involved parties.

Our Service Coordination team has already begun to see improvements and recommends ongoing work to improve structured avenues of communication. This includes communication at a leadership level to ensure that programmatic issues are being appropriately addressed as well as communication between case managers in state administered programs and QI health plan care and service coordinators. These staff should have a consistent plan for sharing updated care plan information, changes in health or social status, medication changes, and any planned upcoming treatment, visits or other interventions. It is also imperative that this includes plans for ensuring that all the member's treating providers, including mental health providers, primary care providers and other specialist providers are consistently aware of all changes in care plans, treatment and medications.

In addition, there should be additional clarity regarding roles and responsibilities. This is important not only to reduce duplicative work efforts for staff, but to avoid multiple redundant calls to members, which create both confusion and frustration. For example, for a member with comorbid medical and behavioral health conditions, who should be responsible for coordinating with hospital staff to ensure all services are in place at the time of discharge or for care transitions to a lower level of care? Similarly, if a member has a change is medications, who is responsible for communicating these changes to all providers involved in the member's care?

Finally, it is important that responsibilities for coverage of services are clearly defined. This is not only important to understand financial responsibilities but allows staff to focus their energies on ensuring members are getting the care they require rather than questioning coverage responsibilities. For example, if a member calls into the CARES program and is recommended to receive a particular level of service, there should be clarity regarding the QI health plans' role in determining the appropriateness of that level of service.

It would also be helpful for MQD to align the procurement for CCS as well as any other contracts for DOH programs with the QI RFP and to include incentives for these programs to coordinate and collaborate with QI health plans. Coordinating timing of these contracts would allow everyone to implement new contract requirements in collaboration and avoid changes from any involved agencies during the course of the contracts.

Kokua Kalihi Valley:

CCS case managers need to have a good working relationship/communication with Primary Care Providers (for physical health care needs and ensuring and supporting clients are able to follow through with care) and with Psychiatrists or APRN Psych, or Therapists to ensure they follow through with mental health recommendations. CCS case managers are (or supposed to be) resourceful with social services- benefits/housing/transportation/ supported employments or psychosocial rehab and lifestyle programs. Currently this is not always the case.

Some ideal models from our perspective:

CCS case managers who are based at patients' medical homes such as settings like community health centers where PCPs and Behavioral Health providers including Psychiatrist/APRN psych.

If CHCs do not have Psychiatrist or Psych APRN on site, the care for patients with SMIs who usually high risk and require psych meds and have multiple medical conditions, will be fragmented if they are seeing outside psychiatrists.

Alternatively, make SMI patients' medical homes at Community Mental health centers (like AMHD clinics) where a complete Mental health team including CCS case managers are based there and PCPs also work there on site; or CCS Case management agencies like Care Hawaii or Mental Health Kokua which have Mental health team like psychiatrists/APRNs on site and CCS case managers are based there. If they cannot have PCPs on site, their CCS Case managers need to find structured ways to work closely with Outside PCPs for physical health coordination.

If lifestyle programs and psychosocial rehab programs are also onsite (like KKV), it will be more holistic and readily accessible. Use these sites to model/test out the utility and benefit.

Incentives for CCS case managers should not be just hitting acuity and the number of contacts with their clients, but their participation in care for Physical health care and mental health recommendations of the clients.

There are examples where we see no involvement of CCS case managers of our mutual client's complicated medical needs and they know little to nothing of that side of the patients care.

CCS case managers are required to know psych eval and med lists from psychiatrist, again which they just request through consent of release for records. Most of them do not have direct communication with the psychiatrist unless they need something.

Briefly, it would be advantageous for health plans to provide incentives for having integrated Care plans for their members for physical health including for chronic medical conditions, and behavioral health and if they can provide incentives for regular screening of behavioral health including substance use, having meaningful care planning which is coordinated by Care coordinators who know the patients and able to communicate with Providers in the team, payment for PCPs for Psychiatric consultation (like Medicare is paying for collaborative care) etc.

Hawai`i Primary Care Association

The HPCA recommends the establishment of carve-out programs to allow for focused and intensive services. However, these might pose some difficulty in realizing a whole-person, patient-centered healthcare home approach.
As shared previously, it is critical that CCS, AMHD, CAMHD, and CARES services and care plans are shared with health center care teams and that there is a clear understanding of each entities' roles.
MQD should invest the time necessary to work with MCOs and other contracted entities to develop common processes and shared infrastructures to reduce fragmentation and inconsistencies.
Investments should also be made to support a bi-directional sharing of data and streamlining communication across clinical and community care.
In some instances, instead of requiring the Medicaid beneficiary to seek care at another source, it might be more prudent to have the specialist (CAMHD provider) go to the healthcare home, where the individual may feel safe and the environment is familiar.
More health centers are implementing substance use disorder (SUD) interventions in primary care. Consideration should be given for the

expanded role health centers are playing to fill the community needs.

Ohana

In our experience, increased alignment can be achieved through the following strategies:

- Align funding so that members can seamlessly access the services they need without having to meet separate eligibility requirements.
- Establish a defined set of streamlined quality metrics that all MCOs and providers are working together to achieve.
- Establish a core set of screening and assessment tools to be used by all providers and systems.
- Develop standard processes for member referrals, including closed loop referrals and continued care coordination.
- Promote system-wide adoption of best practices.
- Offer system-wide training on key topics such as Trauma Informed Care, Mental Health First Aid, and Recovery and Resiliency.
- Create a system of clinical support to increase providers' capacity and comfort level with serving individuals with co-morbid needs and complex conditions.
- Develop standards and processes for information-sharing across providers and systems.
- Encourage enrollment alignment for members served by both the QI and CCS programs to promote whole person care.
- Execute statewide contracts for all systems of care, reducing member disruption if they move or their program eligibility changes.

Community First:

For CCS, MQD should keep the behavioral health and medical benefits with one health plan. There are difficulties in managing the medical benefit and the behavioral health benefit across different plans for the same patient. It's been said that processing CCS eligibility can take months.

In East Hawaii there are approximately 1,000 CCS members. If this number is large enough to support the infrastructure for two plans, we recommend CCS re-procurement be limited to 2 plans. If not, it should be limited to 1 plan. But in either case the medical plan should be the same as the CCS plan.

We have no comments regarding AMHD, CAMHD, and CARES.

Healthcare Association of Hawaii:

Our organization – along with MQD and several plans – participated in the Involuntary Hospitalization Task Force in the summer and fall of 2019. There were a number of important recommendations that came from that report, not all of which are related to MQD. However, some of the important findings from that report concur with the findings from the Complex Patients Working Group from 2017, including investing in a more robust mental health workforce and strengthening wrap-around services.

Important new recommendations from the Involuntary Hospitalization Task Force include supporting more alternative sites of care and finding ways to support those efforts through sustainable funding sources, such as public insurance programs. We would support, for example, the transfer of patients without acute psychiatric needs to stabilization beds in service sites other than emergency rooms. A database to allow providers to understand what resources are available and what resources have already been provided to a patient would also be critical. As part of that database, a real-time bed availability count would be similarly helpful.

We believe it is very important for MQD to support mental health providers, other state agencies, and other stakeholders in establishing and providing stable support for the various stages in the mental health continuum. This would include early intervention, robust social and supportive services, and sites of care such as stabilization centers for individuals experiencing intoxication or a crisis that does not require acute intervention. Further, there may be opportunities to work with less traditional partners, such as law enforcement, to encourage treatment and transportation of individuals to the most appropriate care sites, especially as they are stood up as part of an expanded continuum.

CMCH:

CCS needs to be held accountable to have equal services on all islands. Currently CCS does not have their own in-house level 5 teams on Kauai and Maui. This creates a disparity of care between the different islands.

One health plan for both medical and behavioral health services will make it easier to align the program. MQD does not have to align the behavioral health programs with CCS if it is integrated to the QI plans.

AlohaCare:

AlohaCare recommends state-led multidisciplinary efforts to standardize and align program requirements, expectations, processes, and tools. State-led efforts make it possible to reduce duplication and fragmentation of efforts that lead to decreased program costs and optimal beneficiary outcomes.

Such state-led efforts could include the following:

☐ Develop and promote a provider learning forum among MQD, CCS, AMHD, CAMHD, CARES and all QI health plans to develop standardized referral forms, processes, program eligibility requirements, and service authorization processes. This could be accomplished through web-based training platforms, regional forums, or virtual trainings with shorter modules to promote increased opportunities for alignment and standardization to support providers, beneficiaries, and payers.

- Provide a single entity for referrals for state BH carve out programs such as CARES.

- Establish consistent care plan requirements, tools and processes to better identify lead agencies and individuals accountable for each area of a beneficiary’s care plan including health care and community service provider referrals, the payer source for each identified service, and an aligned timeframe for service initiation and renewals. Establishing consistent care requirements for exchanging clinically relevant data and information between QI health plans CAMHD, CCS, AMHD, CARES, clinicians and community-based providers, and centralizing transitions of care data collection and distribution between QI health plans will also help improve program alignment, resource allocation and support timely and collaborative sharing of beneficiary healthcare information. MQD, QI health plans, and other state and community partners can support the development of a secure data sharing site, such as the HILOC, to facilitate efficient year-round information sharing rather than only during annual QI health plan change periods.

- Streamline access to ADAD substance use services by creating a uniform BH authorization form and process for requesting Alcohol and Drug Abuse Division (ADAD) services.

Hawaii Health Information Exchange:

With the statutory and regulatory changes being advanced by the 21st Century CURES Act, the CARE Act and the effort to harmonize the HIPAA regulations, 42 CFR Part 2 on patient consent, the vision of MQD to promote a continuum that integrates physical/medical health with behavioral health will be achievable in the next few years. HHIE recommends the following actions be taken by MQD, the QI HEALTH PLANs and/or their provider networks:

- Support and participate in the HHIE effort to closely monitor the requirements of the CURES Act, CARES Act and changes to other pertinent statutes. Leveraging better understanding of the changes in policies and technology that will be required by TEFCA and QHIN, MQD can effectively promote interoperability and remove obstacles in acquiring behavioral health information on Med-QUEST members.

- Leverage the HHIE technology like the platform-agnostic, unified closed loop electronic referral platform. Encourage its adoption among QI HEALTH PLAN network members to better track the consultation and follow-up of patients with behavioral health and/or substance use disorders (BH-SUD patients).

- Promote and support the use of HHIE to deliver secure notifications and communications that inform providers and care coordinators of BH-SUD patients’ health events and their transitions across care settings. (e.g., emergency to home, hospital in patient to skilled nursing facility, etc.).

- Encourage and support development of a common patient consent model among all healthcare providers in the community so that hospitals, PCPs and behavioral health providers can effectively share physical and behavioral data through a common, legally compliant and secure exchange platform.

• Encourage and support the development and sharing of unified, standardized care plans through a common, secure exchange platform. The standardized care plans should include clinical, behavioral health and social-determinant data.

• Incent network providers who are caring for BH-SUD patients when they effectively share their patient's records with QI HEALTH PLANs, MQD and other providers. Following the best practices of data sharing will bring about marked improvement in outcomes and cost of care for this population of MQD Beneficiaries.

HMSA:

DHS should consider the following immediate steps to better align these programs:

• Allow the health plans to delegate care coordination to CCS, CAMHD, AMHD, and CARES. • Establish some level of centralized data and communication before defining responsibilities and coordinating care. Each entity − DHS, QI Plans and their Care and service coordination program leadership, CCS, CAMHD, AMHD, and CARES − should collaborate and come to consensus on how to define responsibilities. The member should choose the entities that participate in delivering their care and how they interact with the member. • The health plans would have clearly defined responsibilities, including coordinating members' medical needs with the delegate and ongoing monitoring of metrics for oversight.

Pacific Medical Administrative Group

MQD's transformation vision in supporting a robust continuum of services for behavioral health is laudable and is well within the scope of the QI program and CCS, AMHD, CAMHD, and CARES. The current MOU's in place with these organizations should continue to promote the importance of behavioral health, while also ensuring that standards are created and met that help address the unique needs of those living in Hawai'i. Providing clear evidence of patient outcomes and cost-savings can help ensure that MQD can provide uniform and flexible coverage to a variety of patients. It is important for all programs to collect data and standardize outcomes across agencies. It is crucial to measure outcomes including but not limited to initial member engagement success, successful connection to specialist care including appointment and medication compliance, and symptom improvement over time.

Waianae Coast Comprehensive Health Center:

Responding to the Pandemic - Telehealth - The COVID 19 environment has expedited change and will result in the permanent adoption of remote service delivery. The Health Center has converted almost half its visits to telehealth visits in the last several months. We have also uncovered substantial disparities in poorer rural communities that affect telehealth adoption. Broadband services are unreliable in some areas. Many patients cannot afford a data plan to interact through visual format. We suggest health plans do a geographic assessment of their market and identify communities with socioeconomic or technological access barriers to telehealth services and support (a) Be allowed to support infrastructure development and (b) support telephonic (voice only) services where certain follow-up services are provided. The latter could include follow up care coordination linking patients to a full complement of needed services.

Queens's:

Comments from Chief Medical Officer, Queen's Accountable Care Organization

The Queen's Clinically Integrated Physician Network (QCIPN) currently runs a transitional case management program (TCMP). The TCMP is complimentary service provided by the hospital to patients who qualify to ensure that they have a smooth transition from hospital to home. Through this program patients are provided clinical support, resource coordination and education. The TCMP encompasses a range of medical needs, including behavioral health assessments and referrals. There is opportunity for MQD to provide this kind of care coordination service through the contract QI plans.

The TCMP integrates teams made up of physicians, LSWs, RNs, patient community navigators, pharmacists, dieticians, and behavioral health specialists to work together to provide comprehensive care for our patients.

Hawaii Pacific Health:

Since all of these resources are State resources, MQD should identify a single patient navigator for these patients that require coordination and knowledge across these various state programs. MQD developing this capability within DHS would be the most helpful to the patient and reduce administrative burden amongst plans and providers.

NCQA:

Promoting a Behavioral Health Continuum.

Recommendation: Require NCQA PCMH Behavioral Health Distinction for PCMH practices.

To support Hawaii's goals for promoting a behavioral health continuum, we recommend the state utilize the existing PCMH program and enhance oversight by requiring practices receive the Behavioral Health Distinction, available to NCQA recognized PCMH practices. NCQA's Distinction in Behavioral Health Integration recognizes primary care practices that put the right resources, evidence-based protocols, standardized tools, and quality measures in place to support the broad needs of patients with behavioral health related conditions within the primary care setting. This enhances the level of care provided in a primary care practice and improves access, clinical outcomes, and patient experience for patients with behavioral health conditions. Distinction in Behavioral Health Integration (BHI) is a way for practices to highlight where they excel beyond the PCMH standards. Nationally, 200 recognized practices have achieved BHI, with 250 additional practices in the Transformation process. Of Hawaii's 51 NCQA recognized Patient-Centered Medical Homes, two have already achieved the Distinction for Behavioral Health Integrations. Requiring this Distinction for primary care practices in Hawaii would assure plans of a providers' capabilities to provide whole-person care.

NCQA is extremely supportive of the state's efforts to build a highly integrated Medicaid program. Our goal is to be a valuable resource as you think through critical quality oversight policies and functions.

Value-based Payments (VBP) and Alternative Payment Models (APMs)

(Limit response to 3 pages)

Question 7 – What strategies should MQD adopt that align QI incentives and programs that improve outcomes and efficiency? What strategies should MQD consider adopting that support behavioral health integration within QI that results in movement along the continuum of value-based care/payment models?

Lana`i Community Health Center:

Facilitating MCO investment in Patient Centered Health Care Home or PCMH recognition and advancing team based care.

UHC:

We encourage MQD to ground its VBP and APM strategy in prioritizing the value VBP and APM agreements are producing rather than setting a target for the volume of agreements that are implemented. This approach will help to ensure models are facilitating improvements in health and financial outcomes.

To support a strategy focused on the performance of VBP and APMs, we would encourage MQD to define shared quality and performance measures to align providers (including both primary care and behavioral health) and MCOs in improving outcomes and population health. While MQD holds MCOs accountable for the same measures, there are variations in which measures providers can or are willing to focus on. Both MCOs and providers have felt that overly complex metrics are not entirely under their control and thus have not supported use in incentive programs. Linking incentives to health and financial outcomes will require selecting metrics that are clinically meaningful, easily measurable, and not overly burdensome to report. Therefore, we recommend MQD convene providers, MCOs, BHOs, CBOs and members to define shared measures to support provider engagement and build collective momentum around outcomes in priority areas for Hawai'i.

Additionally, health equity must be an overarching principle for MCOs and providers working on population health efforts. MQD and stakeholders should work together on quality improvement initiatives to reduce health disparities, particularly as it relates to race and ethnicity. This is an opportunity to standardize data collection on priority SDOH elements (as discussed in Questions 3 and 4) and incorporate aligned social risk measures.

Kaiser Permanente:

We fully believe that in order to improve outcomes and increase efficiency, MQD should partner with stakeholders to create a system where providers are well equipped and able to enter mature VBP arrangements that allow providers to manage the members total cost of care. When providers are supported through robust VBP arrangements, such as capitation and other risk-based models, they respond in a manner that drives quality and efficiency. Mature VBP arrangements allow financial flexibility to provide the right care at the right time. Providers also need predictable funding in order to create an environment for members to thrive.

Nationally and in Hawai'i KP's integrated health plan and delivery system model has been proven to drive the highest quality outcomes in the country. Our model is structured to enhance the coordination of care and to embed best practices in the clinical care setting, therefore creating a system that has decreased fragmentation across a complex healthcare system. According to the Harvard Business Review, the way to create payment reform that drives quality and reduces waste is to pay providers a capitated payment rate this allows providers to invest accordingly to support their members.

In Hawaiʻi, Patient-Centered Medical Homes (PCMHs), such as KP are well positioned to provide high quality care to QI members. We believe that in order to reform the healthcare delivery system in Hawaiʻi, payers must invest and pay providers, such as PCMH's, in a manner that creates sustainable and predictable funding. This funding allows providers to invest in staff to care for the entire member and address issues such as SDOH, ensuring whole-person care.

Hawai`i Primary Care Association

In addition to previously mentioned recommendations related to care management, data transparency, and additional supports to care for highneeds, high-cost patients and reduce preventable admissions and readmissions, MCD should consider:
- Facilitating MCO investment in Patient Centered Health Care Home or PCMH recognition and advancing team based care;
- Promoting MCO collaboration with HPCA for training and technical assistance through HPCA's learning network (learning health system infrastructure) to achieve shared outcomes, and investment in health center systems improvement, including consideration of using NACHC's Value Transformation Framework;
- Working collaboratively to address SDOH at multiple levels (from individual care to systems change/upstream factors), including consideration of infrastructures and investments that are needed to support this work;
- Investing in primary care, including consideration of measures that track overall MCO investment in primary care, relative to overall health care spending, and consider state level benchmarks, and

asking plans to estimate primary care expenditures and plans to improve that;

- Investing in technology infrastructure and health information exchange; and
- Considering, if still possible, implementation of Health Homes, Section 2703.

Ohana

ALIGNING QI INCENTIVES AND PROGRAMS

MQD can achieve strategic alignment with key priorities and goals, such as those in the HOPE Initiative, through collaboration with health plans, providers, and other stakeholders to identify outcome measures and encourage adoption. We recommend that MQD consider limiting the volume of outcome measures to a manageable number of well-defined, nationally recognized quality and cost efficiency measures. Starting with a few standardized measures will help establish a solid measurement foundation, simplify data collection, and reduce provider administrative burden.

MQD should encourage health plans to align their VBP quality and cost measures with these standardized measures. The alignment with State priorities can help drive system-wide improvements in health outcomes, quality of care and cost containment. These measures can be incorporated into health plans' VBP arrangements as appropriate depending on provider type and member population mix. Health plans should retain flexibility to incorporate unique quality and cost efficiency measures within VBP arrangements, as improvement goals may vary by provider.

SUPPORTING BEHAVIORAL HEALTH INTEGRATION

In order to support behavioral health integration within QI that results in movement along the continuum of VBP, we recommend that MQD encourage health plans to develop VBP arrangements that incentivize behavioral health integration as a fundamental aim of the program. Health plans should be encouraged to offer programs of varying levels of complexity in order to not only meet providers where they are in their current capability and readiness to assume risk, but allow them to progress along the Health Care Payment Learning and Action Network (HCP-LAN) APM Framework to higher degrees of risk assumption and, simultaneously, to increased levels of behavioral health integration. However, limiting the panel size to 300 members has proven to be a significant barrier to provider progress along the VBP continuum. In our experience, a provider needs a panel size of at least 500 members in order to responsibly participate in a risk arrangement.

Collective Medical:

The most important strategy we can suggest to support any measure included in Performance Incentives is that each measure be supported by strong tools for sharing healthcare information and reporting on outcomes so that these measures can be accurately tracked, evaluated, and iterated upon so that the system can continue to reach for ideal efficiency, resilience, and patient outcomes. We point to two key Medicaid managed care incentives below, with explanations for how a robust data sharing platform supports achieving each one and measuring its outcomes.

Any data sharing platform chosen for use by CCS, QI, or other plans and providers should be able to adapt to function on par with the descriptions below for any measure DHS decides upon.

1. Emergency Department Utilization (EDU): Assesses emergency department (ED) utilization among commercial (18 and older) and Medicare (18 and older) health plan members. Plans report observed rates of ED use and a predicted rate of ED use based on the health of the member population. The observed rate and expected rate is used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less emergency department visits than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the emergency department visit rate across all health plans to produce a risk-standardized rate which allows for national comparison. How data sharing supports this measure: The data sharing platform works with existing solutions and with hospitals and health plans to determine criteria for high ED utilization. Patients who meet the chosen criteria will be flagged as high utilizers upon presentation to the ED. This should trigger increased collaboration to help meet the patient's needs in more appropriate care settings—for example, if a patient presents repeatedly to the ED for management of asthma symptoms, they probably need a better connection with primary care for medications and education; if a patient is using the ED for food or shelter, they probably need connections with community resources for food and housing.
2. Plan All-cause Readmissions (PCR): Assesses the rate of adult acute inpatient stays followed by unplanned acute readmission for any diagnosis within 30 days after discharge. NCQA also specifies that plans report a predicted probability of readmission to account for the prior and current health of the member, among other factors. The observed rate and predicted probability are used to calculate a calibrated observed-to-expected ratio that assesses whether plans had more, the same or less readmissions than expected, while accounting for incremental improvements across all plans over time. The observed-to-expected ratio is multiplied by the readmission rate across health plans to produce a risk-standardized rate allowing national comparison.

How data sharing supports this measure: Readmissions are a perfect case study for a data sharing platform activating an interdisciplinary team across care settings. Consider a patient who is discharged from the hospital to a skilled nursing facility for rehab after orthopedic surgery, then from the SNF to home after their stay there. If the patient has a fall at home and presents to the ED shortly after that last discharge, the data sharing platform can alert the SNF, which can then intervene to prevent a hospital readmission, possibly admitting the patient to the SNF instead, if needed.

Acumen Fiscal Agent:

Acumen's FMS solutions for MCOs include optional tools that can be leveraged by the independent provider in the home that can decrease risk and costs, by providing real time insights into risk indicators. Additionally, an individual could also choose to share this information with a family member (such as an Aging parent and an adult child), to give them piece of mind that they are receiving the supports they need and to understand any potential risk factors.

Our solution allows a skilled or unskilled independent provider to answer a series of customizable questions to identify risk as early as possible. Some examples of simple questions to identify risk include:

- Eating, Drinking, Bathing
- Blood Pressure or Blood Sugar within pre-determined norms (yes/no)
- Medication Compliance
- Adherence to post discharge instructions (e.g. compression socks, ambulating, etc.)

The responses to these simple questions can be provided to a case manager at an MCO and include a potential risk level (e.g. green – yellow – red) to allow for immediate identification of potential risk and the need for a call to action. These tools ultimately can lead to individuals leading healthier lives and decrease potential out of pocket costs, thus leading to higher patient / member satisfaction. Additionally, effective use of these tools can lead to decreased risk and costs for payers / MCOs.

Community First:

The general strategy should be to move from volume to value, from the regulation of billable services to services that improve outcomes and efficiency. The general strategy should also be to identify the relevant system that is needed to do this for populations of patients and reward that system for gains (savings) and penalize it for lack of accountability (not medical loss).

Specific to behavioral health integration, MQD should move from FFS to PMPM to pay for behavioral health services and ideally align the rewards and penalties for the BHC provider with the medical home of the patients they treat.

Healthcare Association of Hawaii:

We have appreciated MQD's focus on behavioral and mental health as a whole-person approach and believe more can be done along the continuum to alleviate some of the pressures put on hospitals, nursing homes, and other providers to manage these difficult conditions without sufficient reimbursement or support. Supporting more workforce and infrastructure may help with any plans for integration and will provide a release valve for providers currently struggling.

CMCH:

If MQD adopts the Value Based Payment (VBP) and Alternative Payment Models (APMs) it should be done when and if the QI plans also manage the behavioral health portion of the program. This will make it easier for MQD to add incentive payments for providers that provide high quality and cost-efficient care. It will be cost-efficient care since the behavioral health portion of the program is within the QI plans not in a separate program which will require much more administrative burden to comply with contractual requirements for both QI and behavioral health programs.

AlohaCare:

AlohaCare recommends aligning MQD, QI health plans, and the provider community on a limited set of quality measures/initiatives to reduce provider administrative burden, meet MQD’s underlying objectives and maximize the efficient use of limited staff and resources within our healthcare communities. Alignment will reduce gaps in care, ensure appropriate care transitions and levels of care, and increase beneficiary engagement. Together, these initiatives and incentives support system transformation goals to achieve the quadruple aim of better health, better care, sustainable costs, and satisfied providers.

Performance and quality measures must be consistent with QI health plan withhold incentives, the hospital pay for performance (P4P) programs, and QI health plan beneficiary engagement strategies for aligned incentives to produce the most benefit for the healthcare system.

Similarly, AlohaCare recommends that MQD considers adopting a combined QI health plan and CCS P4P program that aligns administrative and clinical measures, and supports stakeholder performance of coordination, physical and BH integration and movement along the continuum of value-based care and payment models.

AlohaCare offers the following considerations in support of our comments above:

- Convene a multi-stakeholder collaborative to develop a set of aligned performance measures across VBP models/categories to ensure incentive programs are focused on the highest priorities for Hawai‘i as well as to reduce provider administrative burden for various performance standards across different QI health plans and programs.
- Develop and adopt a core set of Advanced Payment Models (APMs), requiring all QI health plans to utilize them. Standardized APMs would help reduce administrative burden for providers and insure APMs effectiveness. For example, MQD could establish an APM that includes all hospital in-patient services for OB delivery--regardless of vaginal or C-section delivery--and the first two NICU days. This would encourage physicians and hospitals to build effective coordination of care models for prenatal, hospital and post-natal care. This case rate would be hospital specific (based on the current per diems and QI actuarial data) and could provide for limited outlier reimbursement. For the core APMs mandated by MQD, common quality, service and cost measures should be developed and tracked. MQD could phase in the requirement for these core APMs, perhaps one every six months until their performance can be evaluated, and provider feedback obtained. APMs should be specifically tailored to encourage small and independent provider practices to participate in the future.

 Implement provider incentives and/or penalties based on established goals for complete and accurate data submission, which is required for HEDIS (Healthcare Effectiveness Data and Information Set) and other performance measures, and a methodology to verify accuracy.

 Establish consistent, complementary program measures and incentives across the QI health plans and the CCS program to promote physical and BH integration, coordination, and collaboration. Initial program measures and incentives could be focused on administrative activities around joint beneficiary risk stratification and care plans. Moving along the continuum, shared savings and risk models could be developed to incentivize improvement on key performance metrics such as reduced emergency department visits, avoidable inpatient admissions, and medication adherence.

Health Team Works:

We advocate strategic consideration in two distinct areas for aligning QI incentives and programs:

- • **Design** of VBP model and APMs
- • **Implementation Support** through Practice Facilitation for provider networks (detailed in ARHQ - Practice Facilitator handbook)

A downfall of many integration programs and APMs is underestimating the time and resources provider networks require to achieve significant and sustainable change. With this consideration, our strategy recommendations focus on implementation support. There are benefits to delegating implementation support for provider networks to a 3rd party organization as a single source of accountability for statewide Practice Facilitation across health plans and provider networks. A neutral party facilitation approach leads to greater standardization and the value of such implementation support has precedent in the Medicare Innovation models including CPC and CPC+ (see HealthTeamWorks - Medicare CPC+ for Colorado & Nebraska). Both were collaborative multi-payer models where implementation support was delegated to 3rd party support organizations. Illustrative examples of roles and responsibilities of Practice Facilitation include:

- • Supply experienced practice coaches well-versed in best practices, change management, performance improvement and workforce development
- • Support practices with administrative details of an APM such as educating and providing guidance on APM funding models intended to support delegated evidence-based care management and develop additional Advanced Primary Care practice capabilities
- • Data analytics support that builds practice capabilities to develop and effectively use actionable reporting for measures of clinical quality, utilization, care coordination, patient experience (CAHPS/PEC), financial and other metrics relevant to an APM
- • Support practices with improving patient experience, management of quality, clinical best practices, cost performance and financial sustainability
- • Leading collaborative learning and continuous quality improvement with provider networks including on-demand telephonic and email support, practice and small group coaching, cross-community online and in-person learning events
- • Lead facilitative role in multi-payer collaboratives and other stakeholder groups

The result of a well-designed implementation support strategy delegated to an experienced 3rd party Practice Facilitation organization includes:

- • Improved standardization of QI incentives and programs, reduction of administrative burden and provider burnout and greater adherence in provider networks to evidence-based practices that underlie an APM and lead to improved outcomes and efficiency
- • Trusted resource for practice support vs. coaches from multiple entities
- ☐ Improvements in team-based care, care management and coordination, behavioral health integration and other Advanced Primary Care capabilities
- • Improved communication across stakeholders which results in greater alignment with incentives and programs
- • Feedback from provider networks that leads to continuous improvement, increases provider satisfaction, and strengthens program integrity

HMSA:

HMSA’s general approach to encourage movement along the continuum of value-based payment (VBP) models can easily be applied to support behavioral health integration. HMSA designs and implements VBP models in a logical, stepwise fashion that allows providers enough time to transform their practices by addressing people, processes, and technology. This encourages integration across the health care continuum along with relevant quality measures and shared savings opportunities. Providers often need significant support for these changes to be successful. However, this is a challenge for health plans because of budget limitations. When health plans invest in system transformation, HMSA recommends that DHS reward health plans that implement or advance VBP models in Hawaii.

HMSA appreciates the collaboration with DHS on the QI health plan Quality Payment Program as well as DHS’s efforts to encourage continuous improvement. HMSA has seen that individual measure rates can fluctuate from year to year, which may have a significant negative impact to a health plan as performance approaches the Quality Compass 75th percentile because the “gap” becomes smaller.

To help mitigate the impact of these fluctuations, HMSA recommends rewarding plans based on improvement as well as maintaining performance year over year. In addition, HMSA recommends including a larger number of smaller-increment improvements and exceptional performance rewards. This is different from the current approach that defines a small number of larger-increment improvement rewards. In addition, where there are opportunities to encourage coordination of care, HMSA recommends aligning measures across DHS’s hospital and health plan quality programs (e.g., Follow-up After Hospitalization for Mental Illness, Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence, Follow-up After Emergency Department Visit for Mental Illness).

Ohana Pacific Management Company:

Quality incentive pools for key measures can provide meaningful alignment between QI health plans, providers and state programs. Frequently, providers face negative adjustments for rates, however, creating a program of upside incentives typically results in gains and are more favorable for providers and beneficiaries. Many states have adopted provider level incentives, which target key providers (e.g. Primary Core Physicians, Skilled Nursing Facilities, and Hospitals). The incentives focus on specific measures for the given target population.

Although, it seems these programs typically lack accountability between levels of care and the integration/coordination. A mitigation strategy is to develop an incentive pool, which creates up/down-stream alignment between different care settings will help to eliminate one of the key drivers in poor outcomes, which is the handoff and coordination of care.

Additionally, use and coordination of patient medical records through Continuity of Care Documents {CCDs) should also be a measured and component of incentives. If a provider does not contribute to clinical documentation on 90% of their assigned patients, then a financial disincentive should be applied. CCDs should include the full medical record, up to and including, Vital, Narratives, Orders, Medication Administration, etc.

The quality programs should be developed and applied consistently across all payers for state funded programs to eliminate variation and duplicative administrative aspects, which create waste and confusion.

Pacific Medical Administrative Group

IIHH CC model has grounded its work in evidence-based practices that have been documented both in other service/care coordination models (Langer et al., 2018) as well as those here in Hawaii. Much literature discusses the importance of Patient Centered Medical Homes (PCMHs) to help ensure that the patient is at the forefront of their own care. PCMHs often have care coordinated with Alternative Payment Methods (APMs) and are necessary for any successful ACO. It is important that statewide APMs be designed to provide incentives to reward high-quality health care; linking payment to evidence based metrics that would represent process, outcome, and patient experience measures. Currently, IHH's CC model has focused on ensuring that certain outcome measures like reduction in depression scores, connection with care standards, and metrics of assessing patient improvement of symptoms have been documented and met.

Waikiki Health Center:

The State should pay for population health management platforms that is integrated with the clinics EMR (example: Azara). MQD could get the data from here to reduce administrative burden and costs incurred by the clinics.

Waianae Coast Comprehensive Health Center:

QI Administration - Optimal Number of Health Plans - We support a maximum number of 5 health plans on Oahu and statewide. Competition is good and allows our community choices. We also support organizations of informed community boards that might offer a "360°" evaluation of the strengths and weaknesses of each health plan.

Hawaii Pacific Health:

Reduction of administrative burden and meaningful incentive payments to encourage participation. Some of the most successful innovation models provide overall direction and financial incentives and then minimize the actual requirements. Less micromanaging and removing administrative barriers to implementation of innovative approaches to providing care would be welcomed by those that are ready to move beyond traditional FFS.
Greater utilization of primary care occurs when the PCPs are appropriately reimbursed for the care and outcomes of their panel of patients (and know who they are) and the patients also have some reason to seek primary care, rather than seeking care elsewhere.
Attribution must occur prior to care being provided, not after expensive care has already been provided. We recognize the challenge of continuous in/out flow of patients across various contracted plans. Therefore, developing a system for auto-enrolled patients to have an incentive to start a relationship with a PCP is key.

- Reimbursement should be based on actual interventions/interactions. For outreach but no contacts made there should be reasonable reimbursement, however, for face to face contact and virtual visits there should be a higher reimbursement scale. Individuals with high needs appear to benefit from consistent direct contact. Having face to face interactions could potentially reduce harm as the service provider may notice or be aware of something physically going on with an individual that they would not pick up on over the phone. Therefore, by financially incentivizing direct or virtual face to face contact there is more reward for both parties involved.
- Consideration needs to be given for patients that are noncompliant, high need and high utilizers. Providers who treat these patients should be given a different payment model or higher fee schedule to help offset costs and resources required to engage and create continuity of care for high need patients.

Question 8 – Providers report that maintaining multiple VBP contracts across their patient population can lead to challenges and complexity. What infrastructure, tools, and resources need to be in place to support provider participation in VBP and decrease administrative burden on providers? What is the best approach for assessing provider readiness to participate in VBP?

Lana`i Community Health Center:

- Establishment of a sound patient attribution methodology that is patient-centered;
- Collection of evidence that the value-based payment methodology would work for the identified population

UHC:

UnitedHealthcare appreciates the flexibility QI MCOs are afforded when working with providers and encourages MQD to continue to foster innovation by allowing MCOs and providers to design VBP models to produce meaningful outcomes. Providers have varying capabilities to participate in VBP. More providers are likely to participate in increasing levels of performance compensation or risk if MCOs can use their tools and expertise to inform agreements on an individual basis based upon provider readiness.

To support providers and MCOs in successfully developing and executing meaningful agreements, we encourage MQD to consider pursuing the following opportunities to create a strong VBP environment while reducing complexity and administrative burdens:

Consistent quality metrics across MCOs. To ease provider administrative burden, we support a consistent approach to identify a common set of quality metrics (industry standards and benchmarks) consistent across all MCOs and aligned to current or future contract requirements. The benefits of MCOs working together includes administrative simplicity for other stakeholders and providers and the mitigation of competitive approaches that could hinder overarching progress.

Shared data support model. While it is important that MCOs have flexibility in designing the data analytics support for providers (e.g., developing reports and tools based upon provider performance strengths, value-based contract and transformation goals), the support model used across providers can be consistent. In UnitedHealthcare's experience across the country, we find three areas of health information technology are foundational to support providers and assuming risk for patients:

- Access to identifiable claims data to perform analysis of savings targets;
- Ability for providers to share data and provider level access to electronic health record (EHR); and,
- High comfort with reporting and data aggregation within those systems.

UnitedHealthcare is highly supportive of tactics to use established data solutions such as all-claims databases and health information exchange (HIE), to enhance the availability and sharing of data. This approach allows the collating of clinical detail at the individual level which can, in turn, be made available to MCOs.

Provider education. There is an opportunity to educate providers on the existing consistencies providers can use. For example, aligning incentives with performance, common outcomes focus on quality and efficiency, use of population registry, and collaboration with MCOs to directly address patient needs.

Regarding assessing provider readiness, moving to VBP strategies requires that providers are ready and willing to adopt new models that come with increased risk and enhanced care coordination and quality outcome management. To support these efforts, we encourage MQD to perform or support an in-depth analysis of the current status of adoption of information technology infrastructure such as adoption of certified EHR software at the practice level, participation and evolution of meaningful use, provider engagement in the HIE and adoption of advanced models of care. This work could be coupled with a transformation map to enable system transformation at a pace that is meaningful to the delivery system, maximizes adoption, and rolls out support or funding that aligns with the system's readiness to act.

Kaiser Permanente:

KP has executed the most mature VBP arrangements along with the necessary supports for providers to be successful. We ask that MQD recognize KP's success in executing the most mature VBP arrangements within the HCP LAN continuum. We also recommend that MQD allow QI health plans to partner with providers to develop and implement VBP arrangements that move providers along the VBP continuum and minimize practice pattern disruptions while improving the quality of care for QI beneficiaries.

Based on our wealth of experience driving high quality outcomes through VBP, we urge MQD to create a system that fosters robust data sharing and EHR adoption for providers. We recommend that MQD convene a workgroup comprised of QI health plans, providers (inclusive of hospitals, specialists, rural and integrated providers) and other stakeholders. This group can establish a system that standardizes data sharing protocol and capabilities and provides resources and tools to support adoption of EHRs. We also recommend that QI health plans work together to align quality measures and targets which will decrease provider administrative burden.

Based on our experience in administering mature VBP arrangements in addition to contracting with other payers in markets to execute similar structures, we recommend that providers be assessed for readiness in a comprehensive manner. We believe that the above-mentioned workgroup would be well positioned to collaborate and create a readiness tool that standardizes criteria. Creating alignment amongst payers and providers can create cohesion and ensure that all parties are working toward the same goal.

We fully support MQD engaging providers and QI health plans to determine what gaps currently exist in the provider community that prohibit success in VBP arrangements. We are well positioned to partner with MQD and other QI health plans to share our best practices and experience utilizing VBP to drive high quality care.

Hawai`i Primary Care Association

The HPCA urges:

- Promotion of data transparency as described in #2, including the electronic sharing of data (via an existing system or platform (not excel spreadsheets) without having providers enter data in different systems/platforms;
- Establishment of a sound patient attribution methodology that is patient-centered;
- Collection of evidence that the value-based payment methodology would work for the identified population;
- Support for technical assistance through ACO's or similar organizations to assist providers in decreasing administrative burden; and
- Assess provider readiness to participate in VBP, ask providers via in person interview or surveys or use information that may have already been collected by providers to determine readiness. Because HPCA has also assessed readiness, it would be prudent for MCD to work collaboratively with HPCA to accomplish this.

Ohana

We are keenly aware of the complexity and administrative burden involved for providers participating in multiple VBP contracts. To reduce that burden and encourage consistency among health plans' VBP arrangements, 'Ohana recommends that MQD convene a multi-stakeholder collaborative to define a set of quality measures that align with MQD's performance standards and can be incorporated into VBP arrangements as appropriate. Aligning performance measures across VBP arrangements will ensure that incentive programs are focused on the highest priorities for Hawai'i, while reducing provider administrative burden of trying to meet various performance standards across multiple health plans.

We recommend that health plans continue to have the discretion to design and implement a variety of VBP arrangements based on provider type and capability in order to meet providers where they are in their ability to participate and advance along the VBP continuum. Lack of flexibility may prevent providers who lack critical panel mass, technology, infrastructure, and staff to succeed in the adoption of and movement towards more advanced VBP models. Allowing health plans flexibility to develop new VBP arrangements encourages innovation and promotes collaboration between health plans and providers to find mutually beneficial solutions focused on high quality care and cost effectiveness.

INFRASTRUCTURE, TOOLS, AND ASSISTANCE

MQD and health plans can support providers through technology, data, and training that meets their current needs and prepares them to advance to higher levels of engagement in VBP. We recommend the following support for providers:

- Investing in infrastructure development and technology, including electronic health records, which increase administrative simplification.
- Offering training to help providers understand and accurately report data that impacts a provider’s ability to meet performance standards and outcome measures included in VBP arrangements. For example, health plans should collaborate with providers to assess and support complete and accurate coding, which is critical for providers’ success in VBP programs.
- Sharing timely, actionable, and accurate data that empowers providers to improve quality and reduce costs and inappropriate utilization, including through the HHIW.
- Offering education, tools, and assistance to support providers in analyzing and effectively using that data to improve VBP performance.
- Delivering frequent provider communication through multiple modalities (e.g., in person, telephonic, online, etc.)

ASSESSING PROVIDER READINESS

Proper assessment of a provider’s readiness is crucial to positioning the provider to succeed in the right VBP arrangement. We suggest the assessment should include staff qualifications, panel size, and technology infrastructure. We recommend providers be placed into categories of readiness along with a roadmap for assuming increasing levels of risk. ‘Ohana has access to a broad set of readiness assessment tools for providers to help assess their ability to take on greater levels of risk assumption across the HCP-LAN continuum. MQD might consider a standard readiness assessment be discussed as part of a multi-stakeholder VBP collaborative.

Collective Medical:

Collective agrees that providers in VBP contracts should have consistent measurement and tools available across payers. A single platform for coordinating care improves outcomes and patient experience as all stakeholders work from the same game plan. Under these conditions, VBP providers gain real-time insight into how their assigned patients are accessing care across the continuum, enabling providers to engage that population during an encounter or immediately afterward. This immediacy in data sharing should allow providers to become more effective in achieving outcomes set by the state and health plans.

Columbia Medical Associates, a Medicare Shared Savings Plan Accountable Care Organization, saw the following results after using their new data sharing platform for 12 months:

- 15 percent reduction in ED utilization per 1,000 paneled patients
- 7 percent reduction in avoidable ED admissions
- 16 percent increase in patient satisfaction regarding availability of urgent appointments
- 13 percent increase in provider engagement scores (internal staff surveys)
- $6.5 million reduction in the cost of care

- Overall increase in patient satisfaction scores, placing CMA at #1 in Washington State

Additional Input: Data Sharing Platform in Harmony with Established HIE, EMR and ENS Systems

We acknowledge that existing systems in use in Hawai'i provide electronic notifications (ENS) that overlap with part of our capabilities and recognize the value of those systems. It would be beneficial for DHS to work to expand upon current ENS capabilities by incorporating additional data sharing solutions. We offer the table below to illustrate how a robust data sharing platform such as Collective's can accomplish this.

The Collective Platform Compared to Standard ENS Platforms		
Functionality	Collective Medical	Standard ENS
Accessible to all emergency room providers and case managers throughout the state for cross-organizational care coordination	✓	
Accessible to all payers, behavioral health clinics, LTPAC and primary care providers throughout the state for cross-organizational care coordination	✓	✓
Curated insights summarizing disparate data sources: • ED admit, transfer and discharge encounters (ADT) • Inpatient/hospital ADT • Patient pertinent medical history • POLST advanced directives • Continuity of Care Document (CCD) • Payer and Medicaid Pharmacy and Medical Claims data • Collaborative care plan • Workforce Safety and Security events • State PDMP integration • Public health registry integration • Real-time analytics based on hospital/plan configured criteria	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓
Cross-organizational patient matching capability	✓	✓
Real-time analytics identify high-risk patients/target populations and alert providers only to those patients who require additional context or attention, eliminating 'notification fatigue'	✓	

Context-specific notifications embedded into existing workflows through the existing HER (e.g., ED tracking board) or clinical management system	✓	

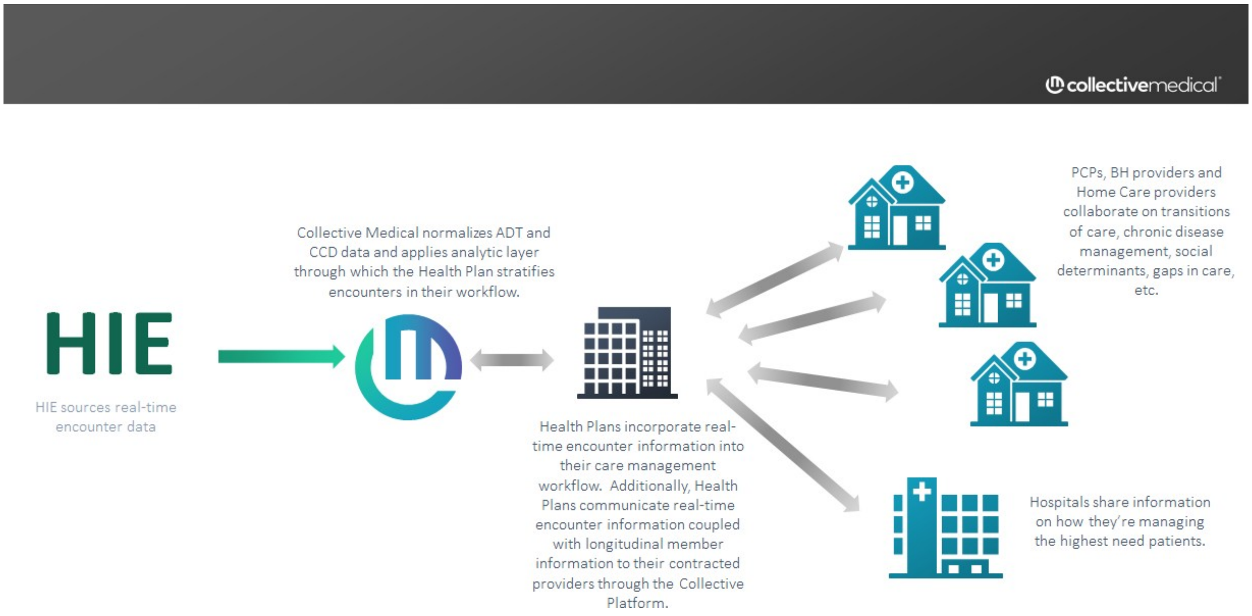
Functionality	Collective Medical	Standard ENS
Notifications with clinical content, curated and synthesized to meet the unique needs of acute, post-acute and ambulatory care providers	✓	
Incorporation of ED or system-wide related security incidents into real-time analytics and provider notifications	✓	
Incorporation of collaborative care plans and care recommendations that can be consumed and contributed to by all stakeholders involved in a patient's care	✓	
Configurability of notification mediums by stakeholder, either individually or by type (e.g., HER integration, secure [DIRECT] mail, SMS / text, email, web portal, network printer, or fax)	✓	
Customizable population-level dashboards and reports based on payer or facility	✓	

A robust data sharing platform also represents an important addition to a traditional health information exchange and an electronic health record system. We do not consider ourselves to be in competition with those means of data sharing. We aim, instead, to collaborate with those who provide them to round out and enrich the data offering as well as ease the delivery, where possible, to the providers, payers and others who use the data to collaborate with each other. As HIE and EHR systems vary in their features and functionalities, we typically work with our customers or innovation partners to ensure they are receiving the parts of our offering they most need to reach their goals. A comparatively modest investment in advanced interoperability solutions should boost the use and value of existing ENSs, HIEs and EHRs—not supplant them. Consider an HIE that provides patient record look-up, clinical alerts and clinical summaries. A broader data-sharing platform such as Collective's should have the capability to enrich that content as follows:

- Patient record look-up
  - Comprehensive history of utilization from in and out of state
  - Ability to surface key patient attributes with unique, goal-driven flag or tag capabilities
  - Deployment of integrated provider workflow

  - Inclusion of detailed patient-specific care insights from collaborative care plans as documented by providers and payers on the network
- Clinical Alerts
  - Real-time, context-specific, predictive insights, at the point of care in workflow, to enable point-to-point collaboration across the spectrum
- Clinical summaries
  - Addition of detailed, user-generated, patient-specific care plans shared across the network, in workflow at the point of service

Figure 1, below, will help visualize one example of how Collective can work in partnership with an HIE.



HIE sources real-time encounter data

Collective Medical normalizes ADT and CCD data and applies analytic layer through which the Health Plan stratifies encounters in their workflow.

Health Plans incorporate real-time encounter information into their care management workflow. Additionally, Health Plans communicate real-time encounter information coupled with longitudinal member information to their contracted providers through the Collective Platform.

PCPs, BH providers and Home Care providers collaborate on transitions of care, chronic disease management, social determinants, gaps in care, etc.

Hospitals share information on how they're managing the highest need patients.

Figure 1. Collective rounds out and enriches the data provided by an HIE, boosting its value to providers and payers. For simplicity here, we show data flowing in one direction. In practice, the HIE and Collective also connect directly to providers.

Community First:

There should be multi-payer business models that create a coherent financial framework for healthcare delivery within the community. Health plans who want to participate must agree to metrics of quality, savings, and accountability which will be worked out with the community, both medical and social service providers and community leaders. The community will be organized into a Regional Health Partnership which will determine these metrics. Health plans and MQD should be accountable to communities to provide clear, actionable data and feedback regarding community interventions. Health plans, like providers, should have penalties for lack of accountability.

Infrastructure, tools, and resources which would support provider participation in VBP include the common metrics mentioned above. The infrastructure necessary to support a community is a common data platform which integrates data from multiple plans to provide community level data, for example, the rates of avoidable ED visits and inpatient admissions in each medical home in the community, and also a community platform for referrals between medical and social service providers which creates accountability in the system, at the very minimum regarding the response time to referrals. The community should have analysts that can use this data platform to answer the community's questions.

Many characteristics to assessing provider readiness for VBP have been articulated: standardization of protocols for managing chronic disease such as high blood pressure and diabetes, staff working as a team and at the top of their licenses, practices comfortable with using EHRs, and PCPs are no longer on FFS payment models but have switched to PMPM/Quality models. The key, however, is the leadership ability of the provider. The best approach would be to rate them on the characteristics, establish thresholds, but assess the leadership ability and commitment of the provider as an essential factor.

Healthcare Association of Hawaii:

One of the biggest benefits would be standardization and improved communication between plans and providers. Especially now, providers are managing a public health emergency while also trying to keep up with regulatory and plan changes that require immense time and resources to understand and implement. QI plans should be required to be more hands-on in their approach and have open, constructive discussions with providers to ensure that standards are not needlessly onerous and that any questions can be answered quickly and comprehensively. We would also suggest that plans should initially focus on education and practice transformation, which will enable providers to better transition to other models.

In creating a value-based program, MQD should create one that is broad-based rather than creating multiple programs that create excessive data reporting and tracking burdens. Working with providers to incorporate these practices into their everyday work would be helpful. We would also ask that considerations be made for smaller facilities, such as some skilled nursing facilities and rural facilities.

CMCH:

It is hard for providers to participate or even maintain the VBP program because there are too many requirements. Gathering data for different health plans is more of a burden than an incentive. CMHC is not currently participates in VBP program.

AlohaCare:

AlohaCare believes that QI health plans have a responsibility to support successful provider VBP model adoption. Conditions that prevent provider readiness may include limited financial reserves to support risk-bearing arrangements; inability to cover reductions in revenue resulting from missed performance benchmarks; or inadequate data analytic capabilities. QI health plans and MQD should collaborate to establish benchmarks for consistent assessment of provider VBP readiness to increase VBP model adoption.

To avoid over burdensome processes, MQD could encourage QI health plans to collaborate to create models responsive to provider readiness, from P4P to total cost of care. This approach is similar to the CHC QPP program approach MQD recently supported. A variety of models supports providers with various levels of financial reserves, capabilities, readiness, and panel size. Approaches that focus on large and high-volume providers (health systems, large clinics, CHCs, and PCMHs) may present the greatest opportunity for gathering input on approaches to support successful implementation.

AlohaCare offers the following suggestions for supporting providers in VBP models:

- Sharing timely, actionable, and accurate data that empowers providers to improve quality and reduce costs and inappropriate utilization. MQD should establish a method to deliver provider access to claims data for medical, institutional, pharmacy, BH, LTSS, and other MQD funded services in a central repository or by providing QI health plans with access to claims not covered under the Plan’s QI contract.
- Offering education, tools, and assistance to support providers in analyzing and effectively using data to improve VBP performance.
- Providing technology solutions that increase administrative simplification.
- Investing in infrastructure development, data and technology, and/or education and technical assistance.
- Delivering frequent provider communication in collaboration with QI health plans through multiple modalities (e.g., in-person, telephonic, online, etc.) to promote a consistent message across all stakeholders.

Health Team Works:

Our INFRASTRUCTURE AND TOOLS recommendations include the following:

- One standardized HIT platform that aggregates timely claims data across health plans awarded Med-QUEST contracts under the RFP, providing practices consistent tools to manage their Med-QUEST patient population regardless of payer. At a minimum, the HIT platform should have the following capabilities:

o Data analytics tools and functionality to support two-step risk stratification, care management and service coordination, population health and management of patients with complex medical and social conditions
o APM performance management capabilities that allow practices to manage performance for measures including clinical quality, utilization and financial
o The ability to interface with Hawaii's market leading EHRs and other sources of ancillary data such as labs, Hawaii Immunization Registry, etc.
o Participation in the Hawaii Health Information Exchange (HHIE)
o Consistent and timely actionable data reports
• Follow North Carolina's NCCARE360 with one standardized platform deployed statewide to connect healthcare delivery systems and practices with community organizations that address Social Determinants of Health.
CONSIDERATIONS:
o Consider requiring health plans awarded contracts to participate in a multi-payer collaborative with the goal of arriving at statewide solutions for the infrastructure and tools bulleted above
o Consider involving other Hawaii stakeholders including state and local government, University of Hawaii, legislature representation, Hawai'i All-Payer Claims Database, Hawaii HIE, and Laulima Data Alliance
o Consider using a 3rd party Practice Facilitation organization to convene and facilitate the multi-payer collaborative with other stakeholder involvement and ensure provider interests are considered
Our RESOURCES recommendations include the following:

Practice Facilitation is described on page 2 with details of the multifaceted roles and responsibilities for an implementation support role for VBP. Practices transitioning to care models driven by VBP contracts require access to resources to support practice transformation. Consider a 3rd party organization solely accountable for statewide Practice Facilitation to assess provider readiness, provide consistent support across health plans and provider networks and facilitate multi-payer collaboratives and other stakeholder groups.

ASSESSING PROVIDER READINESS

Consider using a standard tool to assess provider readiness. An example is the HealthTeamWorks Advanced APM Readiness Evaluation.

HMSA:

In HMSA's experience, implementing VBP models that are focused on comprehensive primary care or population health management requires a significant investment in people, processes, and technologies.
In Hawaii, solo practitioners and small medical groups often lack the financial and resource capacity to make the necessary investments to be successful. Therefore, HMSA has invested considerable resources in developing educational materials, conducting meetings and webinars, and being available for individualized question and answer sessions as many providers are not familiar with VBPs.

Additionally, the alignment of incentives, measures, and member benefits across multiple payers can help to reduce the administrative burden for providers and strengthen the potential for behavioral change. Historically, providers have noted that the adoption of a common set of quality measures for incentive purposes helps with adopting clinical best practices, standardizing office workflows, and reducing program-specific reporting efforts. HMSA implements its Payment Transformation model across all lines of business and seeks to align with national VBP and quality programs.

The ability to adopt population health management strategies requires tools and data that allow the provider to risk stratify their entire panel, identify and build strategies around member cohorts, and analyze utilization and cost data across the entire patient panel. Health plans and/or providers aggregate data from multiple sources including claims, labs, facilities, electronic health records, and other community partners to construct a longitudinal care record that enables coordinated care. Health plans and providers can use this aggregated data to view quality metrics and care gaps, as well as conduct analytics on the costs and utilization of the practice.

Ohana Pacific Management Company:

This will be dependent on what VBP contracts are requiring

Pacific Medical Administrative Group

Value based payment models are challenging to apply in a meaningful way in any particular marketplace. Most VBP's are modeled on the same principles with similar focuses. The application to any locale, such as Hawaii, or any group, such as independent providers or Quest members, will encounter significant barriers for success. If these barriers are not resolved appropriately for provider and patient support, the VBP will not promote the value it is intended for.

Providers need support in a clinically relevant way and incentive to perform clinically relevant outcomes that benefit our patients. Providing a system that lacks the right framework to encourage and allow this, because it is the current trend is unwise. Providing a system that is relevant, but at the wrong time is also unwise. It is more appropriate to decide on a meaningful VBP model and determine how best to achieve this goal through a step-wise progressive process that encourages improvement throughout development.

Many of the responses in this RFI will cover how best to supply infrastructure, tools, and resources needed for any VBP system to succeed. MQD would benefit the most by having all plans support and contribute to as many common support systems as possible. Why pay 5 different plans for the same support systems 5 different ways? Providers only need one system that works and can accommodate their patients.

In any case, assessing provider readiness will depend on the VBP system and the current situation. Only experienced, knowledgeable, and appropriately motivated entities can provide an objective evaluation for any system implementation.

Waianae Coast Comprehensive Health Center:

Healthcare Home Standards - NCQA standards do not reflect all needed competencies underserved communities seek. Complementing national standards with what our community has asked for in terms of provider proficiency in cultural practices, community engagement, help in developing job skills, and a systematic reduction in care access barriers should be implemented. Health Plan support to develop these capabilities seem appropriate if they can be proven to be impactful on desired outcomes.

Hawaii Pacific Health:

The greatest barriers related to VBP implementation are related to failure to have actionable data to identify areas for improvement and efficiency; (1) lack of data integrity to accurately capture Attribution data/integrity; (2) lack of data integrity to accurately capture patient plan status across the continuum of the entire MedQuest population. Delayed enrollment data is still a problem which adds to the above issues. Also, improvement in VBP models requires data specs that are known, preferably with baseline data also known, at the outset of the measurement period.
Require plans to accurately and consistently provide detailed attribution data, utilization details (What provider did patient engage, for what services and when did they receive the care) with providers. Without timely (at least weekly) detailed data, providers cannot manage much less track the care for QUEST patients. Plans must provide attribution, utilization, and member's status to providers. Increased data transparency is key.
Greater establishment of uniform standards by MedQuest division, with appropriate resources would assist in the minimization of variation and complexity across VBP programs across the plans. Consistent with CMS Medicare metrics, with adjustments to benchmarks appropriate for the Medicaid population. Also particular population for pediatrics to be based on nationally based benchmark tools such as (e.g. Vermont-Oxford Network).
Some evidence for provider readiness include: (1) Electronic Health Records; (2) Experience with existing Medicare VBP programs (e.g. CPC+).

Question 9 – Please describe a recommended approach for expanding implementation of APMs within the QI program over the next 2-4 years. Would you recommend targeting specific provider groups? Would there be a focus on specific measures, and if so, which measures? How would this model be implemented to support providers during the transition period? What should the schedule of implementation be?

Lana`i Community Health Center:

- FQHCs should retain PPS.
- Focus should be on quality measures that are evidence-based

UHC:

UnitedHealthcare supports the state in accomplishing its goals and values the opportunity to provide insight and recommendations as the state considers the best ways to move forward with expanding APMs. Strong partnerships and alignment between the state, members, providers, local communities, and MCOs are essential to fostering better health outcomes and controlling the total cost of care.

Provider Engagement

We recommend MQD first explore a pilot APM with federally qualified health centers (FQHCs), which serve over a quarter of QI members. In working with FQHCs and our National FQHC Advisory Board, we have found these providers to be well positioned and interested in pursuing new models to drive quality, integration, access and total cost of care savings. With unified goals, MQD, QI MCOs and FQHCs could develop an APM that supports a strong, stable primary care system and produces meaningful health and financial outcomes. Additionally, FQHCs are part of a larger health care system. Their coordination and quality improvement actions will influence the clinical practices of others and offer insights to inform the development of APMs with other provider groups.

We encourage MQD, QI MCOs and provider associations to explore a multi-payer ACO model, with participation from all MCOs, for providers with smaller QI membership. Aggregating QI membership across MCOs will create scale to create shared incentives to improve quality and achieve savings targets.

Measures

As mentioned in earlier questions, we recommend MQD work with stakeholders to define a set of common measures to promote alignment and system change. MCOs and providers will be able to develop agreements tailored to a practice based upon measures in the unified set most relevant to a provider's scope and patient population. When partnering with stakeholders to define metrics, we would encourage the inclusion of measures related to maternal and infant health, opioid use disorder, diabetes, and total cost of care.

Implementation

UnitedHealthcare has found deployment of models across the APM spectrum is most successful and has the best outcomes when there is flexibility to create programs based upon the provider and members' needs rather than an arbitrary target. We encourage MQD to prioritize ongoing APM evaluation to understand and learn from the value produced.

As part of implementation, MCOs should support providers with data, consulting, and technology to help them transform their practices in preparation for more advanced

APMs, but provider scale, engagement, and capabilities will determine their advancement along the APM spectrum. It is important that the timeline be relevant to provider readiness and ability to impact cost and quality outcomes. Additionally, the timeline may need to be flexible given resource limitations due to the current public health emergency. However, we do expect the COVID-19 experience to influence APM advancement long-term as more providers consider the benefits offered by engaging in risk-bearing models.

Kaiser Permanente:

support MQD in working with payers, providers, and other stakeholders to create a systematic approach for VBP. Many providers in Hawaiʻi have long been struggling to stay afloat financially. Surveys have found that complex VBP arrangements have not only increased administrative burden but disincentivized providers to practice medicine, and that complex VBP arrangements have led to providers leaving the islands and/or retiring, which has furthered provider shortages. We recommend that due to the impact of the COVID-19 pandemic, MQD should delay requiring the implementation of new VBP requirements in order to reduce further financial strain on providers. If MQD decides to make a change to the current contract requirements, we recommend MQD require QI health plans to have a percentage of medical spend allotted to VBP arrangements.

We believe that the best approach for expanding implementation of APMs over the next 2-4 years is to first and foremost gain stakeholder buy-in; this is inclusive of payers, providers and stakeholders. Providers often want to decrease administrative burden when moving to more mature VBP arrangements (HCP LAN Category 3-4). However, providers often don’t understand the operational requirements associated with mature VBP arrangements. Successfully developing VBP arrangements for providers that meet providers where they are within the HCP LAN continuum requires creating a standardized process for assessing readiness, as well as education on implementing and operationalizing VBP arrangements. A process for measuring outcomes must be defined in order to determine if arrangements have demonstrated success. Stakeholder engagement in the development of VBP arrangements and technical assistance during implementation is essential to ensure success.

As stated in the above response, we recommend that MQD convene a workgroup comprised of QI health plans, providers (inclusive of hospitals, specialists, rural and integrated providers) and other stakeholders, to develop a roadmap for expanding the use of APMs within the QI program over the next 2-4 years. This workgroup would drive standardized data sharing protocols, measures, and program elements to reduce administrative burden for providers and drive greater adoption of VBP. In addition, quality measures should continue to align with MQD’s priority outcomes.

Kokua Kalihi Valley:

The evidence of VBP and APMs is NOT robust. MedQuest should see these strategies as needing more proof of concept before widespread introduction. Moreover, medical providers intrinsic motivation to provide excellent care should not be undermined by simple payment schemes that seek to reward good behavior. Finally, we know that in order for these schema to work, we need to be able to accurately adjust for risk, something that is NOT currently possible

Hawai`i Primary Care Association

As previously shared, HPCA recommends that FQHCs retain PPS. There is a focus on quality measures that are evidence-based. Options should be considered to address social determinants of health including provider level risk adjustment and MCO-level risk adjustment.

Ohana

We recommend MQD maintain a foundation of standardization based on the HCP-LAN APM framework while building flexibility into the VBP/APM requirements in the next re-procurement to encourage innovation. VBP is not “one size fits all” and models require tailoring to meet the needs of the market. However, as stated above, providers need to be able to accept a panel size of at least 500 members in order to responsibly participate in advanced VBP arrangements with downside risk. We look forward to discussing additional recommendations including a schedule of implementation through follow-up discussions from this RFI, and in detail through an RFP response.

Community First:

We recommend MQD focus on FQHCs. They are essentially the preferred provider in the Federal/State insurance system for Medicaid beneficiaries. FQHCs receive a high PPS rate because they treat the uninsured and a population with many social determinants of health. It is a cost plus system, but ultimately what drives revenue is the number of billable encounters; it is fundamentally a FFS model. These billable services may not be the highest value services. For example, the services of a community health worker who owns and manages the personal relationship with SHCNs patients may contribute more to better health outcomes and lower costs but would be overlooked in favor of billable service of a PCP.

There should be quality measures set on a state-wide basis following CMS measures to minimize variation. There should also be focus on creating a process to allow a community to set some measures specific to its needs and capabilities. The most important VBP measure should be the rate of avoidable ED visits and inpatient admissions by medical homes.

To expand implementation of APMs within the QI program in the next 2-4 years we recommend focusing on getting FQHCs off of FFS onto a PMPM model with quality incentives, shared savings, and penalties for lack of accountability. MQD must address the challenge of how shifting to a PMPM model while protecting the PPS equivalency. How can an FQHC be incented to develop higher value services and not be penalized for decreasing billable encounters?

In 2021 we suggest a pilot with one or two FQHC's begin whenever the MQD contract starts. Points should be given to health plans who have made progress with any FQHC to develop APMs in the mean time. These pilots should run for two years and lead to a model which can be implemented throughout the State. Given the PMPM payment transformation for primary care in the commercial market, this could lead to a single, coherent, value based payment model for primary care in the State in four years.

FQHC's will need access to timely, clear actionable data. They will need access to a common data platform with claims data from all QI plans in the region. Ideally the data platform would be sophisticated and flexible enough that a business analyst in the FQHC could develop reports. Perhaps the HHIE could serve as this platform? Access to timely, clear actionable, multi-plan data is critical to APMs and MQD should be accountable for providing this.

Healthcare Association of Hawaii:

A common set of metrics for VBP is highly desirable, as is a common reporting platform. This will allow the VBP program to be more successful and enable providers to participate more fully. Having clear guidelines of what needs to be achieved and how to report those achievements would also benefit the department in collecting data on the efficacy of a program. We would suggest that measures be limited and targeted to reduce provider burden and encourage provider participation.

Some providers are more prepared to implement VBP than others, especially in light of federal VBP efforts. In cases where providers have had less time to learn about VBPs, it will be important to hold multiple open forums to address concerns. Our members specifically requested that MQD hold meetings and convene groups of providers for this purpose. Collaboration with these providers will be key to getting a successful program off the ground and reducing obstacles to implementation.

In any VBP, it is important to create meaningful incentives to reach goals. However, as noted above, some providers may need more time or help in complying with VBP requirements, especially if they are not used to such arrangements. Working collaboratively with provider groups can ensure smooth implementation of VBP efforts. Further, the lack of standardization of VBP programs is a barrier to more widespread uptake. MQD must collaborate with providers to promote adoption, especially to address concerns prior to the implementation of any program.

One of our members provided the narrative below and we felt that it is useful to recount their answer below in response to this question.

Until recently, paying for care delivered as part of a VBP has been difficult because payers were not always reimbursing for care management and consultation time that occurs outside of a direct patient encounter. In particular, the difficulty with some of the VBP models is that solo or small group practitioners do not have enough patients to warrant the employment of full-time care managers or social workers and consulting psychiatrists.

Much of the current work is self-funded by organizations. However, this is changing for federal programs and we would support MQD moving in this direction. For example, since 2017, the Centers for Medicare and Medicaid Services (CMS) has been reimbursing a group of collaborative care G-codes that cover the non-face-to-face time necessary for its success. Beginning in 2018, these codes were given official CPT codes. There is now growing expectation and hope that other payers will soon be reimbursing these codes as well. This should create a revenue stream for practices that will further the adoption of this model to the benefit of patients and practices.

One large member is working on a collaborative care model available to primary care practices in its network to help address mental health and substance use disorders in a way that benefits patients and providers while being financially sustainable. The member is working to provide care management support through a core team of behavioral health social workers and contracted psychiatrists. We believe strongly that services like this should be made available and reimbursed by all payers. We hope that MQD’s new contracts can support this type of effort so that these are coordinated and uniformly implemented.

Some of the potential models to consider include:

1. Value Based Contract Model. This model will allow better coordination between care managers and specialized providers. The model could also include a reimbursed

telemedicine option, which would be ideal to support the smaller solo and rural practices that could not employ or contract directly with care management and psychiatric services.

2. Comprehensive Primary Care Model of Reimbursement (CPC+). The CMS CPC+ program seeks to improve the quality, access to, and efficiency of primary care. There are several tracks and payment elements in this model that can support the stated goals of MQD. This model could be utilized for larger practices or healthcare system-employed physician groups who would be able to employ or contract services directly.

CMCH:

For CMCH – this will be difficult to accomplish due to a lot of administrative requirements that we have to meet. Behavioral health providers will be a good provider groups for this APMs program but not sure if all will participate again due to administrative requirements for this type of programs. The data that needs to be gathered in order to qualify for APMs.

AlohaCare:

Variation in provider APM aptitude and financial risk tolerance calls for strategies that begin with assessment of each provider's readiness for VBP. Reduced revenue due to COVID-19 safety measures may impact provider appetite for financial risk.

AlohaCare recommends collaboration between MQD, QI health plans and CCS to assess provider readiness for the Healthcare Payment and Learning Action Network (HCP-LAN). Once assessed, MQD should develop a set of core APMs and establish common quality, service, and cost measures. QI health plans can then support providers to develop an approach to participation based on current capabilities.

AlohaCare recommends partnering with larger, high-volume, clinically integrated organizations experienced with coordinated care models and complex populations during the initial phases of APM model development. We also recommend supporting patient centered medical homes to build relationships with the BH and Community Based Organizations (CBOs) through incentive payments and supportive infrastructure to advance the Collaborative Care Model.

QI health plans should focus on measures that are currently aligned with MQD's QI health plan withhold incentives and the hospital pay for performance programs to produce the most benefit for the healthcare system payment transformation.

AlohaCare recommends the following schedule for implementation:

☐ Assessment of provider readiness, capabilities, and willingness to move along the HP-LAN APM framework (Q1 2021).

☐ Convene a multi-stakeholder collaborative to develop a set of aligned performance measures across VBP arrangements to ensure that incentive programs are focused on the highest priorities for Hawaiʻi (Q1-Q2 2021).

☐ Identification of high-volume Medicaid providers for APM model development (Q3-Q4 2021)

☐ Development of Model APM Models across the QI health plans based on providers and capabilities (Q3-Q4 2021).

☐ Convene a multi-stakeholder collaborative to develop a roadmap for implementation of a diagnosis-related group (DRG) payment model that allows hospitals and QI health plans the time to plan for a successful conversion from per-diem reimbursement (Q1-Q4 2021).

☐ Implement APM Contracts with identified providers based on QI Program timelines for January 1, 2022.

Hawaii Health Information Exchange:

Hawaiʻi HIE recommends that Med-QUEST build on the investment already made so that HHIE can work on:

- Development of a Provider Credentialing portal. Each health plan needs to credential providers to participate in the MQD program. Rather than have each do this separately, HHIE could stand up an interface into its existing provider repository to support the credentialing function. This would provide a single location for Med-QUEST to review for all their providers/clinics/facilities and would also get us to the desired state of full participation in the HHIE by Medicaid providers. (Supports Question 2).

- Value Based Program tracking. HHIE could serve as the repository for tracking performance under the Value Based Program (VBP) based on metrics input by MQD and actual services rendered by participating providers/clinics/FQHC's. The information repository already exists for the health care services. A common set of rules can be established and then analytics applied, leveraging the capabilities of the Health Analytics Office at Med-QUEST. This approach would also increase the level of participation in the HHIE by not only Medicaid providers but also health plans. (Supports Questions 2 and 8).

- Performance reporting and dash-boarding. Being able to have MQD staff review a single set of dashboards and reports would reduce the administrative burden and also allow for more accurate reporting to CMS. Creating this reporting function in a central location will not only reduce the overhead for MQD but should also provide health plans and providers with a clearer method for operationalizing their reporting obligations. (Also supports Question 2).

- Integration with Social Services Hub (SSH). There are ongoing efforts to explore the creation of a social services hub by various entities in the community. HHIE has been actively engaging with our stakeholders to progress toward setting up an SSH that supports care coordination and to bring about improved outcome. This hub would assist with triaging social services needed as part of a wellness or health care course of treatment. In an ideal state this hub would also allow social service agencies to refer individuals for healthcare services. Because HHIE is used to managing and protecting the confidentiality, integrity, and availability of Protected Health Information (PHI) we would be able to interface with the SSH to ensure an appropriate approach to information transfer. (Also supports Questions 2, 3, 4, 5, 6).

Health Team Works:

Success in any APMs requires integrated care delivery, strategic prioritization, infrastructure support, and workforce development and training. Additionally, the amount of time required for practices to transition to an APM depends on practice performance, culture and leadership, readiness to change, and access to adequate resources to support and fund practice transformation.

With these considerations, we recommend the following approach for expanding and supporting APM implementation led statewide by an accountable 3rd party Practice Facilitation organization:

- Conduct an open call for applicants and solicit provider and provider group feedback on the design of APMs (including specific measures)

- Convene and lead Patient and Family Advisory Council(s) “to bring

the perspectives of patients and families directly into the planning, delivery, and

evaluation of care”

- Assess readiness in provider networks and stratify practices based on performance, readiness, performance capabilities, integrated delivery capabilities, organizational structure, and experience with APMs

- Work with health plans awarded the RFP to establish a multi-year APM implementation plan that includes schedule, resource allocation, and evaluation with metrics and key performance indicators. The plan will reflect practice stratification, assigning aggressive timelines and goals to higher performing segments of the provider networks. Additionally, lower performing segments of the provider network will have more conservative timelines and greater allocation of Practice Facilitation resources.

- Facilitate a multi-payer collaborative and other stakeholder groups with the goal of improving infrastructure and tools available to provider networks to support practice participation in VBP

HMSA:

HMSA strongly supports expanding the implementation of APMs, as we have been designing and implementing APMs across the Learning Action Network (LAN) framework for over 20 years. HMSA's recommendations below draw from this extensive experience working with primary care providers, specialists, hospitals, and health systems.

1. Definition of implementation targets and schedules to allow for meaningful design and implementation, especially for providers with minimal or no experience under any APM. The most effective APMs require close collaboration with providers from design to implementation, which takes significant time. In addition, providers need time to develop and modify workflows. Health plans need time to develop processes to calculate and distribute payments (e.g., attribution, shared savings, quality). Realistic targets and schedules should consider the current state of APMs in Hawaii (e.g., current value-based spend for QI) and the time required to successfully implement an APM. Additionally, health plans should receive credit for payments that support and connect providers across the health care continuum as these provide important infrastructure for APMs (e.g., care management fees).

2. Achieve successful APMs by expanding in a logical, stepwise fashion across the LAN continuum. Transitioning from fee for service requires a significant amount of resources and time for providers and health plans.

3. Expansion of APMs over the next two to four years should focus on two key provider groups. The greatest impact on quality and costs will occur if health plans simultaneously focus on the same provider groups. The first key provider group is PCPs since they are the foundation for any successful health system. The second group is acute care hospitals since they are responsible for the majority of health care spending. Additionally, these hospitals are familiar with LAN Category 2C due to the various CMS quality programs. However, this will require hospital payments to shift from per-diem to DRG, which is already in process. While we recognize the importance of other provider groups, there are some inherent challenges of significantly moving them across the LAN continuum. LTSS providers are diverse (e.g., a family member) and the volume of services are relatively low. Similarly, most Critical Access Hospitals have inadequate inpatient volumes to design an effective APM. Finally, specialists vary significantly in how they practice (e.g., cardiologist vs. endocrinologist), as most are solo practitioners and not organized sufficiently to significantly shift quality and costs across the state.

4. All Hawaii PCPs should move to LAN Category 4A as quickly as possible. This allows PCPs to provide high quality, continuity of care for members even if they are unable to be seen in-person, which is particularly important in a pandemic for this vulnerable population.

5. Recognize health plans who are leaders in VBP implementation, specifically within the state of Hawaii. HMSA believes that health plans that have significantly moved providers across the LAN continuum in Hawaii should be recognized and rewarded for this effort. The primary reason for this is that providers likely implement similar workflows and processes when caring for patients, regardless of the requesting health

plan. Therefore, all QI members benefit when providers participate in APMs implemented by other health plans.

6. Minimize impact of enrollment churn for health plans and providers. One of the biggest challenges to APMs is timely and accurate attribution, including selection of PCPs and contact information. This information is needed as close to the day of any enrollment changes as possible to ensure that health plan payments align with panel management for providers.

Ohana Pacific Management Company:

Provider specific targets make sense for many reasons; however, there are however, common ones which if standardized and applied consistently would help in integrating care and focusing on outcomes for beneficiaries. Examples as follows:

a. All providers tied to 30 day all cause readmissions (including PCP's, Specialist, Hospitals, SNF and QI health Plans)

b. All providers required to participate in CCD requirements - lack of at least 90% participation for all state funded patients results in negative rate adjustment for provider and positive for those who exceed (incentive pool concept) - 4 year rollout.

I. Year 1 – baseline
II. Year 2 – Measurement Year
III. Year 3 – Incentive/Penalty
IV. Year 4 – Improvement (must meet or exceed prior year and be in top 50th percentile) & Incentive/Penalty

c. All providers tied to universal quality measures (TBD)

Pacific Medical Administrative Group

If MQD desires to expand Alternative Payment Models, it would best be achieved using smaller pilot groups, such as groups of PCP's or a particular specialty. Once successful, further expansion to include more providers could be done. Choosing a PCP group or specialty would depend on a needs assessment for MQD.

Measures should be chosen by experienced QI providers and be specific to the focus group. The focus group should have full input into adopted measures and outcome expectations in order to facilitate the most effective use of any incentive money, provider time, and patient efforts.

Measures that support the APM models would best augment providers by encouraging efforts to become more efficient and reward good patient outcomes. Again experienced facilitation is the key to successful implementation.

Queens's:

Developing a value based contract model with clinically integrated physician networks or accountable care organizations would allow organizations to employ or contract with the care managers and psychiatrist to provide this service for multiple small practices. In addition, including a reimbursed telemedicine option will enable organizations to offer this service to rural practices large or small, increasing access to evidence-based psychiatric and substance use care to those who have had limited access due to the inability to imbed behavioral health care specialists in the practice and lack of psychiatric providers.

Hawaii Pacific Health:

Difficult to track MedQuest to oversee transition of plan. Recommend a consistent VBP model across all QI plans, with differences in performance/outcomes being the differentiator for payment differences. VBP models require investment in infrastructure that MEDQUEST and Providers are hard-pressed to provide given the current economic climate and outlook. Payers, however may have the financial means and could be required to provide an infrastructure investment to be allocated to providers who participate in VBP models. Overall savings to be shared between MEDQUEST and Providers. Providers will use the retained portion of shared savings to continue and further develop VBP integration. Strongly recommend paying attention to the problem of small denominators and consequently unstable data as QI metrics are adopted. This will greatly limit the available metrics.

There is a limited set of measures that have been widely adopted nationally. We should limit the programs to these and try not to create custom measures. Unintended consequences often arise when we attempt new measures. It is also really important that the measured population has a large enough population base for variation to be valid and not simply a change in status of a single /enrollee patient or two. This is why three QUEST plans are preferred, it is more likely that each plan will have a large enough population base to support VBP programs across all providers. There is already a lot of VBP work in the community (i.e. HMSA programs). Support will still be needed, but don't overlook what has already been learned.

Primary care providers and mental health providers would benefit from more awareness about the community resources that are available to individuals. Often times community health providers are not aware of the process to request a service/care provider or submit referral for mental health/community based case manager programs that would provide additional stability for patients/individuals in the community. Perhaps some reimbursement for training staff on the process and successful submission of appropriate referrals. Being able to identify the needs of individuals at the primary care level and putting things in place to address those needs while they can still be managed could reduce the mental/physical decline of individuals in the community and perhaps reduce hospitalizations for those that were unable to access care/support services but need it.

HHAeXchange:

Value-based Payments (VBP) and Alternative Payment Models (APMs)

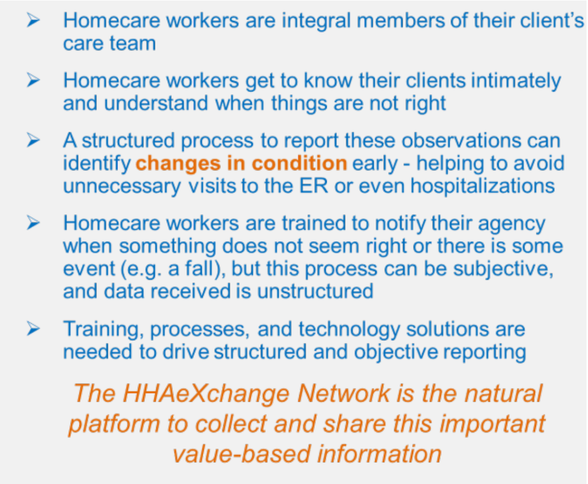
Technological advancements have created the opportunity to capture change of condition data directly from the member’s home. This data can be used to reduce hospital readmissions, track the risk of COVID-19 infection, as well as supporting value-based payment and alternative payment models.

In order to obtain this data, the industry has shown a need to deploy a software platform that can be used by caregivers while providing care in the member's home, during scheduled and authorized visits. It is essential to provide the caregivers with a technology platform that can easily capture the necessary data elements for the advancement of a value and quality reimbursement model. Clinical experts from existing stakeholders, such as MCOs, can provide input into the content of the clinical questions as well as structure and repetition of such questions that can easily be correlated to each member specific diagnosis. The selected MCOs will need to work with the State to help define the change of condition metrics or conditions to be configured within this technology platform. The Caregiver can use telephony or a mobile application to gather the change of condition metrics as part of the clock out process.

Empowering the caregivers with this type of technology will improve quality measure scores and ultimately help drive current and future value-based payment methodologies within the State of Hawaii.

HHAeXchange has designed a platform that provides this type of functionality that is critical to markets that are transforming to value-based payment arrangements for MLTSS environments. Using a web-based technology will empower caregivers to notify their agency when something does not seem right, or if there is a triggering event (e.g. a fall) that needs to be reported and captured. Without such a process and technology, the data may be captured but it will be reported in an unstructured way to the agency, MCO, or State Medicaid agency. A structured process to capture and report the observations and changes in conditions early in the home at the time of clock out will help to avoid unnecessary visits to the ER or even hospitalizations.

Training processes and technology solutions are needed to drive a structured and objective environment.



- Homecare workers are integral members of their client’s care team
- Homecare workers get to know their clients intimately and understand when things are not right
- A structured process to report these observations can identify **changes in condition** early - helping to avoid unnecessary visits to the ER or even hospitalizations
- Homecare workers are trained to notify their agency when something does not seem right or there is some event (e.g. a fall), but this process can be subjective, and data received is unstructured
- Training, processes, and technology solutions are needed to drive structured and objective reporting

The HHAeXchange Network is the natural platform to collect and share this important value-based information

A platform like HHAeXchange's is a natural solution to collect and share this important value-based information and change of condition metrics. Structure and technology will not only drive better outcomes for members but also increase the caregiver's confidence in their ability to care for their clients. Having a technology platform with appropriate alerts provides a very needed structure for all stakeholders in the homecare ecosystem. An integrated solution for providers and payors enables better outcomes, efficiency, and economic performance across all stakeholders. With a connected homecare platform, the members, caregivers, providers, and payors can have the ability to be compliant, efficient, and visible to all stakeholders in the process.

In summary, the HHAeXchange mission supports the move to Value-Based Payment. Quality-Based Care comes from actionable, real-time data obtained from the caregiver when providing services in the home. State agencies are in a unique position to guide payors and providers alike in the move to value-based payment methodologies. Transforming the Hawaii Medicaid program from fee-for-service to one that supports value-based outcomes will help the State to achieve operational efficiencies, increased compliance, and improve member outcomes in line with its Guiding Principles. More importantly, it will help to ensure the long-term sustainability of the system by fundamentally changing the way that providers and MCOs deliver healthcare services in the community. HHAeXchange is strategically aligned with Hawaii's Guiding Principles and can provide transparency on key performance measures in the home to meet the high standards of member-centered care across multiple care settings. We welcome the opportunity to engage with key State leadership in a deeper discussion on this topic.

Responding to the Pandemic

(Limit response to 2 pages)

Question 10 – MQD is interested in understanding what programmatic flexibilities should be continued beyond the public health emergency. How can MQD better support providers during this time? What can MQD do to expand and promote telehealth?

Lana`i Community Health Center

The pandemic reaffirms the concept of primary care as essential health care and the importance of health centers as a part of the safety net. Primary care is often the first level of contact for individuals, families, and communities and health centers bring health care as close as possible to where people live and work. Again, MQD and MCO should invest in primary care.

UHC:

The recommendations put forward on streamlined administration, care and service coordination, behavioral health integration and value-based payment will help create program efficiencies, strengthen support for members and their families, and build sustainable provider capacity to serve the whole person. Additionally, we recommend MQD consider long-term changes to expand telehealth and advocate for enhanced data connectivity.

Telehealth

Telehealth has provided safe access to needed health services during the pandemic. MQD has an opportunity to build upon recent flexibilities to improve access for underserved communities, improve provider capacity, and foster innovation. To expand and promote telehealth long-term, UnitedHealthcare recommends:

Reimbursement for audio-only evaluation and management services (E&M) with an established patient. This would provide members with another access point if technology is not available to facilitate a live audio-visual visit and while providers build their telehealth capabilities. We recommend reimbursement be limited to the following procedure codes as more research is done on the effectiveness of audio-only visits:

- 99441, 99442, and 99443
- G2012 (virtual check-ins)

Reimbursement for remote patient monitoring (RPM) with an established patient. RPM offers a more holistic view of a patient's health over time, supports earlier identification of health risks, and improves disease management. UnitedHealthcare supports the use of RPM to equip providers with additional tools to deliver timely and convenient care, particularly when caring for members with such conditions as diabetes, chronic obstructive pulmonary disease, and congestive health failure.

Reimbursement for provider-to-provider consultations when a professional medical opinion is sought. These inter-professional consultations increase access to specialty care and expand PCP's scope of practice while reducing the need for specialty visits. Research has shown that eConsults, which use telehealth technology (such as store-and-forward), with dermatology, ophthalmology, radiology, and pathology can be particularly effective for both cost and quality. We encourage MQD to reimburse for these consultations, including eConsults.

Implementation of person-centered metrics to reinforce the appropriate use of digital platforms and resources. Telehealth expanded rapidly under COVID-19. In the short-term, MQD and the MCOs could use process measures as digital platforms are introduced. Over the long-term, we could work together to establish person-centered metrics and measures to understand telehealth's impact on:

- Emergency department utilization changes
- Medication adherence
- Behavioral health access, adherence, and quality
- Specialty care access and quality
- Social isolation mitigation

Data

COVID-19 has emphasized the need for improved and comprehensive data. In response, several states have been working to expand their Health Information Exchanges (HIEs). HIEs can provide a comprehensive view of a patient's health history in one place, reducing the administrative burden required by tracking down data from a variety of sources, resulting in improved quality and patient safety. HIEs are especially valuable during disease outbreaks as they can serve as a tool to track cases, disease related codes, and testing. To make Health eNet most effective:

Make certain key stakeholders are connected. State and public health departments, providers, and laboratories are all critical to public health responses and should have established connections to Health eNet.

Assist with technical needs. Providers and health care organizations may need assistance and technical resources to use Health eNet most effectively.

Mandate COVID-19 test results be reported to Health eNet. To allow for complete surveillance and coordination, HIEs must have a complete picture of COVID-19 across the islands. Any entity testing for COVID-19 should be required to input data.

Incentivize the aggregation, collection and dissemination of data to confirm data sharing (push/pull) between stakeholders. Efficient and accurate data sharing will be critical to successful deployment of digital health care tools. Providers, caregivers, and health plans need a comprehensive view of members' needs and goals to design and implement an effective care plan. MQD and the MCOs can explore methods to encourage adoption if incentives do not spur action.

Strengthen Health eNet and provider connection to the Hawai'i Immunization Registry. This will support the state's current response to COVID-19 and future pandemics, as well as crucial ongoing immunization efforts.

Unite US:

This current pandemic has served as a vital reminder of the urgent need for reliable public health infrastructure that supports the immediate needs of individuals, while also laying the groundwork for a long-term solution as needs evolve. Our team has been in contact with government, health plans, health systems, and community leaders across the country on how we can assist in addressing the need for an integrated community-level response that will set communities up for short and long-term support. Several governments, plans, and systems have utilized and partnered with Unite Us already to rapidly respond to the pandemic, to include integrating programmatic contact tracing (whether conducted in Unite Us or a CRM), testing, and tracking needs/services delivered across health and social service providers.

As part of this strategy we know providing our communities with access to quality services is a critical need and one that requires partnership with local communities (i.e., 211s and existing collaboratives). We are also working with many 211s and collaboratives to accelerate the launch of networks focusing on emergency needs first and growing immediately from there, as well as managing out of network resource data in a much more scalable fashion. This would allow Unite Us to focus on our strengths in building accountable and resilient public health infrastructure through our networks but also collaborate with local partners like 211s to provide better access to resource information.

Our customer success team deployed across the country is working deeply with our networks to support capacity management in real-time. We are working closely with all partners and helping each organization keep their capacity and programs up-to-date as the situation develops to ensure accurate electronic referrals (i.e., 93% acceptance rate of electronic referrals in New York City). This is action critical for network operations, and our entire team is supporting all organizations through this process.

In addition, we are responding to the pandemic with the following adjustments and enhancements to support our local networks during this time of need:

Rapid and Targeted Network Deployment

- Access to a focused network in a condensed 4-8 week timeline:

o Five priority service types (we work with you to identify priority service types)

o Minimum 10-20 CBOs that support immediate needs

COVID-19 Social Needs Screening

With the increased need for both health and social services, it is imperative to ensure that we enhance our ability to connect people to accurate resources, avoiding unnecessary utilization of healthcare and community services. We have added a COVID-19 algorithmic screening option to identify social needs related to COVID-19 and quickly connect clients to services based on results. This helps identify which needs are exacerbated by COVID-19 vs. traditional medical and social needs already occurring.

COVID-19 Exposure Assessment
To support the immediate objective of identifying individuals in the community (not just in the hospital) who may be exposed to COVID-19, we have added an exposure assessment form that appears in every electronic referral workflow to determine a client's exposure to COVID-19. Depending on a client's responses, the assessment will provide instruction to redirect them from the hospital or connect them to the appropriate local resource if they have been exposed.

Public-Facing Websites for Individuals in Need
In order to better connect individuals with local resources, we will update existing public-facing websites and assistance request forms with new COVID-19 assessment questions to support individuals.

Here is a link to our COVID-19 Response.

Kaiser Permanente:

We fully support MQD in furthering flexibilities amongst QI health plans. COVID-19 created a situation that has demanded rapid change and has resulted in the creation of policies and procedures that have advanced Medicaid innovation. We believe there are additional program flexibilities that all QI health plans can continue to collaborate and innovate on to improve care for Medicaid beneficiaries in Hawaiʻi. The current QI health plan workgroup should continue to meet to provide MQD with suggestions regarding programs that could benefit from program flexibilities. For instance, relaxing MQD approval on communications could increase efficiency for all QI health plans as well as decrease burden for MQD. In order to minimize disruption in care for QI members, we urge MQD to allow flexibility for redetermination processes and continue to relax timeliness standards. Members are at risk for having a lapse in coverage and may suffer a decline in health if they are terminated from their current QI plan.

The COVID-19 public health emergency has accelerated the adoption of telehealth, including audio only. Members have quickly adapted to utilizing telehealth and have come to appreciate the convenience, allowing them to maintain care and address health and safety concerns. Providers and members have learned to adapt in order to ensure critical care and services are not delayed. We fully support MQD in continuing to allow flexibility for telehealth. We encourage MQD to focus on continuing to expand telehealth for specific services including behavioral health; chemical dependency counseling; pediatric services; reproductive and maternal health services; services for beneficiaries with COVID-19; and speech therapy, physical therapy, and occupational therapy. While these services are valuable for QI members, many QI members have barriers that create challenges for utilizing telehealth technology, including no or unreliable internet service. Maintaining audio-only telehealth services will help to ensure continued access to care. Providers may also lack the necessary infrastructure to successfully implement telehealth.

Another benefit of telehealth is addressing social needs. During the COVID-19 pandemic our staff quickly pivoted to address social needs by assisting members with applying for nutrition services by using their cell phones and other electronic devices. We urge MQD to reimburse for activities related to addressing social needs in order to provide equitable access for all members.

We encourage MQD to create reimbursement strategies for store-and-forward and remote patient monitoring each of which can enhance the health of members and be of assistance to providers in providing timely health services. We also recommend MQD relax telehealth provider requirements and allow telehealth services originated by out-of- state providers. These providers should be able to provide services and be reimbursed, allowing flexibility on this issue also assists with healthcare workforce shortages.

Community Paramedicine programs allow emergency medical technicians to operate at the top of their licensure and practice in an expanded role. Community Paramedicine programs can assist providers, particularly rural providers by providing preventative healthcare services in the community. Many members have barriers to accessing care and often, as a last resort, utilize 9-1-1 to obtain healthcare in non-emergency situations. These scenarios create strain on the Emergency Medical Systems (EMS) system and divert services from true emergencies. Community Paramedicine programs can partner with providers to create a strategic approach to providing care to members. Many states including Arizona, Georgia, and Arizona allow for Community Paramedicine programs to be reimbursed for treating members in the community. QI health plans can work with MQD and providers to define reimbursable services and adopt best practices from other states. We believe this is an opportunity that can improve the healthcare community in an innovative way and decrease the burden on the current systems.

Kokua Kalihi Valley:

Incentivize care teams, including those whose services are not directly reimbursed: interpreters, bilingual case managers, outreach community health workers.
Provide examples from KKV COVID-19 outreach response.

Hawai`i Primary Care Association

The COVID-19 pandemic has caused dramatic changes in utilization that threaten the financial stability of health centers and other providers. This jeopardizes access to care during and after the public health emergency as our state recovers. HPCA appreciates the collaboration established with MQD as well as how MCOs facilitate payments to health centers through the Quality Payment Program. The pandemic reaffirms the concept of primary care as essential health care and the importance of health centers as a part of the safety net.

Primary care is often the first level of contact for individuals, families, and communities and health centers bring health care as close as possible to where people live and work. Again, MQD and MCO should invest in primary care. According. the HPCA urges MQD to consider:

- Establishing measures that track overall MCO investment in primary care, relative to overall health care spending;
- Implementing State-level benchmarks for investment in primary care;
- Asking plans to estimate primary care expenditures; and Promoting continued collaborative efforts to strengthen primary care and Hawaii's public health infrastructure.

In addition, telehealth has rapidly been implemented by all health centers. (See HPCA Telehealth Utilization Attachment.) Despite this successful implementation, the HPCA believes more must be done to promote better access and adoption of telehealth, including:

- Promoting community access to communication devices (computer, smartphone) compatible for telehealth;
- Facilitating broadband access;
- Negotiating with communication providers to allow for data plans/minutes to support audiovisual care using a smartphone;
- Providing support to FQHCs to deliver technical support and community/member education to access telehealth via their electronic device; and
- Coordinating with other groups (DOE, Broadband Hui, State Library services, community based organizations) to increase member access.

Telehealth provides a viable alternative should FQHCs need to cease in person visits as a result of an impending natural disaster (ex: hurricane, tsunami, etc.).

Furthermore, telephone visits have provided a means for patients to have continued access to care during the public health emergency and stay at home order. They also provide a viable alternative in a natural disaster for patients who decline telehealth or do not have telehealth (video/camera, broadband, poor connectivity, etc.) capabilities. Because of this, the HPCA recommends that MQD:

- Continue support for telephone visits at PPS rates to ensure equitable access to care, particularly, in time of pandemic and until the all clear is given;
- Facilitate the use of a phone, access to a phone, and necessary ancillary devices (battery, solar charger, minutes) by recipients.

Despite the pandemic, some high-needs, high-cost patients experienced communication challenges. Providing access to a telephone and telephone services will foster better communication with service providers and allow for improved coordination of care; and

- Allow telephone visits in supportive housing SPA.

Ohana

The programmatic flexibilities that MQD has authorized in response to the COVID-19 pandemic help members access needed services while minimizing disruptions in care. While these short-term solutions mitigate the immediate impacts of the pandemic, the long-term impacts on the QI program will continue into the future. Consequently, ‘Ohana recommends that MQD continue allowing the following programmatic flexibilities after the public health emergency is lifted to best support providers and members:

☐ Flexibility for added benefits such as home delivered meals

☐ Flexibility with deadlines for conducting initial evaluation of eligibility, annual eligibility redetermination, and initial assessment of need to establish a care plan

☐ Personal Care Service (PCS) Payments to Legally Responsible Adults

☐ Expanded service settings and scopes of service

☐ Expanded benefits and service limits which protect members’ health and safety

TELEHEALTH FLEXIBILITY

The telehealth flexibilities MQD has authorized in response to the pandemic enable more members and providers to adopt this channel of care. Consequently, ‘Ohana recommends that MQD permanently incorporate the flexibilities listed below:

☐ Flexibility on originating sites

☐ Expanded CPT codes for audio-only telehealth at a lower rate than audio with video

☐ Waiving the established relationship requirement for telehealth check-ins/reassessments (Brief Virtual Check-In Visit)

☐ Telehealth for comprehensive health assessments

☐ Streamlining provider licensure and enrollment

☐ Expanding provider types who can deliver telehealth services

However, we urge MQD to allow QI health plans to resume former precertification, prior authorization, and other utilization management levers after the public health emergency to ensure that members receive the most cost-effective and medically necessary treatments while preventing costs from rising due to unnecessary utilization.

TELEHEALTH ADVISORY COUNCIL

We recommend that MQD convene the Telehealth Advisory Council to guide telehealth expansion. The Council can serve as a coordinating body for all QI plans, providers, and community partners to standardize and simplify telehealth processes, such as pre-authorizations. In addition, the Council can spearhead efforts to establish Interstate Telehealth Compacts to grow the workforce of telehealth providers. Finally, in collaboration with QI health plans, the Council can organize an awareness campaign to promote telehealth to members and providers.

Acumen Fiscal Agent:

During the COVID-19 pandemic, self-directed programs have in the news as a safer alternative to other models of care for people who require Long Term Services and Supports. In a recent article published by healthaffairs.org it cited that people in nursing homes and group homes have been disproportionally effected by COVID-19 and encouraged State's to expand the reach of Home and Community Based Services offerings where people in the members immediate circle could be used as caregivers in their homes. While telehealth can be a great solution for some aspects of healthcare; most LTSS members require hands on care to remain healthy. Participant-direction is a cost-effective, safe solution to support those objectives and to allow the MCO to focus on other, crucial aspects of their member's healthcare.

Community First:

We believe developing telehealth capabilities is the initiative that will most increase the resiliency of the healthcare system in the face of a pandemic. We therefore submitted the following project in response to the Hawaii Island's RFP for CARES funding. The project was not awarded a grant, but we believe it would have jumpstarted telehealth on Hawaii Island.

Project Abstract - HAWAII ISLAND TELEHEALTH (HIT): Infrastructure, Applications, and Adoption

For years telehealth has been viewed as a natural answer to increase access to healthcare for rural areas for many medical conditions and follow up care that do not require a physical encounter or office visit. COVID-19 has shown us that beyond just the barrier of distance, face-to-face encounters may be impossible for public health reasons. Clearly telehealth capabilities would greatly increase the resiliency of the medical system on Hawaii Island in general but particularly in a pandemic. CARES funding gives us an opportunity to jump start telehealth on our island. Community First and the Pacific Basin Telehealth Resource Center proposes to partner to do this by implementing practical applications of telehealth for primary care in medical homes, for homeless people, for COVID-19 Isolation Support and Triage, and for high-risk pregnancies.

The current hodgepodge of platforms, policies, and payment models make adoption by patients and providers difficult and the development of a community-centric system impossible. We need a common telehealth process that everyone in the community can learn to use. Eventually, it should be as easy as using the telephone. For now we need a public education campaign touting the value of telehealth and how to use it with their providers. With a common platform, it would be much easier to execute such a campaign. It goes without saying that we also need more widespread broadband coverage. We believe that developing and implementing use cases that show the value of telehealth will inform the community dialogue and accelerate the resolution of these barriers because of public demand.

There are four major initiatives in our proposal. The first is Marketing Hawaii Island Telehealth, a public education and outreach campaign marketing the convenience, ease, and value of telehealth for primary care and highlighting use cases with the homeless, COVID-19 patients in isolation, and high risk pregnancies. The second is Telehealth for Street Medicine using a combination of outreach workers and telehealth to bring care to the homeless on the streets and in shelters. The third is COVID-19 Isolation Support and Triage which aims to track all COVID-19 positive patients on the island and provide monitoring and support during when they are isolated and appropriate referral to higher levels of care. The fourth is Tele-ultrasound for Best Maternal Care enabling maternal fetal medicine specialists in Honolulu to diagnose women on Hawaii Island.

Healthcare Association of Hawaii:

Our members have found many of the flexibilities provided under the public health emergency to be effective in providing care for many different types of patients safely, without compromising quality, and without introducing fraud into the program. These flexibilities are particularly necessary right now as patients generally are hesitant or unable to go into an office. As we continue our fight against this virus, these flexibilities are necessary to ensure patients feel safe seeing their providers and can maintain some level of access to care. We have not discussed in detail with our members which specific services should be made permanent. It does seem that there is some difference among providers regarding which modalities to use and which services seem best for telehealth. However, members seemingly agree that expanded use of telehealth is a positive for our community.

One of the most important ways that MQD can support providers is to maintain rates. We are keenly aware that the state is in a difficult financial situation and the economy may not recover for many years. Further, we know that many individuals have enrolled for coverage in a QI plan during this time. We believe that reducing rates to providers will limit access for beneficiaries because providers – who are already feeling a massive loss from the pandemic and the economic crisis – will be not be able to take beneficiaries if the rates are too low. We know that there is already an access problem for many beneficiaries and cutting rates further will only exacerbate those issues. We believe that other considerations – such as potentially limiting some benefits – will best serve beneficiaries by maintaining access to care.

The financial sustainability of healthcare providers is not secure. There is a misconception that healthcare providers are “doing well” during this pandemic, but that is simply not the case. A patient’s fear of getting care, cancelled services and treatments, and spending on labor and PPE have caused many providers to expend or lose incredible amounts of money. Many providers – both large and small – are teetering on the brink. Any efforts by MQD during this pandemic must keep in mind that we have a severe shortage of healthcare providers and that this pandemic will likely worsen it—therefore, any changes that would reduce critical payments to providers could be devastating.

CMHC:

MQD could assist by creating MQD Kiosks within the community that could be utilized by patients to contact their physicians. Begin by contracting with Federally Qualified Health Centers and expand to other areas, specialty areas, off island specialists especially.

AlohaCare:

AlohaCare has appreciated MQD’s flexibility regarding telehealth, service coordination and pharmaceutical program adaptations the QI health plans implemented during the public health emergency (PHE). This flexibility ensured beneficiaries remained enrolled, supported beneficiary engagement, expanded access to care, and offered provider relief despite stay at home orders and social distancing guidelines that challenged the healthcare delivery system. AlohaCare recommends that many of these adapted programs and services be continued including:

- Alternative communication modalities, e-signatures on care plans, virtual and alternative assessment and authorizations for LTSS, and provision of personal assistance (PA) Levels I and II by legal guardians to act as an agency or self-directed provider helped to ensure timely care was provided mitigating health risks or decompensation and maintaining individuals in their current setting while stay at home orders were in place.

- Telehealth has been one of the most valuable flexibilities offered during the PHE. As providers and beneficiaries become more comfortable with care delivered through telehealth modalities, MQD and QI health plans should support long term adoption by simplifying requirements. If widely adopted, telehealth can be a tool to increase access, transforming the way care is delivered across Hawaiʻi.

Pharmaceuticals are one of the costliest Medicaid benefits, however, extending the supply of maintenance medications from 30 days to 90 days provided beneficiaries greater convenience and improved compliance. By supporting beneficiaries with chronic conditions whose care requires strict adherence to their medication, continuing this flexibility would decrease non-compliance and avoid more costly care.

As the PHE continues to evolve over the next several months, AlohaCare believes that it will be important for MQD to assess how these adaptations to service delivery have enabled QI health plans, providers and beneficiaries to maintain or improve access to services, improve health outcomes, and satisfaction.

AlohaCare recommends the following to support the continuation of these and flexible approaches to care:

- Revise HRS 431:10A-116.3 to include telephone contacts as a covered telehealth modality. This would allow the continuation of brief virtual check-in visits to continue to complement in-person care.

- Convene a multi-stakeholder collaborative to assess how flexible care has been utilized across the Hawaiʻi healthcare system, levels of adoption and most valuable modalities.

- Allow legal guardians to perform PA services as a last resort, when justified and closely monitored by the health plan to ensure beneficiaries can remain in the community and continue to receive supports. This flexibility offers an additional alternative in situations when agency services are difficult to secure due to geographic location or shortage of service providers.

☐ Collaborate with QI health plans and providers to successfully roll-out the delegation of care coordination activities to community providers.

Hawaii Health Information Exchange:

COVID-19 has pointed out the risks we face as a society related to new and evolving health threats and has clearly shown that any community can be significantly impacted on a recurring basis and that our cultural behaviors are not a barrier to the spread of the disease.

Our current health care system does not seem effective against a fast-evolving threat such as COVID-19 that spreads aggressively through human contact. It is focused on care at the individual level and is not conducive to the effective sharing of information among segments of the population that need to take care. The siloed nature of our healthcare system makes it difficult to treat diseases that affect groups of people and that spread rapidly given the tendency for people to want to gather.

Hawai‘i HIE recommends that Med-QUEST leverages HHIE in the following:

- Build a COVID-19 testing Results reporting hub. The hub will collect results from disparate sources including hospitals, labs and other testing sites and services, send reports as appropriate to providers and care-team staff associated with the Med-QUEST members, aggregate, de-identify and provide data to Med-QUEST HAO for population analytics and support programs planning.

- Support Data Integration with TeleHealth Systems. TeleHealth has served an important function during the COVID-19 pandemic emergency. While the TeleHealth systems in use have varying capabilities in exchanging data with external systems, HHIE can serve as the hub to support the exchange and sharing of standardized information clinical and social determinants data to facilitate the telehealth encounters to different platforms. Med-QUEST should provide funding and policy support so that the TeleHealth systems can share data bi-directionally through HHIE with EHRs from different health systems and providers.

- Support a centralize hub for hosting data for Social Determinants data collected by different sources. While Social Determinant of Health (SDoH) has significant impact on the physical health of the individual, including the level of vulnerability of the individual to COVID-19 infection, the current SDoH data are siloed and fragmented. To achieve the goals of the HOPE initiative, Med-QUEST should provide funding and policy support to create an SDoH hub so that the can be shared through HHIE with EHRs and social services who are part of the care team of the Med-QUEST beneficiaries.

Hawai’i Integrated Early Childhood Behavioral Health Team:

Responding to the Pandemic (MQD RFI Question 10)

Now is the time to increase services through telemedicine and provide opportunities for shortened response time on behavioral health needs for young children and their families.

Recommendation 4.1. Increase telehealth options for behavioral health services for young children and families including parent-child therapies. *Rationale:* Home Visiting and Early Intervention services through many community-based providers have moved to virtual visits with positive responses from parents and other involved family members. IECMH services, including screening, are ideal for expanding into telehealth options. Nationwide Child-Parent Psychotherapy is being delivered through telehealth. Neighbor islands have huge shortages of qualified mental health practitioners, let alone clinicians with IECMH expertise. Allowing for a telehealth option would help alleviate a chasm in services for the neighbor islands, particularly for rural parts of the state.

Recommendation 4.2. Augment clinician and transdisciplinary practitioner knowledge through a rapid consultation line. *Rationale:* Clinicians, like pediatricians, often need advice and consultation when it comes to infant and early childhood behavioral health. To support MCOs in service delivery, implement a rapid consultation for a broad array of clinician and practitioners working with QUEST children. Nationwide, there are many successful examples of these consultation lines, many with a broad purpose such as the Family Advice and Support Text and Telephone line (FASTT) out of University of Oregon which provides rapid consultation on challenging child behavior, child development, stress, and wellbeing. An emerging model through NEST Hui Collaborative is under early development here in Hawaiʻi. During the coronavirus pandemic, care for mental wellbeing is a critical component of overall health and a consultation line would enhance efforts of clinicians and increase confidence in providing behavioral health support.

Recommendation 4.3. Adopt cross-system language and understanding. *Rationale:* MQD serves the same families that often participate in early intervention, child welfare, and other early childhood services. In the MCO contracts use similar language and definitions as other services to promote interdisciplinary services and better overall coordination.

HMSA:

Providers are dealing with several issues related to the COVID-19 pandemic:

- Loss of revenue and volume due to the shutdown.

- Additional requirements for PPE, cleaning, and social distancing often require investments, workflow changes, and training.

- Shift to hybrid models to incorporate telehealth into their practice.

To address some of those concerns, the following are potential policy changes HMSA would like to request:

- Ease some of the provider administrative burden by modifying the way data is collected and submitted. With regards to quality metrics, one example would be to move EPSDT to single system digital form submissions vs. separate paper forms.

- Remove requirement for SBIRT certification. The in-person requirement for training is difficult under COVID-19 restrictions.

- Allow health plans to offer additional member incentives to encourage members to return for needed care (chronic condition management, preventive care, vaccines).

HMSA is eager to continue developing strategies to make telehealth a cost-effective strategy and increase its availability to interested members. In addition, the pandemic has emphasized that telehealth is a way for members to access the health delivery system while remaining in their homes.

HMSA is looking at our telehealth strategy and wanted to share some thoughts.

- Telehealth could be a cost-effective choice across the continuum of care.

- Telehealth can be effective in driving affordability when included as a component of a value-based payment model.

- Telehealth can be effective in redirecting high-cost care such as reducing Emergency Department visits and optimizing in-state and out-of-state access for specialty consultations. The pandemic has presented our state with significant concerns about the long-term sustainability of small and aging medical practices in rural and Neighbor Island locations, so investing in telehealth and reducing barriers to care may be critical in the future.

- Telehealth can reduce the costs and complexities associated with QI transportation, travel, and medical attendant benefits.

- Telehealth allows rural and Neighbor Island communities to be tailored and avoids the one-size-fits-all approach.

- DHS should advocate for improved broadband internet coverage in remote and rural areas, perhaps in collaboration with the Department of Commerce and Consumer Affairs, to increase access of telehealth.

- FQHCs, providers, and health plans should promote the use of telehealth to patients/members. For vulnerable populations, we should use and explore adaptive approaches to overcome unique barriers to access and use telehealth together.

In addition, HMSA continues to evaluate the flexibilities that were allowed during the pandemic to determine if these changes should be recommended long term. For example, telephonic visits may be appropriate in some situations, and perhaps this can be explored in the new DHS telehealth workgroup.

Pacific Medical Administrative Group

The burden of providers to deliver continued excellent care for all their patients will increase progressively as this pandemic worsens in Hawaii. MQD should prioritize their efforts to ensuring continued provider service by:

1. Encouraging plans to promote provider participation

2. Supplying needed practice support

3. Reducing administrative burden

4. Maintaining accountability

5. Encouraging collaboration over the spectrum of the delivery system

6. Mandating plan transparency

As such, MQD should not hesitate to institute temporary relaxation of any and all of the more onerous and restrictive requirements that are not necessary to care delivery. This pertains to both plans and providers. Innovative and collaborative methods to maintain accountability would be a consideration.

Specifically, MQD needs to focus attention on its new direction to strengthen behavioral health. Number of providers, number of encounters, and number of attempts are less important than improved outcomes. MQD must enable innovative and clinically driven efforts to support behavioral coordination at the practice level. Practices are more likely to adopt those systems that help, ignore those that don't, and more nimbly adapt systems to accommodate the numerous Covid-19 changes.

Attention to provider behavioral health and alleviation of physician burnout should be required by all plans. Up to now, only HMSA has attempted to address this critical aspect in ensuring continued provider services. Dr. Kelley Withy, UH JABSOM school of medicine, has reported on Hawaii's physician shortages for years. A critical number of our physicians are in retirement age (30% in Hawaii and >40% in PMAG, which is Oahu only) and can financially take the step to retirement.

Telehealth and the adoption and support by payors has been a tremendous help in patient connection and care. Providers are revising their care procedures and finding innovative ways around physical encounters, such as electronically connected blood pressure and self-administered glucose measurements.

Likely for the next year, relaxed Telehealth use requirements will be necessary and all forms of HIPAA compliant modalities should be allowed. Payment adjustments should be negotiated in collaboration with providers using Telehealth to account for the financial viability of their practices.

Waikiki Health Center:

Expand/Promotetelehealth

a. MQD can help expand and promote telehealth by providing smart phones/minutes to our QI patients without phones. This becomes a barrier to care, if they lack access. Phones could be issues by a FQHC Care Coordinator or Payer Service Coordinator
b. Telehealth should also reimburse enabling services (ie. care coordination, CHW).

Queens's:

The big barriers for telehealth have been the originating site requirement (i.e. patients being in their home which MQD has already made an option). Also, the inability to do telehealth visits for new patients was a barrier to care. What should continue as a part of the flexibilities is the new patient allowance and the allowance for other providers to conduct telehealth visits. MQD should continue to ensure telehealth parity by reimbursing the same as in person visit reimbursements, while maintaining quality of care and services provided.

All clinical providers/programs should be able to continue bill for telehealth including Home Health, Dieticians, Diabetes educators, PT/OT/Speech.

Historically there has been a risk adjustment based on diagnoses from in-person visits, but CMS now allows for risk adjustment to be based on telehealth visits as well. MQD should also consider implementing a risk adjustment for telehealth visits, similar to in-person visits.

Finally, with COVID-19 and the decrease in in-person visits, policymakers should be mindful in selecting quality measures and their appropriate benchmarks for measures that require in-person visits and testing (like blood pressure control, unless bluetooth bp cuff readings could count; A1c testing and control; paps, mammograms, and colon cancer screenings, etc.)

Hawaii Pacific Health:

Health care is only one piece of the care continuum. To help providers connect our patients with the care we cannot provide, give providers a resource list of state and private agencies/departments/companies/resources that we can use to help meet he non-health related needs of our QUEST patients.
Connect workers to patients while they are still hospitalized to assist with faster transition.

Telehealth education and equipment will be key to increasing the use of telehealth programs. Some individuals do not have appropriate smart devices to use so it limits their ability to participate in this type of care. Perhaps a program to provide subsidy for electronic devices and step by step education/training on participating in these appointments. Maybe in person training while the individual is with their care provider in anticipation of the next visit being telehealth.
There are a number of areas that MQD could assist. First, support making permanent the statutory exemptions granted under the COVID-19 emergency response proclamations. Stakeholders have adapted to the current regulatory environment which has resulted in rapid adoption of telehealth. Therefore, maintaining the regulatory changes that facilitated this telehealth robust environment needs to be sustained. This includes permanent reimbursement for all levels of telehealth services, telephonic visits, e-consults, virtual visits. Second, support and create incentives for consumer training and education of telehealth to address health equity. As with any technology, there are individuals that have experienced barriers to access health. In some cases these are resource constraints, in other situations it is educational constraints. Therefore, recognizing this need and addressing this gap will be key in promoting telehealth adoption amongst more groups.

HHAeXchange:

Responding to the Pandemic

In order to continue to support providers, it is critical that systems and processes maintain or receive added functionality that takes into consideration the full impact COVID-19 has had on the homecare environment. Any platform chosen by the MCOs needs to be modular and able to adapt quickly to the changing healthcare environment.

In response to COVID-19, HHAX quickly, in a matter of days, developed and deployed tools for provider agencies to ensure open communications and the health of their caregivers and members. With caregivers acting as the first line of defense for some of the most vulnerable and fragile members of our society, we altered our change of condition questions in our system to address some of the main indicators of infection. This same approach can be utilized for any future emergencies, or other statewide communications, providing a unique tool to engage the network and provide guidance in difficult times.

The below example illustrates the announcement of new reasons we deployed, after approval from the State Medicaid Agency.

> *Please note that as of Tuesday, 3/17/2020, additional missed visit reasons were added in order to better track and understand missed visits associated with COVID-19. Any missed visits due to COVID-19 should be reported using one of the new reasons added below.*
>
> - *COVID-19: Participant refused and is self-isolating*
> - *COVID-19: Participant is in hospital or NF*
> - *COVID-19: Worker unable to staff because they are sick*
> - *COVID-19: Worker unable to staff because of childcare issues*
> - *COVID-19: Worker switched to cover another case*
> - *COVID-19: Other*
>
> *If choosing COVID-19: Other, please provide additional detail in the Notes section for the missed visit.*
>
> ***Provider Communication****: If you need to send a message to the Department related to a COVID- 19 issue, please select the new reason value of COVID-19 and select the urgent message check box.*

As part of the MCO RFP, the State should consider requiring not only COVID-19 specific codes and missed visit reasons, but also a dynamic tool that allows MCOs to visualize the impact COVID-19 is having across their entire homecare network. In addition, this tool should also be able to easily distribute data to the State Medicaid Agency to provide you with actionable insights into the impact of COVID-19 on a statewide basis.

If choosing COVID-19: Other, please provide additional detail in the Notes section for the missed visit.
Provider Communication*: If you need to send a message to the Department related to a COVID- 19 issue, please select the new reason value of COVID-19 and select the urgent message check box.*
As part of the MCO RFP, the State should consider requiring not only COVID-19 specific codes and missed visit reasons, but also a dynamic tool that allows MCOs to visualize the impact COVID-19 is having across their entire homecare network. In addition, this tool should also be able to easily distribute data to the State Medicaid Agency to provide you with actionable insights into the impact of COVID-19 on a statewide basis.

Crystal Costa:

Responding to the Pandemic (Limit response to 2 pages)

Situation:

The COVID-19 pandemic has already had profound impact on healthcare delivery in Hawaiʻi due to social distancing. Looking forward, Hawaiʻi will experience further health, social, and economic effects related to COVID-19. MQD is interested in stakeholder input on how the QI program can continue to respond to the pandemic

The COVID-19 pandemic has spotlighted the need to improve our ability to care for high risk individuals who contract COVID-19 but who want to be cared for at home, not in the hospital. It is important to provide appropriate in-home care to better manage hospital and acute care resources while honoring individual choice.

Background:

COVID-19 has spread throughout the country and Hawaii is not exempt from the threat that this new virus imposes on society. COVID-19 is known to have a high mortality rate among older patients and those with chronic conditions(1. There are many community-dwelling Hawaii residents who fall into this high-risk category. If they become seriously ill from COVID-19 , the chances of survival may be slim(2. Since many Americans prefer to die at home(3, it is reasonable to assume that there are a significant number of Hawaii residents who would prefer to remain at home if they became ill from COVID-19 rather than being sent to hospital where they might not be able to have their family around them. Unfortunately, as we have seen in other parts of the country, many who died of COVID-19 in the hospital were separated from their families in their final days. Therefore, it is crucial to have a health care system that supports COVID patients who opt to stay at home. This is important not only to respect the wishes of the patient but also to better manage the strain on our hospital systems by ensuring that resources are available for those who choose hospital care.

Assessment:

Critical role of palliative care in the COVID-19 pandemic

COVID-19 can cause severe symptoms including shortness of breath, pain and delirium. This can make communication challenging particularly when care management processes are conducted telephonically rather than in person. Additionally, there is a great deal of clinical uncertainty with COVID-19 resulting in caregivers and patients requiring substantial support to appropriately care for and keep each other and their communities safe. In our view the pandemic has highlighted the importance of palliative care, the medical specialty that can provide sophisticated symptom management, tackle difficult conversations, and provide timely support for caregivers. In fact, an academic medical center in New York City, the previous epicenter of COVID-19, provided a “palliative care hotline” to meet the huge demand for palliative care in the crisis(4. Thus, we believe that it is ideal for high risk patients with COVID-19 who opt to stay home, to have access to palliative care at home.

Challenges to prepare for the rapid decline of COVID-19 patients

COVID-19 is well known to cause rapid decline of a patient's condition. Even though the patient may initially have mild symptoms such as fever, cough, severe shortness of breath and rapid, diffuse damage to the lungs by the virus suddenly may occur. This rapid decline can happen in a matter of hours and it is crucial for the patient and family to be prepared There are several important points in this preparation: first medications for comfort including morphine need to be in the home and available before this predictable crisis happens(5. Second, supplemental oxygen should be in the home before the patient develops a low level of oxygen and acute shortness of breath. Perhaps most importantly, the patient and caregivers must be prepared to recognize the worsening of the patient's condition and how to utilize the medications and equipment appropriately. They also require skilled emotional support and guidance when things get difficult; that support must be available 24/7.

The provision of controlled substances is best managed by palliative medicine specialists to ensure the highest level of safety. Additionally, there will be the need for health plans to make adjustments for the provision of oxygen as patients may not immediately qualify for supplemental oxygen under usual coverage criteria.

Challenges to accessing palliative care at home in the current system

Hospice can be a great resource to provide palliative care at home for COVID-19 patients. However, admission to hospice requires that patients have a terminal condition (i.e. the patient likely dies within six months). Recent reports showed that many patients, even those who are frail with multiple conditions from nursing homes, do survive COVID-19(6. In addition, there is the recognized phenomenon of going from relative medical stability to acute and rapid decline to death, which can occur within hours. This means that there will be significant numbers who initially do not meet CMS eligibility criteria for hospice but who die so rapidly as to make enrollment into hospice impossible. Hence, high risk patients with COVID-19 who opt to stay home need to have access to palliative care to safely and effectively their course of illness.

Recommendation: A simple solution is the "supportive care model" by HMSA

In order to tackle the above-mentioned obstacles, we recommend that QUEST plans provide benefits similar to supportive care benefits provided by HMSA. The supportive care benefit is designed to provide community-based palliative care to seriously-ill patients with cancer, lung disease or heart failure. It provides an interdisciplinary team with 24/7 availability, who can, if indicated, make home visits and are overseen by a physician with palliative care skills and experience. Supportive care can facilitate the availability and proper use of controlled substances for symptom management and provide appropriate equipment including supplemental oxygen from the start of care. Patients can be transitioned to traditional hospice if and when that is indicated. Lately, as a response to the pandemic, HMSA has expanded the supportive care admission diagnosis to include COVID-19. Therefore, any HMSA patients who contracts COVID-19 and meets additional enrollment criteria can receive supportive care. Enrollment can occur within 24 hours of referral.

Each hospice in the state of Hawaii has home-based interdisciplinary care teams that are available now to provide quality palliative care.

If MDQ can provide coverage for home-based palliative care, many COVID-19 patients will benefit significantly. This will help to keep patients who choose so to remain at home surrounded by their loved ones, and keep them comfortable even after a rapid decline of the condition from COVID-19. This simultaneously respects their wishes and ensures appropriate use of scarce medical resources.

Additional Input from Stakeholders

(Limit response to 2 pages)

Question 11 – Stakeholders may write two pages on other issues of their choice concerning the procurement to provide input to MQD.

An Individual member of the Maui County Council: Alice L. Lee

Med-QUEST needs to ensure an adequate number of providers are available, especially on the neighbor islands, to service the expected growing QI population

- Fairness and equity of health care choices for Hawaii residents across all of its counties and islands, not just Oahu, as stated in Maui County Council Resolution No. 20-22 adopted by the Council at its meeting on March 13, 2020,
- Innovative health plans to reach the growing number of QI beneficiaries and ensure uninterrupted access to healthcare,
- Consumer choice of health-care plans for all Medicaid beneficiaries statewide – both on Oahu and the neighbor islands,
- Access to providers, particularly specialty-care providers on the neighbor islands additional patients, and
- Timeliness of payments to providers.

Lana`i Community Health Center:

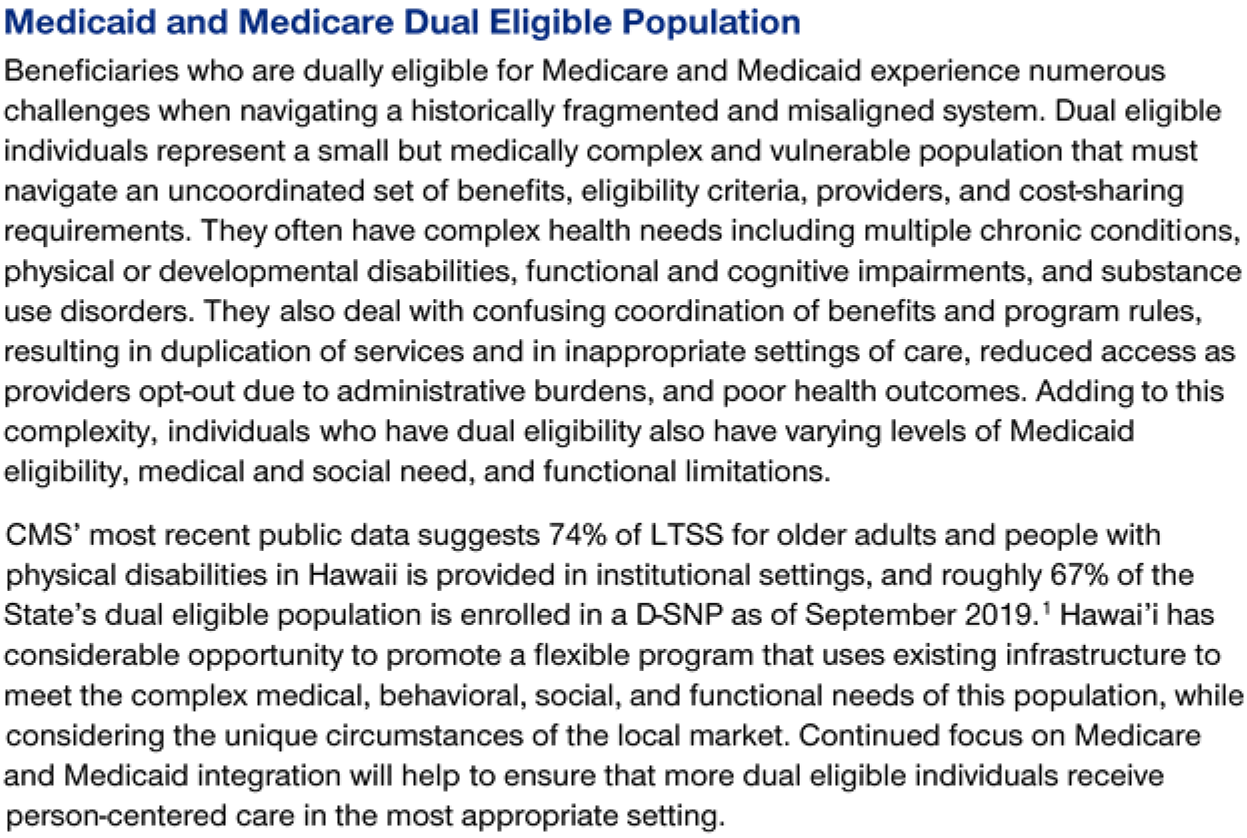
- Med-QUEST needs to have health plans that are dedicated to serving the unique needs of Hawai'i's Medicaid population.
- Medicaid beneficiaries are better served when decisions by health plans are made locally, not at corporate headquarters on the Mainland, which means decisions can be made quickly and are informed by first-hand knowledge of the community.
- Successful Medicaid health plans have leaders who have deep expertise in healthcare and Hawai'i's Medicaid population – including local non-profits and community health centers with representatives from the neighbor islands.
- Successful Medicaid health plans need to have boots on the ground throughout the state and take time to listen to beneficiaries and providers about their needs and concerns in order to be a true partner that supports all aspects of community health.
- Managed care plans should spend time developing strong relationships with individual medical providers, community health centers and non-profits statewide through volunteering, philanthropy and programs that assist both members and providers.
- Medicaid plans should look at meeting the needs of the whole-person, including behavioral health and social determinants of health, as key to developing healthy individuals and communities.

Member of the Hawaii County Council; Karen Eoff

I request that MQD consider the following in the next RFP process:

- Neighbor islands need the same choices in health plans and services as people on Oahu.
- Health Plans must work in partnership with our local community and that requires them to know our patients and our providers who live and work on our island.
- RFP should prioritize the health plans that prioritize the health and welfare of patients above profits and are grounded in our local communities not the national marketplace.
- Thoroughly examine and vet a health plan's history of timely compensation to the health care providers across the state.
- Health Plans must demonstrate, with examples and history, their commitment to the unique needs of low-income patients living in our rural communities.
- Health Plans must encourage and support local innovation in delivery of care, one size does not fit all.
- Health Plans must address the whole person's needs—food, housing, education, employment, etc. Treating a disease is not caring for the whole person.

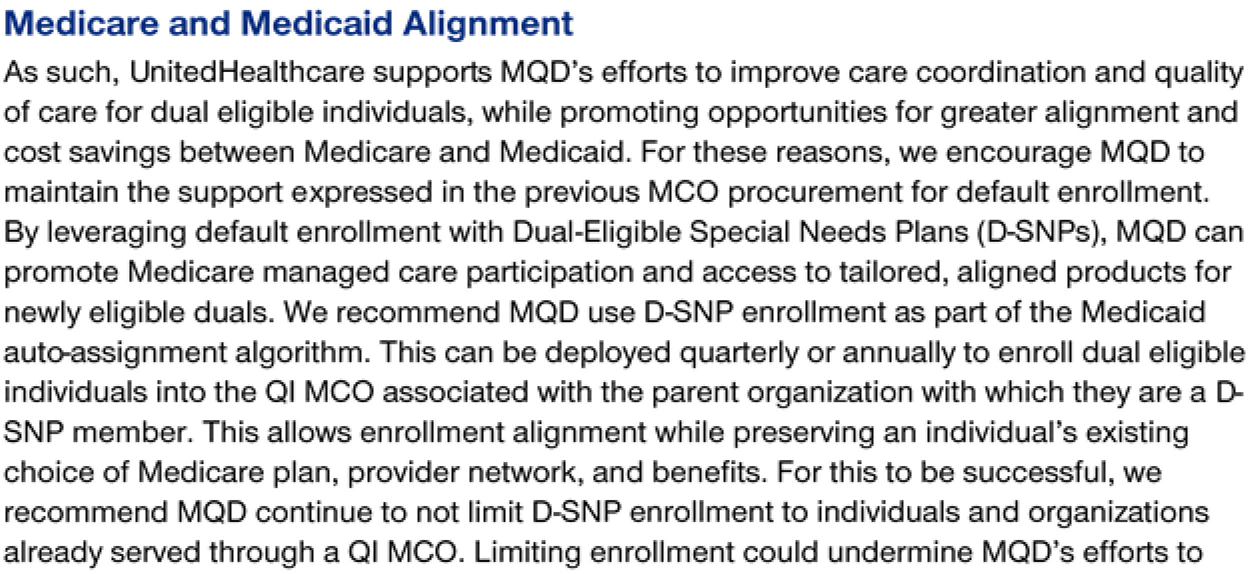
UHC:



Medicaid and Medicare Dual Eligible Population

Beneficiaries who are dually eligible for Medicare and Medicaid experience numerous challenges when navigating a historically fragmented and misaligned system. Dual eligible individuals represent a small but medically complex and vulnerable population that must navigate an uncoordinated set of benefits, eligibility criteria, providers, and cost-sharing requirements. They often have complex health needs including multiple chronic conditions, physical or developmental disabilities, functional and cognitive impairments, and substance use disorders. They also deal with confusing coordination of benefits and program rules, resulting in duplication of services and in inappropriate settings of care, reduced access as providers opt-out due to administrative burdens, and poor health outcomes. Adding to this complexity, individuals who have dual eligibility also have varying levels of Medicaid eligibility, medical and social need, and functional limitations.

CMS' most recent public data suggests 74% of LTSS for older adults and people with physical disabilities in Hawaii is provided in institutional settings, and roughly 67% of the State's dual eligible population is enrolled in a D-SNP as of September 2019.[1] Hawai'i has considerable opportunity to promote a flexible program that uses existing infrastructure to meet the complex medical, behavioral, social, and functional needs of this population, while considering the unique circumstances of the local market. Continued focus on Medicare and Medicaid integration will help to ensure that more dual eligible individuals receive person-centered care in the most appropriate setting.



Medicare and Medicaid Alignment

As such, UnitedHealthcare supports MQD's efforts to improve care coordination and quality of care for dual eligible individuals, while promoting opportunities for greater alignment and cost savings between Medicare and Medicaid. For these reasons, we encourage MQD to maintain the support expressed in the previous MCO procurement for default enrollment. By leveraging default enrollment with Dual-Eligible Special Needs Plans (D-SNPs), MQD can promote Medicare managed care participation and access to tailored, aligned products for newly eligible duals. We recommend MQD use D-SNP enrollment as part of the Medicaid auto-assignment algorithm. This can be deployed quarterly or annually to enroll dual eligible individuals into the QI MCO associated with the parent organization with which they are a D-SNP member. This allows enrollment alignment while preserving an individual's existing choice of Medicare plan, provider network, and benefits. For this to be successful, we recommend MQD continue to not limit D-SNP enrollment to individuals and organizations already served through a QI MCO. Limiting enrollment could undermine MQD's efforts to promote alignment by pushing dual eligible members to Medicare fee-for-service or non-D- SNP Medicare Advantage plans in search of specific Medicare providers or benefits.

Additionally, we recommend that opportunities be identified in partnership with CMS to promote alignment in processes directly impacting dual eligible individuals, such as member materials and appeals and grievances.

Fully Integrated Dual Eligible Special Needs Plans

UnitedHealthcare encourages MOD to maintain support in the next procurement for implementing a Fully Integrated Dual Eligible (FIDE) SNP program alongside the existing D- SNP program. This will promote aligned enrollment and targeted models of care based upon the complexity and needs of the dually eligible population. To make sure members have access to benefits best tailored to their needs, we recommend MOD limit FIDE SNP enrollment to individuals eligible for **L**TSS and allow traditional D-SNPs to serve dual eligible individuals with lower complexity. MOD can work with D-SNPs and CMS as part of the FIDE SNP implementation to transition existing D-SNP LTSS members to the organization's newly created FIDE SNP to ensure continuity of care and consistency in provider relationships.

Benefit Design for Duals Special Needs Plans

The COVID-19 public health emergency has shown the need for flexibility in meeting the health care and social needs of individuals with dual eligibility. UnitedHealthcare recommends MOD continue to allow D-SNPs maximum flexibility to design benefits responsive to their members' needs. Prescriptive oversight of the D-SNP Medicare bid can limit the ability of D-SNP products to compete with the benefit design of non-D-SNP Medicare Advantage plans, inadvertently causing individuals to enroll in non-D-SNP products.

Conclusion

We once again voice our appreciation for the opportunity to provide feedback on the QUEST Integration procurement. We believe our recommendations will support QI members in meeting their goals of access and improved health, and support Hawai'i in achieving its goals of improving and integrating care while managing costs and improving system efficiencies. We look forward to continued collaboration with MQD and are happy to provide additional information or clarification on any points made in this response.

Kalo Physical Therapy Multispecialty Group – Dr. Carey

I am writing as the only Physical Therapy Clinic owner that accepts all Medicaid plans on Hawaii Island. As far as I know - I am and have been the only one willing to accept all plans.

Overall, I am pleased with the care coordination process and the ease of authorizations for services. As I am sure you are familiar with: the National average rate of reimbursement for Physical Therapy services is $110 per visit. Currently, Medicaid plans offer at most $86 per visit. This rate or reimbursement is right about at the break even point for most clinics.

Additionally, the no-show rate is on average higher for Medicaid patients. According to our research, the higher no-show rate tends to center around poor transportation and generally Medicaid members travel further distances to arrive at our clinic. Since $86 per visit is break even at best, when a Medicaid patient no-show, even over the course of additional visits, we will not break even.

The Medicaid fee schedules need to be in line with at least Medicare rates. The low rates are creating greater disparities for Medicaid members because very few clinics are willing to take on any Medicaid patients. My clinic is located in downtown Kailua-Kona, and I have had patients travel 90 miles, twice per week to see me, because no clinics near them would accept the low reimbursement rates.

Thank you for your continued efforts to serve the underserved. Please contact me with any questions.

Kaiser Permanente:

We appreciate the opportunity to provide additional input to MQD regarding the upcoming QI procurement. We hope that MQD seriously considers the impact that a reduction in QI health plans will have on members, providers, and our communities. Medicaid members and our broader community are already experiencing negative impacts of the global pandemic. Creating a further shift in the healthcare payment and delivery system will cause unnecessary disruption for members who now more than ever need continuity of care and a healthcare system that is familiar and easy to navigate.

In addition to the disruption for significant numbers of QI beneficiaries, a decision to reduce the number of QI health plans will result in lost revenue and jobs in the Hawaiʻi economy. Currently, all QI health plans provide economic viability by employing individuals in Hawai‘i. If MQD reduces the number of QI health plans through the upcoming procurement, it will cause a reduction in the healthcare workforce by eliminating jobs at health plans that lose their QI contracts. . According to the Hawai‘i Department of Labor, Hawai‘i has the 3rd highest unemployment in the country at 23% unemployment. Any action that will negatively impact employment in the State should be avoided. QI health plans also invest in the community through grants and other charitable contributions. If the number of QI plans is reduced, these contributions will also be reduced. Such a reduction would be particularly problematic given the need in Hawai‘i to sustain community reinvestment and does not comport with MQD’s own stated goals of helping the healthcare workforce in areas that need it the most.

Throughout COVID-19, there have been multiple opportunities for QI health plans to collaborate. This has been a unique opportunity that has brought QI health plans together and has demonstrated that QI health plans want to work together to help improve the QI program and to better serve our collective members. It is critical that we continue this collaboration across our community. Such collaboration is paramount in order to ensure a member-centric approach, particularly around the COVID-19 response. QI health plans demonstrated collaboration on approaches for members who reside with other QI health plan members and have jointly developed comprehensive plans to minimize COVID-19 exposure. We have also collaborated to create strategies for members who are experiencing homelessness or are at risk for becoming homeless. We urge MQD to leverage the synergy that has occurred amongst QI health plans and maintain a system where we continue working together to serve our most vulnerable members.

We encourage MQD to simplify the procurement process and consider postponing the release of the RFP or issuing an RFA rather than an RFP that allows existing QI health plans to apply based on service area. Simplifying this process will help avoid disruption, eliminate a needlessly competitive environment, particularly as we all work to meet our members needs during the COVID-19 pandemic, and will not divert attention and resources from the current collaborative work underway.

Again, we appreciate the opportunity to give feedback on these questions and look forward to continuing a partnership with MQD and other QI health plans.

Kokua Kalihi Valley:

As part of a network of FQHC CHC’s KKV is very concerned

Hawai`i Primary Care Association

The HPCA would like to conclude with the following points:
• MCO accountability and oversight -- please consider MQD oversight over MCO network adequacy and include a mechanism to see if MCO providers are actually seeing and accepting QUEST patients;
• Many of the services and the time spent to support a complex, high needs high cost patient are funded by grants, some of which are not

sustainable. Please consider exploring how Medicaid Administrative Claiming can support SDOH related services; and

- Capacity-building investments are necessary for continuous quality improvement and health system transformation. MQD/MCOs should work closely with HPCA and other training and technical assistance organizations for staff training, community engagement, and data infrastructure and technology.

Thank you for the opportunity to submit information and comments on this Request for Information. For your review and information, attached please find:

(1) Hawaii Health Center Telehealth Utilization -- January to June 2020;
(2) Hawaii Primary Care Association Addressing Data Transparency; and

(3) A Case Study of High-Needs, High-Cost CHC Patients and Associated Services.

Hawai`i County Council Maile David:

I request that MQD consider the following in the next RFP process:

- Neighbor islands need the same choices in health plans and services as people on Oahu.

- Health Plans must work in partnership with our local community and that requires them to know our patients and our providers who live and work on our island.

- RFP should prioritize the health plans that prioritize the health and welfare of patients above profits and are grounded in our local communities not the national marketplace.

- Thoroughly examine and vet a health plan’s history of timely compensation to the health care providers across the state.

- Health Plans must demonstrate, with examples and history, their commitment to the unique needs of low-income patients living in our rural communities.

- Health Plans must encourage and support local innovation in delivery of care, one size does not fit all.

- Health Plans must address the whole person’s needs—food, housing, education, employment, etc. Treating a disease is not caring for the whole person.

Ohana

‘Ohana does not have additional input to offer at this time. We are happy to discuss these or other issues with MQD at any time.

Collective Medical:

Conclusion

To achieve optimal outcomes, Collective recommends that QI plans participate with their entire provider networks as well as community-based service providers using an advanced data sharing platform to create a robust, active network of appropriately shared health information, facilitating a well-informed, highly interactive virtual interdisciplinary care team for any patient who needs it. Our experience shows this will save costs, improve experiences, and most importantly, create better health outcomes for the citizens of Hawai'i.

Community First:

We believe the healthcare cost crisis has gone over the cliff. Financially we are in free fall along with most of the economy. Incremental changes don't make a difference that makes a difference. The greatest barrier to disruptive VBP models in Hawaii is the gravity of the status quo which only a compelling force and urgency can overcome. At the Federal level our deficit is $2.8 trillion not yet accounting for the $2.2 trillion in CARES funding already passed nor the funding still to come. At the State level we have a $2.3 billion dollar deficit with QUEST membership exploding. The basic barrier to transformational change was that we did not experience the house was burning. Perhaps free fall will create the urgency and commitment to "go for broke" and to implement transformational change.

Our work for the last five years in East Hawaii provides a foundation for a Virtual, Social ACO (VSA), a radical, disruptive transformation that could make a difference. A 'Social ACO' brings together both medical and social service providers in order to effectively address social determinants of health which impact care and costs particularly for SHCN patients. As demonstrated by the Commonwealth Care Alliance of Massachusetts, a social ACO would have the following characteristics:

A) Would rebalance spending between social and medical services

B) Would develop trusting, longitudinal relationships between providers and between providers and patients

C) Would fully integrate financing of medical, behavioral health, and social supports

D) Would be committed to a longer time horizon for measuring impact

E) Would have a fierce commitment to community-based and community-centric delivery of medical and social services

Unlike the social ACO of the Commonwealth Care Alliance of Massachusetts, however, we believe the ACO should not be an independent entity with significant administrative expense and its own bureaucratic complexity. Such an arrangement might make sense for a much larger population but not for a rural area. We believe a social ACO can be achieved contractually without an overarching, independent entity.

In healthcare we are facing adaptive challenges. Technical solutions which were developed in a different time when society could put more money in the system will not work. Incremental quality improvement, increasing pre-authorizations, capitation without distinguishing between costs which providers can be accountable for and uncontrollable insurance risk, and win/lose negotiating are all examples of technical solutions which might have worked in the past. We are facing an adaptive challenge which requires new ways of conceiving the problem and the relevant system and new ways for all stakeholders in the community (health plans, medical and social service providers, and patients/residents) to relate to each. These solutions require trust and collaboration. Adaptive solutions can only come from the people who have the problem. (The distinction between technical problems and adaptive challenges comes from the work of Lou Heifetz, Leadership on the Line, Harvard Business Review Press, 2002). When technical solutions are applied to adaptive challenges, little progress is made.

We have no illusions that VSAs would be quick and easy, but it offers the possibility of transformative change that follows MQD ‘Ohana Nui principles, particularly those regarding addressing SDOH, emphasizing primary care in patient centered medical homes, and leveraging and supporting community initiatives. Our proposal for a VSA also encompasses the HOPE strategies of investing in primary care, improving outcomes for SHCN patients, reforming and aligning payment, and supporting locally driven initiatives to improve population health. It would be disruptive, but in East Hawaii we believe we can do this with Aloha given the strength of our community spirit.

John Mizuno:

I believe DHS must ensure that there is fairness and equity of healthcare choices statewide for all of Hawai‘i’s residents, not just those on O‘ahu. Here are some other points we raised during the last session (2020).

Med-QUEST’s new RFP for Managed Care Organizations must consider:

- Access to providers, particularly specialty care providers on the neighbor islands
- Timeliness of payments to providers
- Consumer choice of healthcare plans for all Medicaid beneficiaries statewide – both on Oahu and the neighbor islands
- Due to COVID-19, health plans will need to be more innovative than ever to reach their members to ensure continuity of quality care to patients.

CMCH:

For CMHCs- our concern is mostly the contractual requirements as a provider for our CCS clients. Our focus is to provide quality care and continuum of quality care to our patients not using two system for the behavioral health service we provide our patients and enter it in our EMR system and then to the health plan system also. Eliminate this administrative burden from our providers.

AlohaCare:

AlohaCare appreciates the opportunity to provide input to MQD regarding these specific areas of interest. As MQD gathers input from this RFI, AlohaCare suggests that MQD summarizes and publishes the collective input obtained from stakeholders. This allows for sharing the information gathered in an open and transparent way with all stakeholders prior to issuance of the formal Request for Proposal for the QI and CCS Programs. Allowing stakeholders to understand the input gathered and the policy and operational recommendations that MQD intends to pursue as a result of this RFI and other feedback mechanisms is important to allow for all interested parties to understand the policies, processes and areas of focus for MQD.

MQD has communicated its commitment to the roadmap for health system transformation in Hawai‘i through the HOPE initiative and its core strategies of investing in primary care, prevention, and health promotion; improving outcomes for high-need, high-cost Medicaid beneficiaries; payment reform and alignment; and support for community-driven initiatives to improve population health. AlohaCare suggests that MQD re-evaluate these goals and strategies in the context of the changing health and care delivery environment created through the COVID-19 PHE.

The impact of social determinants of health on individuals and families has been exacerbated by the effects of the COVID-19 pandemic. For instance, PHE communication has proven unsuccessful in preventing COVID cases for Micronesian language speaking individuals and families. While Micronesian residents represent 4 percent of Hawai’i’s population, they disproportionately comprise 34 percent of COVID cases. New and innovative approaches that depart from traditional Medicaid services are necessary to support PHE mandates. We believe this represents a timely opportunity to implement immediate and long-term interventions to improve health outcomes for this and other populations. This in turn creates new opportunities for Medicaid program development and funding models.

New beneficiary engagement strategies are key to improving beneficiaries’ health and well-being. We recognize that MQD’s vision is for the people of Hawai‘i to embrace health and wellness. AlohaCare supports that vision and actively seeks new opportunities to partner with MQD and others in considering how beneficiaries, especially those of different race and ethnic backgrounds, can be engaged in a way that influences their behaviors to increase overall health and well-being.

AlohaCare continues to support the goals of the HOPE initiative and recognizes that strong partnerships between MQD, QI health plans, providers, health systems, CBOs and other state and community partners are necessary to develop innovative strategies and innovations to improve the delivery system for physical, behavioral, and LTSS. Just as QI health plans are moving providers from volume to value through APMs, so too should MQD evaluate the value of QI health plan networks based on more than the size of the network. QI health plan partnerships with essential community providers and network diversity are critical to achieving the vision of healthy families and healthy communities across Hawaiʻi.

Berry Dunn:

Project Management

An established project management methodology based on best practices is vital to many MCO related projects to help ensure work is completed on time and within scope and budget. By using proven project management processes, tools, and techniques, such as those principles in A Guide to the Project Management Body of Knowledge (PMBOK® Guide) and those of the Project Management Institute® (PMI®), a project team is able to increase success and lessen risk. These are services core to BerryDunn's Government Consulting Group. Our team has been called upon to provide project management, project advisory, and implementation oversight for numerous large, highly visible state projects, including "at-risk" or "failing" implementations. Our experience includes leading teams comprised of BerryDunn project management personnel, business and technical analysts, client and vendor personnel, and subject matter experts.

Within BerryDunn's Government Consulting Group, we retain a team of 35 certified Project Management Professionals® (PMP®s) and six Certified Associates in Project Management (CAPMs), both designations of the PMI®. Project management best practices form the foundation for all of the consulting services provided by BerryDunn.

Policy and Research Analysis

MQD's goals of laying the foundation for innovative programs that support and create healthy families and healthy communities through the QI program can be supported by policy and research analysis. BerryDunn has previously assisted in providing recommendations for managed care contracts based upon thorough policy research to understand federal guidance and trends in other states to inform a continuum of innovative approaches to managed care contracting. Our strong policy background provides us the ability to synthesize the benefits of certain approaches to managed care quality, network management, compliance and program integrity, care coordination, behavioral health and population or service carve-ins, as well as value-based payments and alternative payment models. These recommendations and policy analyses have been integral in the development of our client's managed care contracts, and have led to long-term planning and goal-setting related to the maturation of Medicaid and CHIP managed care programs.

Procurement Assistance

The re-procurement of the QI health plans involves planning and information-gathering, defining requirements, developing the Request for Proposal (RFP), and issuing and evaluating responses. MQD has started the planning and information gathering phase with the release of the QI health plans RFI. However, these steps can overwhelm a state agency and often an agency needs outside help to fairly and efficiently handle this process. BerryDunn has a strong history of helping a variety of clients through vendor procurements in the Medicaid space and otherwise. Most recently, we assisted a client with the procurement of a specialized MCO serving the foster care, adoption assistance, and select waiver populations. We have also assisted with the re-procurement of MCOs for a managed care program serving Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), Medicaid Expansion, as well as the carve-in of the CHIP population. Our approach to procurement assistance includes a detailed review of state purchasing standards and procedures, engagement with key stakeholders, and requirements gathering and alignment with state program goals and federal standards.

Encounter Data Quality

EDQ is a critical factor in successfully managing a state's Medicaid managed care program, with implications related to measuring and monitoring MCO quality, service utilization, finances, and compliance. As encounter data is used to determine capitation rates for MCOs, poor EDQ can have significant impacts on actuarial services and can inflate or misalign financial incentives and payments for MCOs. BerryDunn is currently providing project management services to support EDQ initiatives to optimize MCO encounter data processes for our client's risk-based managed care programs. Such project management services involve the coordination of activities for our client, the state's MCOs, the data warehouse/decisions support system vendor, and fiscal agent.

Mental Health Parity

The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) helps ensure that health plans offer mental health and substance use disorder benefits that are comparable to their coverage for general medical and surgical care. To support compliance with the MHPAEA, BerryDunn has provided project management services and the delivery of compliance plans to our client to help ensure compliance by its MCOs and management care programs.

Public Health Emergency Response Services

Critical to assisting a state's response to a public health emergency is pursuing MCO program flexibilities to expand coverage and telehealth support to a state's provider network. Through supporting our clients in the development and monitoring of blanket 1115 and 1135 waivers and state plan amendment opportunities, BerryDunn has helped our clients pursue opportunities to deliver medical, durable medical equipment, dentistry, and behavioral health services via telehealth visits. Specific to managed care flexibilities during the public health emergency period, we have also helped clients modify performance deadlines and timetables applicable to their state's administration of their Medicaid managed care.

Independence

A key differentiator that BerryDunn brings to this project—and any procurement that we support for the State of Hawai'i—is our independence from the vendor community. Our team has many years of large-scale enterprise business process, system advisory, and implementation experience, but our firm does not sell, develop, or provide staff augmentation services for software, hardware, or implementation vendors and we do not enter into partnerships with companies that could impair our objectivity. Further, BerryDunn does not partner, consult for, or subcontract with MCOs that might propose on this project.

Hamakua Health Center:

GENERAL SUPPORT FOR PRIORITIES OUTLINED IN THE RFI

Hamakua Health Center supports the scope of the deliverables described in the RFI. We understand the challenges facing our state and wants to be part of the solution in addressing socio-economic disparities in the communities we serve. We conduct a needs assessment yearly and are sharing the results of the assessment conducted in December of 2019.The following input is provided for your consideration:

- Care Coordination provided by the health centers thus embracing the best practices as dictated under Patient Center Medical Homes model {PCMH)

- Data mining of health care disparities by region and addressing them through

predictive/prescriptive data analysis.

- Expanding Lack of access to technology as a Social Determinant of Health.

- Integration of behavioral health in a wrap around model. Providing health to the patient by having all providers share information and best practices to provide for the patient. This would include community based organizations.

- Provide incentives to patients for wellness options e.g. provide a fit tracker and provide the patient goals with incentives. This aligns incentives and outcomes

- Provide better access to transportation.

COMMENTS, RECOMMENDATIONS AND RESPONSES TO QUESTIONS

We support maximum number of 5 Plans in all markets. We support a competitive approach to the Health industry because we know that providing patients with choices allows the Health plans to invest in patient care and communities. We support a plan that treats all the island fairly and equitable with the same choices across the spectrum of health care.

It has been the Health Center experience that the ability to manage costs, and produce other favorable outcomes, is dependent on the capability, and willingness, of Health Plans to share accurate data. Hamakua Health Center has worked with AHARO Hawaii to establish standardized data agreements we hope to use as the framework for data sharing with the Plans. These standards area available on request and if followed would allow accountable care driven health centers to implement the objectives detailed in your RFI. Data sharing by Health Plans is currently incomplete and varies with each managed care organization.

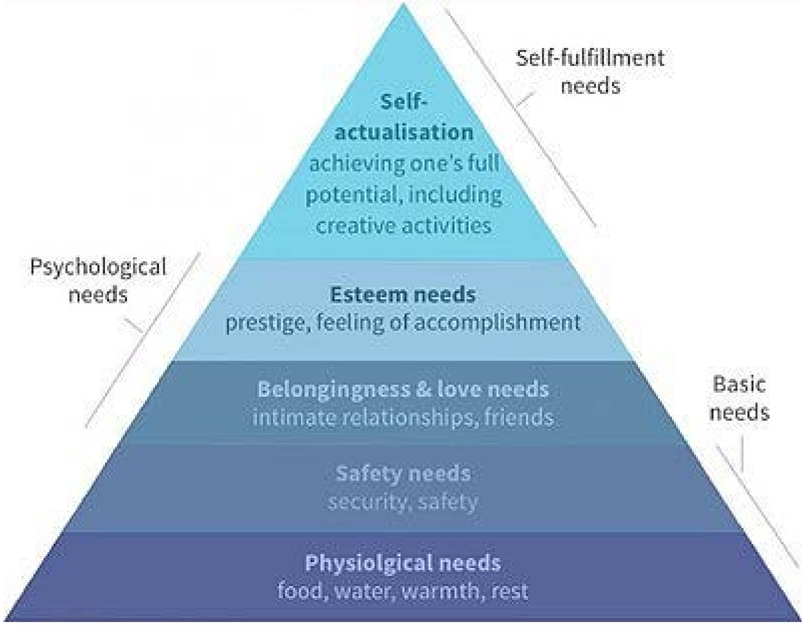
Patients may not afford a data plans nor equipment to interact through visual format. We recommend health plans do a geographic assessment of their market and identify communities with socioeconomic or technological access barriers to telehealth services. We see access to technology as an emerging Social Determinant of Health.

We strongly recommend that telephonic calls (voice only) be considered for equal pay, many times the patient is helped by phone for the following services generally not paid by health plans:

1) Medication support
2) Referrals support,
3) Insurance Eligibility
4) Care Coordination
5) Outreach
6) Transportation

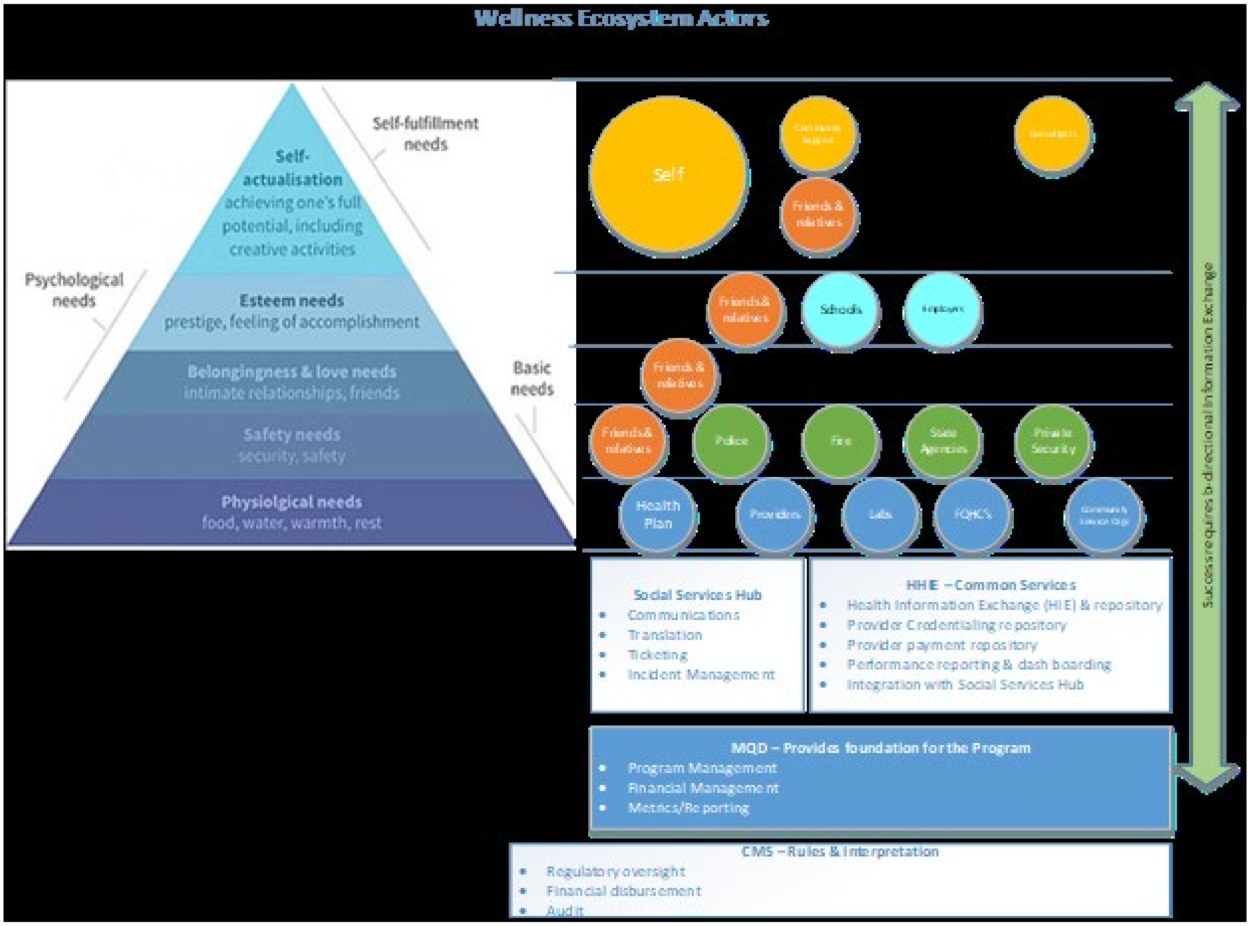
Hawaii Health Information Exchange:

Maslow's hierarchy of needs illustrates the basic needs that humans have. First and foremost are the physiological needs for things such as food, water, warmth and rest. Health care services have primarily focused on needs at this level as evidenced by the focus on reducing pain, suffering and the maintenance of bodily functions.



Source: https://en.wikipedia.org/wiki/Maslow%27s_hierarchy_of_needs

The programs envisioned by MQD proposes to extend coverage to higher needs that fall into the psychological and potentially self-actualization levels. HHIE offers the following diagram as one model of the wellness ecosystem as tied to Maslow's hierarchy of needs.



Conclusion

Consistent with Med-QUEST's vision of the HOPE project, Hawai'i Health Information Exchange's mission is to facilitate healthcare transformation and is fully aligned with and committed to supporting Med-QUEST's initiatives as a community partner and collaborator. By encouraging use of HHIE services and promoting data integration among QI HEALTH PLANs and their provider network, Med-QUEST will reap the benefits of leveraging the HHIE governance structure, value, and technical infrastructure to build a continuously learning healthcare system (https://www.beckershospitalreview.com/quality/7-characteristics-of-continuously-learning-healthcare-systems.html) to help achieve the Med-QUEST HOPE goals. HHIE looks forward to working with MQD and contributing to bringing about positive healthcare transformation in the State of Hawai'i.

Hawai'i State House of Representatives-Troy Hashimoto:

I am providing comments for question eleven on the request for information regarding concerns over the procurement considerations for the new request for proposal (RFP) for Med-QUEST.

The last award drastically threatened to limit the number of eligible service providers on neighbor islands to two and was estimated to force a significant number of residents to obtain a new provider. While at the same time gave Oahu residents the ability to have access to four service providers. My colleagues and I from the neighbor islands were appalled that services were to be limited intending to simplify choice for patients and billing processes for providers. However, when a majority of the neighbor islands are not under the two statewide, the Med-Quest division were not ensuring fairness and equity.

I would like the new RFP to address concern over consumer choice of healthcare plans for all Medicaid beneficiaries statewide – both on Oahu and the neighbor islands. With COVID-19, there has been a high rise in individuals applying for Med-QUEST. We want to be able to ensure that each of these new applicants are able to receive care that they can continually afford. These health plans also due to COVID-19 will need to be more innovative than ever to reach their members to ensure continuity of quality care to patients.

I would also like to address that neighbor islands should have access to all types of providers including specialty care providers. With the uncertainty of travel in the State of Hawaii currently, it is so hard to ask individuals to fly to Oahu as they cannot see anyone on their own island. I would also hope that payments to providers are also made in a timely manner as well.

HMSA:

1) Health Plan Personnel

It is very important to clearly define the program responsibilities that health plan employees must fulfill and to specify whether those resources must live in Hawaii. However, we also feel that it should be up to the health plan to decide on the “grade level” and structure of the position within the health plan. Not all health plans require the same qualifications or have the same responsibilities for roles such as analyst, manager, director, and vice president.

HMSA believes that requiring health plan employees to have a particular title limits the health plan from finding the best person to fulfill the responsibilities. In addition, health plans may have different ways of developing their personnel structure to meet QI contract requirements. Allowing health plans some flexibility, with approval by DHS, will allow health plans to meet their contract needs more effectively.

2) Avoidance of “Hollow” Benefits

DHS should ensure that the information members receive is fair and accurate manner when it comes to benefits. HMSA recognizes that health care is an extremely complicated business. Health plans may communicate some benefits to members in an overly simplified manner to make them understandable or due to space restrictions (on posters, pamphlets, and other marketing materials). However, HMSA wants to ensure that the actual benefit that underlies the simple messages are accurate and represent a strong and meaningful value to the member.

Pacific Medical Administrative Group

Pacific Medical Administrative Group, Inc. (PMAG) was established in 1988 in Hawaii to support independent physicians in providing high quality, cost-effective healthcare to their patients. 32 years later, PMAG continues its commitment to this mission. In today’s healthcare environment of increasing costs, physician shortages, limited information sharing and silos, this results in fragmented and inconsistent patient care. As a result, PMAG heightened its commitment to improve on these many challenges.

As the state’s largest network of physician members (over 1,000), PMAG has a unique opportunity to drive system change via the organization, collaboration, and integration of physician (primary and specialty care), inpatient, outpatient and community health care services.

Over the past 25+ years, PMAG has already been operating a successful “accountable care organization” with its partners, HMSA, The Queen’s Medical Center, Kapiolani Women’s and Children, Pali Momi, and Kuakini. At it’s height of enrollment, Pacific Health Care had over 46,000 patients under care management and risk. In 2017, PMAG was also awarded Hawaii’s first Accountable Care Organization contract by CMS.

During the past year, PMAG formed three new companies and a fourth one was fully acquired. The goal was to further invest and ensure that the physician-patient relationship is at the center of patient care decisions. Building a delivery system around this relationship is critical for integrated and coordinated care, but more importantly, optimal patient outcome.

The four companies are as follows:

1. PMAG Care, Inc.

2. Integrated Health Hawaii, LLC

3. Malama Kidney Center, LLC

4. Partners for Quality Health, LLC

In recent years, PMAG has also partnered with and integrated dozens of, if not 100+, existing community programs that were not optimized due the lack of awareness by the physician community. Many of these program offerings are coordinated via our staff in our five respective organizations. We welcome the opportunity to collaborate and discuss further opportunities with Med-QUEST, contracted health plans, and other stakeholders in our community.

Hawaii Pacific Health:

Greater standardization of VBP payments requirements across insurance plans is needed. Much of this could occur through the procurement process by incorporating standards for prospective RFP respondents to bid based on MedQuest established standards. Prospective RFI respondents must also demonstrate a minimum level of infrastructure and decision making authority with nexus within the State.

Molokai Ohana Health Care:

GENERAL SUPPORT FOR PRIORITIES OUTLINED IN THE RFI

MCHC strongly supports the HOPE program and the scope of deliverables as outlined in the QUEST RFI. We believe that Medicaid plans should be advocates for the medically underserved populations, are most impactful when truly partnered with Providers at the local level, and are an essential part of Hawai'i's safety net services, which are now more important than ever due to COVID-19.

MCHC also appreciates the fact that our State is facing financial challenges. Thus the investment of Medicaid dollars into Health Plans that can demonstrate a record of making timely payments to providers to ensure that our local providers don't have to worry about cash flow at a time when our uninsured population base only continues to grow.

Kokua Mau:

Advance Care Planning (ACP) is an integral part of providing patient centered care. Having meaningful conversations about goals of care can improve outcomes and decrease unwanted and unnecessary treatment people receive. Making sure everyone over the age of 18 who is on Quest has appointed a healthcare agent, had conversations with loved ones and doctors about their wishes, and completed an Advance Directive can help people to receive the best care possible. These Advance Care Planning conversations should start early, ideally while individuals are in good health, however it is often a diagnosis or serious illness which prompts these conversations. Advance Health Care Directives can document wishes for care, and designates the healthcare agent if the individual is unable to speak for themselves. Conversations with loved ones, family and health care agents are crucial so that everyone understands the wishes of the patient.

Kōkua Mau has done significant outreach with providers and individuals in the community, and recognizes these conversations can be challenging, and are necessary to provide optimal care. These conversations require good communication skills and should not be included as part of a wellness visit's "checklist". There are unintended consequences of including Advance Care Planning as an annual requirement, as it no longer includes the rich and meaningful conversations, and is often reduced to either asking for an Advance Health Care Directive, handing out blank forms, or completion of a POLST (Providers Orders for Life Sustaining Treatment) when it is inappropriate. Documenting the conversation(s) is a valuable means of ensuring Quality Assurance measures and patient centered care is achieved. Documentation of these conversations by anyone on the care team, including nurses, social workers, physicians, and case managers can ensure that all providers are informed of the patient's wishes and are working together to provide optimal care. Developing the skills to have these conversations is key to ensure good conversations are documented and shared in the EMR. Kōkua Mau has done professional development and trainings with professionals, and recognizes the challenges providers face when having these conversations. Developing the skills needed to have these conversations require training and practice.

A focus on High Need, High Cost individuals is important, with much potential for improving outcomes, especially given the high costs associated with the last year and months of life. The vulnerable population faced with serious illness is in need of whole-person centered care, which requires understanding the individual's needs and goals and having loved ones included in these conversations to support the individual. Advance Care Planning conversations are vital to ensure individuals receive the best care possible. We recommend an emphasis on care throughout the life cycle, including care for those living with serious illness and especially at the end of life. Hospice care at the end of life and specialized palliative care during a serious illness, both offer proven solutions to a variety of the issues, including transitions of care, providing interdisciplinary care teams, and patient centered care.

Individuals with serious illness should also consider completing a POLST. While an Advance Directive is recommended for all competent individuals over the age of 18, the POLST is intended for individuals facing serious illness who may also be medically frail, have chronic disease, advance illness or if a provider feels that they would not be surprised if the person died in the next year. A POLST is a standing medical order that first responders are able to honor and ensures an individual's health care wishes are followed in an out-patient setting. Conversations surrounding the POLST should be documented in the individual's medical records as an extension of Advance Care Planning conversations. The National POLST program, of which Hawaii is a member, recommends that quality measures around the POLST should be measured by conversations documented, and never by completion of the document.

It is important to recognize the value of ACP conversations during times of COVID-19. Providers who have had ACP conversations should review with individuals and agents if documents are still aligned with the patient's wishes for care. This will ensure individuals receive the best care possible, in their preferred setting, whenever possible. COVID-19 has also created an opportunity for earlier ACP conversations with healthy individuals and their providers to discuss wishes for care and can be documented in the EMR and in an Advance Health Care Directive. Early ACP conversations can help to familiarize individuals with identifying their wishes for care for future needs.

Individuals who have a POLST, who may be POLST appropriate but never engaged in advance care planning conversations, or who may be diagnosed with conditions that put them at high risk of dying from COVID-19, should be approached about their treatment wishes and POLST. For many, resource limitations (e.g., ventilator shortages) and the high mortality for older adults infected with COVID-19 may mean the treatment decisions these patients make may apply only to the current health crisis and may change once the crisis abates. This is especially important if the individual prefers to avoid invasive life-prolonging treatment. (POLST.org)

Kōkua Mau stands ready to work with MedQuest and others in our community to normalize conversations on Advance Care Planning. Thank you for your attention.