CMS Annual Report

FFY 2018

Hawaii QUEST Expanded Section 1115

Reporting Period:

October 1, 2017 - September 30, 2018

(Demonstration Year 24)

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I. Introduction

(Annual Summary - Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This is likely to be the same for each report.))

Hawaii's QUEST Integration (QI) is a Department of Human Services (DHS) and Med-QUEST Division (MQD) comprehensive section 1115 (a) Demonstration that expands Medicaid coverage to children and adults originally implemented on August 1, 1994. QUEST Integration uses capitated managed care as a delivery system unless otherwise indicated. Also, QI provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria, to beneficiaries eligible under the State Plan and to the Demonstration populations.

During the reporting period, MQD focused on a comprehensive internal quality improvement project, called the HOPE Initiative. "HOPE" stands for Hawaii-Medicaid Ohana-Nui Project Expansion, and the goal of the initiative is to achieve the Triple Aim of better health, better care, and sustainable costs for our community. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and continued sustainable growth rate in healthcare spending from reductions in unnecessary care and shifts of care to appropriate settings. As a follow-up to the trainings that occurred in the previous quarter, weekly meetings have been established for the "HOPE Leadership Team" to ensure HOPE initiatives are weaved into the new QI Request For Proposal (RFP).

Med-QUEST Division used the Indefinite Delivery/Indefinite Quantity (IDIQ) procurement method to select 11 contractors in the pool for future task order proposal submissions. In July, MQD selected 5 contractors for the following task orders: 1115 Waiver; QI RFP; High-Needs/High-Costs; Primary Care; and Project Support.

During the reporting period, MQD demonstrated progress on its 1115 Waiver renewal. In particular, MQD staff reviewed comments submitted by the public regarding the 1115 Demonstration Extension. The notice for the 1115 Demonstration Extension was posted to the public on February 15, 2018, and public comments were due to MQD by March 19, 2018.

Additionally, two public hearings were held. One was held on March 2, 2018 and the other was held on March 6, 2018. A second public comments period will begin during the next reporting quarter. There was a second public comment period from July 31, 2018 to August 30, 2018. Following the second comment period, MQD reviewed the submitted comments. Med-QUEST Division began working with the IDIQ contractor, Harbage, on moving the 1115 Waiver renewal forward. Another public forum was held on November 28, 2018.

II. Budget Neutrality Monitoring Spreadsheet

(Annual Summary)

The Budget Neutrality spreadsheet for the quarter ending September 30, 2018 was submitted by the November 30, 2018 deadline.

III. Events Affecting Healthcare Delivery

(Annual Summary - Operational/Policy Developments/Issues: Identify all significant program developments/issues/problems that have occurred, including but not limited to the following.)

A. Approval & Contracting with New Plans

During this reporting period, no changes were made to the current health plan contracts.

B. Benefits & Benefit Changes

Community Integration Services (CIS)

The Policy and Program Development Office (PPDO) staff have completed negotiations with the Centers for Medicare and Medicaid Services (CMS) to add this amendment to the current 1115 Demonstration waiver, and the amendment was passed on October 31, 2018. This amendment will increase access to CIS to individuals who are chronically homeless or in danger of losing public housing with either a physical or behavioral illness. MQD continues to work on provision of these services to eligible beneficiaries with providers and collaborative partners in the community.

1115 Demonstration Renewal

The PPDO and MQD administration continue working with CMS on the 1115 Demonstration renewal. We have received an extension of the current waiver through June 30-, 2019 as negotiations with CMS continue. However, MQD feels strongly the renewal will be approved.

HOPE initiative

PPDO and other MQD staff continue to work with our consultants, stakeholders and other parties to develop implementation plans for the initiatives outlined in our HOPE document. These include a focus on special needs (high cost, high needs) individuals, development of delegated care coordination and Care Management Models to enhance and maximize services to our most needy beneficiaries as well as increase community involvement at all levels. In addition, there is a focus on the social determinants of health, as well as addressing the whole family (‘Ohana Nui or Two Gen approach) rather than just the individual, to achieve greater health and over wellbeing for our beneficiaries and their families.

Collaboration with the Department of Education to increase Medicaid Claiming for School Based Services

Med-QUEST Division has formed a workgroup with DOE to continue efforts to maximize federal resources for medically necessary services provided in schools to Medicaid beneficiary children. The work initiated by SCR 81 and information learned at the NAME conference has been instrumental in laying the foundation for continued collaboration with MQD and DOE. Meetings are held bi-weekly to ensure progress continues and allows opportunities for discussion and problem solving.

Hawaii Administrative Rules

PPDO continues to work on amending the Hawaii Administrative Rules to be in compliance with new federal regulations and guidelines, in addition to housekeeping as needed.

Policy and Program Directives

Part of PPDO's responsibilities include drafting and issuing of Policy and Program Directives (PPDs) to MQD staff for information, clarification and action on affected individuals. PPDs are drafted during the year as requests for clarification of current rules are submitted, or to inform staff of upcoming changes in policy or programs until the Hawaii Administrative rules are amended.

Other Duties

In addition to the above, PPDO is tasked with updating/creation of MQD forms, Income Eligibility Verification System (IEVS) monitoring, assist staff with clarifications for Administrative appeals, manage the Medicaid Buy-in Program for payment of Medicare premiums for eligible beneficiaries, work closely with our eligibility branch to improve processes and procedures for implementation of programs and policy, participation in various collaborative initiatives with other DHS offices such as BESSD, EOEL, other divisions such as DOE, DOH as well as with both non and for profit agencies to maximize Medicaid impact and benefits for the people of Hawaii.

C. Enrollment and Disenrollment

The Med-QUEST Division Enrollment Services Section performs application intake and offers a choice to enroll in QUEST Integration health plan at the time of application. The streamlined process reduces cycle time for clients to enroll into the health plan of their choice. During the reporting period, 2,483 individuals enrolled into a QUEST Integration health plan upon completing the Medicaid application.

The QUEST Integration health plan agreement allow individuals the opportunity to select a health plan during the initial enrollment period and grace period of 60 days for MAGI and 90 days for non-MAGI. Health plans may agree for members to change health plans after the grace period. Change is effective the first day of the next month. There were 624 agreed upon plan changes for this period.

The QUEST Integration Annual Plan Change period was October 1 through October 31, 2017, with enrollment effective date January 1, 2018. There were 327,053 clients eligible to participate in annual plan change. The following table summarizes by island the 6,009 health plan changes Med-QUEST processed.

	Oahu	**Kauai**	**Hawaii**	**Maui**	**Lanai**	**Molokai**
MAGI	2839	213	770	673	60	7
MAGI Excepted	990	42	258	148	8	1
Total	**3829**	**255**	**1028**	**821**	**68**	**8**

Med-QUEST offers language assistance to individuals inquiring or enrolling in a QUEST Integration health plan. The leading four languages included Korean, Chinese (Cantonese and Mandarin), Filipino (Ilocano, Tagalog, and Visayan), and Vietnamese.

Outreach/Innovative Activities

(Annual Summary - Outreach activities and/or promising practices.)

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

HCOB began a new Kōkua Services procurement contract year on July 1, 2018 through June 30, 2019 with Hawaii Island HIV/AIDS Foundation on Hawaii Island, We Are Oceania on Oahu and Kauai Economic Opportunity Incorporated on Kauai to continue outreach, education, and health coverage enrollment efforts.

HCOB actively planned and prepared for our Annual KOLEA and Health Insurance Marketplace training to approximately 120 "Kōkua" in-person assisters from Federally Qualified Health Centers (FQHC's), Med-QUEST Kōkua Services Contractors, other community health centers statewide. Working with our community partners on the various islands to arrange logistics and solidify dates for trainings to maximize participation on the major neighbor islands, Oahu, Hawaii Island and Kauai; updating training materials to reflect current and pertinent information. Training curriculum includes detailed overview of how to gain access to and successfully submit an online application for Medicaid through our KOLEA Enterprise system and on www.healthcare.gov which includes overview and understanding of the Affordable Care Act (ACA), the Health Insurance Marketplace; portal.cms.gov MLMS online certification training and the subsidies offered by the ACA at healthcare.gov such as Advance Premium Tax Credits (APTC) and Cost Share Reductions (CSR), the need to reconcile APTC's from a 1095-A form with Annual Tax Filing by way of tax form 8962 to the IRS. Cultural Competency is incorporated in all of the trainings.

This year, we received a request from Lanaʻi Community Health Center (LCHC) to host their own training on their island of Lanaʻi, which HCOB included in our training planning. LCHC committed 8 staff members to attend the training. Their commitment to this training provides greater opportunity for the residents on the island of Lanaʻi to gain access to in-person health coverage enrollment assistance.

Worked at the Disaster Relief Center (DRC) during the Kilauea Volcano eruption on Hawaii Island along with canvassing the affected communities, where approximately 700 families lost their homes and many people lost businesses, such as farmers, restaurants, mom and pop operations, the closing of the Kilauea Volcanos National Park, Kilauea Military Camp, Volcano House Hotel/Restaurant/Camp Grounds and those that had to reduce hours for employees. Attended community meetings, worked at emergency shelters in the affected areas to answer community questions regarding Medicaid coverage and/or access to health coverage.

Worked with the Emergency Operating Center (EOC) on Hawaii Island and participated in Public Damage Assessments (PDA) site visits with FEMA, SBA, and County representatives during the numerous Hurricane/Tropical Storms which hit Hawaii Island.

Worked directly with Maunalani Bay Hotel on Hawaii Island where 204 employees were losing their jobs due to the hotel closing for a 2-year renovation. Held information session to employees, providing information on how to apply to Medicaid and/or Federal Health Insurance Marketplace. Working directly with these employees to ensure continuity of health coverage.

Continued work, in identifying and assisting hard to reach populations and those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers, justice-involved populations and those who are admitted to and discharged from public institutions.

HCOB continues to work with clients and issuers to review and determine applicants' eligibility for the State of Hawaii's Premium Assistance Program (PAP), the State's innovative approach to helping those who are living in poverty, are deemed ineligible for Medicaid due to their citizenship status, whose households are below 100% of the Federal Poverty Level (FPL) gain access to the benefits of health insurance by paying for the remaining portion of a PAP qualified individual's premium, not covered by the Advanced Premium Tax Credit (APTC) they are eligible for, thus meeting the expectations of the Affordable Care Act (ACA) which require individuals without qualified exemptions be insured.

D. Complaints/Grievances

(Annual Summary - QUEST Integration Consumer Issues: A summary of the types of complaints or problems consumers identified about the program. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Corrective actions and the number of outstanding issues that remain unresolved must be included. Also, discuss feedback received from consumer groups.)

October 2017 – September 2018 Complaints/Grievances	
Number and Type of Complaints:	**Description :**
12 – Doctor/ Provider	Provider is very unprofessional, unethical behavior and member feels violated. Provider decreasing member's prescription. Doctor does not follow up with members concerns and or respond when requesting referrals. Member said provider performed a surgery against his will. Provider refuses to prescribe a different type of opioids after member said he received an allergic reaction after taking the original prescription from his doctor. Provider using patients time to take personal calls then rushes them out telling them there time is up. Complaint against provider breaking HIPAA law. Provider falsifying members' medical records. Complaints about doctors calling members names or saying inappropriate things to the members. Providers are getting paid for services that are not performed or completed.
2 - Transportation	Transportation services do not come during schedule times. Drivers and representatives are unprofessional, rude and uncaring to members. Member feels health plan sides with contractors.
32 – Health Plan	Several complaints regarding health plans incorrectly in taking members complaints. Many resolutions did not pertain correct information or has been addressed inaccurately. Health plans denying services even though it's medically necessary. Complaints about health plans siding with contractors. Health plans

	sending false resolutions that have not been solved nor addressed. Health plan being uncooperative and denying recommended services. Health plans not assisting members with needed services and denying request due to members not submitting enough documentation, but member said they been trying to work with health plans and they are not cooperating. Members not receiving an acknowledgement letter and or a grievance resolution from the health plan when they filed their grievance. Health plans are not able to get in contact with providers to discuss discrepancies with members. Providers calling saying health plans are not paying for services and will not cooperate with provider for reimbursement. Health plans have high turnover, they keep changing case workers and doctors. Health plans are unorganized and inconsistent. Health plans are not helping or directing members who really need extra services such as coordinators, chores services, flight arrangements and transportation. Health plans are taking longer than the allowed days to respond and or approve referrals for members. Member don't agree with health plan policy regarding members seeing multiple doctors to find one that specialized in internal medicine. Complaints against long wait times when calling for assistance member waited almost 1 hour to speak with a representative. Member feels health plans are hindering information from him. Insurance not covering emergency transport with the response of the company that transported the member is not contracted with the health plan. Health plans not paying provider claims. Denied dental services reimbursement due to health plans coverages. Members unable to find a PCP for a follow up after an urgent care/ emergency visit.
6 – Services / Service coordinators & Case managers	Member does not want service coordinator to go into her home. Service coordinator denied member services, when they were receiving services for the past year. When member passed away his sister/legal guardian didn't receive no assistance from the case manager. Member feels service coordinator is harassing her; she sanctioned and terminated members services. Caseworkers are not doing their jobs and helping members with services. Member said their chore service worker was committing fraud by charging member cash and adding hours that they did not work.
61 – Miscellaneous	Calling wrong business line. Calls regarding appeal and the process. I explain to the members our Appeals process and provide them with any needed information such as contacts and instructions on how to file. Refer clients to file a grievance with the health plan first before they can file a State Grievance with us. Calls regarding members medical being terminated. Member calls regarding change of health plans. Call asking to review deceased fathers' paperwork regarding his medical. Request for provider applications and questions regarding provider information. Member looking for contacts of inpatient rehab facilities on the big island that take Medicaid. Complaint about premium payments getting taken out from his social security money that he receives. Member call regarding status of medical and information regarding co insurances. Member wants their Medicaid record expunged. Calls requesting Medicaid to cover

	special services. Calls to make changes to their Medicaid benefits. Request of certain documents. Complaint regarding the member getting billed and sent to the collectors for medical bills that were not covered; member asking for reimbursement. Provider revalidation questions and concerns; checking on status of applications. Trying to enroll in Medicaid and need assistance. Members need help with denied benefits. Received dental bill in error.

E. Quality of Care

Last year Med-QUEST worked on additional guidance on the provision of telehealth services. More specifically we concentrated on teledentistry. Teledentistry is a relatively new area so guidance on the provision of dentistry utilizing synchronous and asynchronous methods was needed. In addition, there was a new state statute passed last year that expanded the scope for dental hygienists under general supervision. Clarification to Federally Qualified Health Centers (FQHCs) also was needed for teledentistry that was eligible for PPS reimbursement. The Division worked with the Department of Health and the Department of Commerce and Consumer Protection (Board of Dental Examiners), researched other States to see what was being done, reviewed Hawaii's largest commercial dental plan to see how they were complying with the state statute as it related to the expanded scope of practice for hygienists and supervision requirements of dentists.

Med-QUEST Division initiated work with the managed care health plans to begin receiving information and data for inclusion in the Drug Utilization Review annual report due to CMS. Previous to this, MQD only reported on fee-for-service claims. The information will provide MQD with information on how each health plan is managing drug utilization for their members and provide a basis for MQD issuing guidance in the future on drug utilization policies across all managed care plans. This would result in more consistent application of drug policies that would benefit providers and recipients.

The other item that MQD has worked on is a Conflict of Interest form for the Drug Utilization Review Board members to sign. The form is under review by our Department of Attorney General with the goal of having each Board member acknowledging and signing the form in January, 2019. The Conflict of Interest form will ensure that advice provided to MQD will not be unduly influenced by manufacturers.

F. Access that is Relevant to the Demonstration

An event affecting access to healthcare delivery, which occurred on May 3, 2018, was the volcanic eruption of Kilauea on the island of Hawaii impacting many members by restricting travel and mobility and/or by destroying member homes. Some services were affected due to road closures and mandatory evacuations. The MQD coordinated with health plans to ensure that service authorizations were relaxed, medication access and delivery continued uninterrupted, and vulnerable and impacted Medicaid members were relocated. For more details, see Section XIII below.

Also, Hawaii State was impacted by major hurricane Lane, August 22nd – 26th 2018. Lane at its peak was a category 4 hurricane that was projected to directly hit the Hawaiian Islands. Med-QUEST Division and the 5 QI

MCOs held daily briefing meetings leading up to the projected date of impact, informing the regional CMS office with daily status updates. The Big Island of Hawaii and Maui bore the brunt of the hurricane winds and rain, and eventually Lane veered left avoiding a direct hit on Oahu. Given the circumstances, the impact of Lane on service delivery was lower than anticipated.

G. Pertinent Legislative or Litigation Activity

There was no pertinent litigation activity during this period.

A chart of pertinent laws passed by Governor Ige after the 2018 Legislative Session follows:

ACT	Bill Reference	Bill Topic	Summary	Special Notes
2	HB2739 HD1	Health; Our Care, Our Choice Act	Establishes a regulated process under which an adult resident of the State with a medically confirmed terminal disease and less than six months to live may choose to obtain a prescription for medication to end the patient's life. Imposes criminal sanctions for tampering with a patient's request for a prescription or coercing a patient to request a prescription.	For Medicaid recipients, federal funds will not be available to cover the prescription costs, only state funds will be used.
13	SB270 SD1 HD2 CD1	Sexual Orientation Change Efforts; Conversion Therapy; Prohibition; Minors; Licensed Professionals; Sexual Orientation Counseling Task Force	Prohibits specific state-licensed persons who are licensed to provide professional counseling from engaging in, attempting to engage in, or advertising sexual orientation change efforts on minors. Establishes the sexual orientation counseling task force to address the concerns of minors seeking counseling on sexual orientation, gender identity, gender expressions, and related behaviors.	
55	HB694 HD2 SD1 CD1	DHS; Med-QUEST Division; State Health Planning and Development Agency; Health and Healthcare Information and Data; Health Analytics Program; Appropriation	Establishes the Health Analytics Program in the Med-QUEST Division of the Department of Human Services and authorizes the Department of Human Services to maintain an all-payers medical claims database. Appropriates funds for the establishment of two full-time equivalent positions.	Med-QUEST has hired a lead for this new Branch.

78	HB2144 HD1 SD1 CD1	Medicaid; Inmate; Public Institution; Prisons; Jails; Correctional Facilities	Requires the Department of Public Safety to inform inmates of the availability of assistance to secure or verify applicable Medicaid eligibility prior to an inmate's release.	
111	SB2340 SD2 HD1 CD1	Health Insurance; Extended Coverage; Preexisting Conditions; Nondiscrimination	Ensures certain benefits under the federal Affordable Care Act are preserved under Hawaii law, including: extending dependent coverage for adult children up to 26 years of age; prohibiting health insurance entities from imposing a preexisting condition exclusion; and prohibiting health insurance entities from using an individual's gender to determine premiums or contributions.	Impact to program will happen if ACA provisions are invalidated Federally.
116	HB2729 HD2 SD2 CD1	Medical Cannabis; Reciprocity; Written Certification; Testing; Telehealth; Manufactured Cannabis Products; Dispensaries; Employees; Working Group	Establishes standards and criteria for reciprocity for qualifying out-of-state medical cannabis patients and caregivers including limitations, and safeguards. Authorizes extension of written certifications of a debilitating condition for up to three years for chronic conditions. Clarifies a dispensary licensee's right to retest marijuana or manufactured cannabis products for compliance with standards. Authorizes establishment of a bona fide provider-patient relationship via telehealth. Authorizes dispensing of devices that provide safe pulmonary administration of medical cannabis by dispensary licensees. Increases the allowable tetrahydrocannabinol limit for of certain manufactured cannabis products. Limits felony convictions that disqualify an individual from employment with a dispensary licensee. Establishes a working group to make recommendations regarding employment of qualifying patients and manufacture and dispensing of edible cannabis products.	Section 24 provides for physician-patient relationship may be established via telehealth, provided that certifying a patient for medical use of cannabis via telehealth only after initial in-person consultation

125	HB1812 HD3 SD2	Health Care Surrogate; Medicaid Authorized Representative Application	Authorizes a health care surrogate to act as a Medicaid authorized representative to assist a patient with a Medicaid application and eligibility process and in communications with the Department of Human Services. Specifies the duties and obligations of the surrogate.	
136	SB2487 HD1 CD1	Health; Quality Assurance Committees; Definition	Amends the definition of "quality assurance committee" to include committees established by long-term care facilities, skilled nursing facilities, assisted living facilities, home care agencies, hospices, and authorized state agencies. Allows for the creation of a quality assurance committee outside of a single health plan or hospital.	
139	SB2799 SD1 HD2 CD1	Licensed Dental Hygienists; Public Health Setting; Supervision	Clarifies the scope of practice of licensed dental hygienists in a public health setting.	
144	SB122 SD2 HD2 CD1	Mental Health; Notice; Hearings	Provides designated family members and other interested persons with notice when an individual with a mental health emergency is subject to certain procedures and actions. Provides designated family members and other interested persons with the right to be present for the individual's hearings and receive a copy of the hearing transcript or recording unless the court determines otherwise. Requires a court to adjourn or continue a hearing for failure to timely notify a person entitled to be notified or for failure by the individual to contact an attorney, with certain exceptions. (CD1)	

146	HB1916 HD2 SD2 CD1	Alzheimer's Disease and Related Dementias; State Plan Updates; Executive Office on Aging	Requires the Executive Office on Aging to biennially update the state plan on Alzheimer's disease and related dementias, include an implementation work plan for each goal in the state plan, and include information on progress made toward the goals of the state plan on Alzheimer's disease and related dementias in its annual report to the legislature.	
147	HB1906 HD2 SD2 CD1	Health Care Worker; Intentionally or Knowingly Causing Bodily Injury; Felony Assault in the Second Degree	Makes intentionally or knowingly causing bodily injury to certain health care workers a Class C felony.	
148	HB1911 HD2 SD1 CD1	Care Facilities; Uncertified; Unlicensed; Enforcement; Community-based Care Home; Adult Care Center; Criminal Penalty	Authorizes the Department of Health to investigate care facilities reported to be operating without an appropriate certificate or license issued by the Department. Establishes penalties for violations and for knowingly referring or transferring patients to uncertified or unlicensed care facilities, with certain exceptions. Excludes landlords from licensure, under certain conditions.	
152	HB2384 HD1 SD1	Uniform Controlled Substances Act; Withdrawal; Detoxification; Maintenance	Updates Uniform Controlled Substances Act for consistency with federal law. Allows prescription of drugs to patients undergoing medically managed withdrawal, also known as detoxification treatment and maintenance treatment, by practitioners who are properly registered.	
153	SB2646 SD1 HD3 CD1	Electronic Prescription Accountability System; Prescription Drugs	Requires prescribers of certain controlled substances to consult the State's Electronic Prescription Accountability System before issuing a prescription for the controlled substance, under certain circumstances. Provides that a violation by a prescriber shall not be subject to criminal penalty provisions but that a violation may be grounds for professional discipline. Repeals on 6/30/2023.	

154	SB2247 SD1 HD2 CD1	Opioid Antagonists; Prescriptions; Dispensing; Pharmacists	Authorizes pharmacists to prescribe, dispense, and provide related education on opioid antagonists to individuals at risk of opioid overdose and to family members and caregivers of individuals at risk of opioid overdose without the need for a written, approved collaborative agreement; subject to certain conditions.	
155	SB2244 SD1 HD2 CD1	Workers' Compensation; Opioid Therapy; Informed Consent; Prescription Limits	Requires health care providers in the workers' compensation system who are authorized to prescribe opioids to adopt and maintain policies for informed consent to opioid therapy in circumstances that carry elevated risk of dependency. Establishes limits for concurrent opioid and benzodiazepine prescriptions.	
161	SB2488 SD2 HD1 CD1	Medical Cannabis; Health Insurance Reimbursement; Working Group	Establishes the Medical Cannabis Insurance Reimbursement Working Group to address the complexities surrounding the topic of making medical cannabis reimbursable by health insurance.	MQD Director named to the working group; long term may require State funds for reimbursement
185	SB2647 HD3	Mental Health Counselors; Licensure; Qualifications; Practicum Experience	Amends the practicum experience requirements for qualification for licensure as a mental health counselor.	
192	HB1520 HD2 SD1 CD1	Short-term, Limited-duration Health Insurance; Insurers; Renewal or Reenrollment; Prohibition	Prohibits an insurer from renewing or re-enrolling an individual in a short-term, limited-duration health insurance policy or contract if the individual was eligible to purchase health insurance through the federal health insurance marketplace during an open enrollment period or special enrollment period in the previous calendar year. Specifies that short-term, limited-duration health insurance shall be subject to the same provisions of the insurance code currently applicable to limited benefit health insurance.	

197	HB2145 HD1 SD1 CD1	Health Insurance; Medication Synchronization; Prescription Drug Coverage; Patients; Network Pharmacies	Allows the synchronization of plan participants' medications. Requires plans, policies, contracts, or agreements that are offered by health insurers, mutual benefit societies, and health maintenance organizations and provide prescription drug benefits, to apply prorated daily cost-sharing rates for prescriptions dispensed by network pharmacies for less than a thirty-day supply.	
198	HB2149 HD1 SD1	Dentistry; Dentists; Continuing Education; Ethics; Board of Dental Examiners	Amends the ethics training requirement for dentists in the continuing education program to be six hours of ethics training within the previous two years for each biennial renewal period.	
199	HB2208 HD1 SD1 CD1	Association Health Plan Policies; Authorization	Requires association health plan policies to comply with the laws of this State regardless of the association's domicile. Enables certain voluntary associations, including employer associations that issue association health plans, to qualify for authorization to transact insurance in the State.	
205	HB2271 HD2 SD1 CD1	Practice of Behavior Analysis; School Setting; Applied Behavior Analysis; Developmental Disabilities; Department of Education; Applied Behavior Analysis; Implementation Plan; Reporting; Scope of Practice; Medicaid	Updates and standardizes the terminology used to refer to behavior analysts and applied behavior analysis. Clarifies the licensing exemptions for certain individuals who provide behavior analysis services. Requires the Department of Education to create and implement a plan to provide Medicaid billable applied behavior analysis services to all students diagnosed with autism spectrum disorder within the Department. Establishes reporting requirements.	
209	SB2401 SD2 HD1 CD1	Homelessness; Housing; Ohana Zones Pilot Program; Emergency Department Homelessness Assessment Pilot Program; Medical Respite Pilot Program;	Establishes the Ohana Zones Pilot Program, the Emergency Department Homelessness Assessment Pilot Program, and the Medical Respite Pilot Program. Makes appropriations.	

		Law Enforcement Assisted Diversion; Appropriations		

IV. Adverse Incidents

(Annual Summary - Including abuse, neglect, exploitation, mortality reviews and critical incidents that result in death, as known or reported)

A. Medicaid Certified Nursing Facilities

Total of 93 reported adverse incident reports submitted during the period of October 2017 – September 2018.

- 41 unattended/unwitnessed fall
- 11 witnessed fall
- 40 unknown cause of pain/skin discoloration
- 1 resident on resident abuse

Intermediate Care Facility Developmental Disability/Intellectual Disability Facilities:

Total of 58 reported adverse incident reports submitted during the period of October 2017 – September 2018.

- 42 ER visits due to illness
- 14 ER visits due to injury
- 1 Seizure
- 1 Death

B. Long Term Services and Supports (LTSS)

In FFY 2018, a total of 1,282 adverse events related to the LTSS population were reported. The top five incident categories were the same in all four quarters: Fall, Hospitalization, Emergency Room Visit, Injury and Death. Falls were the top occurring incident throughout all quarters but the occurrences trended down throughout the year.

Hospitalization was the second most occurring incident in the last three out of all four quarters with occurrences trending up.

The downward trend in falls may be attributed to MQD's increased reinforcement of ensuring that fall precautions are in place for members as well as requiring follow ups for individual fall cases. The upward trend for hospitalization may be attributed to varying category labels related to hospitalization among reporting entities. MQD plans to revise the LTSS report in order to more capture incident occurrences on a more granular level for more effective remediation. MQD is in the process of renewing the 1115 demonstration and part of this work is to review and refine the LTSS report.

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

(Annual Summary - Including information on, and assessment of, the operation of the managed care program in regard to encounter data reporting by each MCO, PIHP, or PAHP.)

Med-QUEST Division continues a monthly encounter validation meeting with all participating MCOs to address major issues. In particular, MQD is working with the MCOs to correct MCO existing encounter editing errors. Med-QUEST Division also works with its contractor, Milliman, to use the currently submitted encounters to generate financial reports, and compare financial reports submitted by MCOs to validate completeness of encounters. The goal is to use the State Medicaid encounter system to generate robust financial reports, and use them to monitor the MCOs, and use them for the annual rate setting process.

At the current time, the financial reports generated from the State encounter system and those from the MCOs, differ from less than 5% to over 25% (based on the form types). Med-QUEST Division is working with MCOs to decrease these differences. During the last quarter, MedQUEST compared the MCOs' check register totals to their submitted drug encounters. This comparison process continued for non-pharmacy services. Now, MedQUEST has MCOs paid check registry, total submitted and accepted encounters for the following categories: Hospital inpatients, Long term care, All other UB claims related services, HCFA 1500 claims, and the drug claims. The State is using these as benchmarks to measure if all MCOs submitted complete encounters, and make sure the errors of pended encounters were corrected.

VI. Initiatives and Corrective Action Plans for Issues Identified In:

(Annual Summary)

A. Policy

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

B. Administration

During the reporting period, no administrative issues were identified for any initiatives or corrective action plans.

C. Budget & Expenditure Containment Initiatives

(Annual Summary - Financial/Budget Neutrality Development/Issues: Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the year. Identify the State's actions to address these issues.)

(Annual Summary - Expenditure Containment Initiatives: Identify all current activities, by program and/or Demonstration population. Include items such as status, and impact to date, as well as, short and long term challenges, successes and goals.)

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

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

(Annual Summary - Including member months, as required to evaluate compliance with the budget neutral agreement. Enrollees include all individuals enrolled in the Demonstration.)

A. Enrollment Counts

(Annual Summary - Enrollment Information; Enrollment Counts: Enrollment counts must be person counts, not member months. Include the member months and end of period, point-in-time enrollment for each demonstration population. The table should outline all enrollment activity under the Demonstration. The State must indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State must indicate that by "0".)

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**10/2017 - 09/2018**	**10/2017 - 09/2018**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	1,442,397	118,110
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	458,887	37,169
Aged	Aged w/Medicare Aged w/o Medicare	323,892	27,523
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	296,351	25,067
Expansion State Adults	Expansion State Adults	1,169,795	95,954
Newly Eligible Adults	Newly Eligible Adults	272,834	22,200
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	5,142	
CHIP	CHIP (HI01), CHIPRA (HI02)	340,681	27,735
Total		4,309,979	353,758

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	207,869
Title XXI funded State Plan	27,735
Title XIX funded Expansion	118,154
Enrollment current as of	9/30/2018

B. Enrollment in Behavioral Health Programs

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

Program	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Enrollment			
Community Care Services (CCS) Adult (at least 18 years old) QI beneficiaries with a serious mental illness (SMI) or serious and persistent mental illness (SPMI) who meet the program criteria, receive all behavioral health services through the CCS program.	**4,890**	**4,863**	**4,735**	**4,660**
Early Intervention Program (EIP/DOH) Infant and toddlers from birth to 3 years old receive services to assist in the following developmental areas: physical (sits, walks); cognitive (pays attention, solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	**478**	**504**	**753**	**978**
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**1,089**	**1,108**	**1,106**	**1,041**
Adult Mental Health Division (AMHD/DOH) Uninsured, underinsured, and/or encumbered adults with SMI who meet the program criteria, receive integrated mental health services that are culturally responsive and based on a best practices system to support recovery, by the state Department of Health.	**159**	**148**	**142**	**146**

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

(Annual Summary - of the programmatic activity for the year for demonstration eligibles. This shall include a count of the point in time demonstration eligible individuals receiving MQD FFS services through the DOH CAMHD and AMHD programs.)

See table above in Section B, for the count of demonstration eligible that access DOH services.

AMHD discontinued Representative Payee services. Steps are being taken to transfer this service to CCS program.

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

(Annual Summary - of the number of beneficiaries assisted monthly. The monthly auto assignment rate including MCO information and island of residence. The number of requests to change plans, the outcome of the request, and the monthly disenrollment requests both granted and declined over monthly MCO enrollment.)

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

LTSS Enrollment (Combined Dashboard as of 2/26/19 11:21 am)

1st Quarter Health Plan	Oct 2017	Nov 2017	Dec 2017
Aloha Care	335	336	397
HMSA	656	661	643
Kaiser	166	167	168
Ohana	3324	3287	3297
United Healthcare	1742	2081	2035
Total	**6223**	**6532**	**6540**

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

2nd Quarter Health Plan	Jan 2018	Feb 2018	Mar 2018
Aloha Care	387	359	425
HMSA	728	734	703
Kaiser	170	184	185
Ohana	3217	3189	3212
United Healthcare	2061	2061	2195
Total	**6563**	**6527**	**6720**

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

3rd Quarter Health Plan	Apr 2018	May 2018	Jun 2018
Aloha Care	382	356	462
HMSA	755	738	808
Kaiser	198	210	208
Ohana	3266	3200	3226
United Healthcare	2029	1791	2005
Total	**6630**	**6295**	**6709**

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

4th Quarter Health Plan	Jul 2018	Aug 2018	Sep 2018
Aloha Care	444	423	502
HMSA	832	833	840
Kaiser	209	215	211
Ohana	3211	3149	3143
United Healthcare	1506	1497	2099
Total	**6202**	**6117**	**6795**

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

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

(Annual Summary)

Member Choice of Health Plan Exercised

Number of Members	Oct 2017 – Dec 2017	Jan 2018 – Mar 2018	Apr 2018 – Jun 2018	Jul 2018 – Sep 2018	Total
Individuals who chose a health plan when they became eligible	344	326	302	382	1354
Individuals who changed their health plan after being auto-assigned	2935	2172	2098	2252	9457
Individuals who changed their health plan outside of allowable choice period (i.e., plan to plan change)	110	172	133	175	590
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	12	13	6	13	44

During this reporting period, 1149 individuals chose their health plan when they became eligible, and 23,259 changed their health plan after being auto-assigned. Also, 37,431 individuals had an initial enrollment which fell within this reporting period.

In addition, 115 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

IX. Member Complaints, Grievances, and Appeals, Filed during the Year, by Type

(Annual Summary - Types shall include access to urgent, routine, and specialty care.)

A. Complaints/Grievances

During the FFY 2018, MQD received and addressed the following number of member complaints.

Month	# of Member Complaints/Grievances
October 2017	13
November 2017	8
December 2017	10
January 2018	10
February 2018	13
March 2018	6
April 2018	7
May 2018	11
June 2018	7
July 2018	4
August 2018	8
September 2018	3
Total	**100**

B. Appeals

There were a total of 35 appeals submitted for FFY 2018. Of those submitted, 23 were resolved in member's favor. There were 10 resolutions in DHS favor. One (1) resolution was in member's favor, and one (1) was dismissed as untimely.

Member Appeals													
	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018	Jul 2018	Aug 2018	Sep 2018	**TOTAL**
Submitted	6	5	1	3	0	4	3	3	3	3	1	3	35
DHS resolved with health plan or DOH – Developmental Disabilities Division (DOH-DDD) in member's favor prior to going to hearing	4	5	0	2	0	1	2	2	2	3	0	2	23
Dismiss as untimely filing	0	0	0	0	0	0	1	0	0	0	0	0	1
Member withdrew hearing request	0	0	0	0	0	0	0	0	0	0	0	0	0
Resolution in DHS favor	2	0	1	1	0	2	0	1	1	0	1	1	10
Resolution in Member's favor	0	0	0	0	0	1	0	0	0	0	0	0	1
Still awaiting resolution	0	0	0	0	0	0	0	0	0	0	0	0	0

Types of Member Appeals													
	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018	Jul 2018	Aug 2018	Sept 2018	**TOTAL**
Medical	1	1	0	0	0	2	1	0	0	0	0	0	5
LTSS	2	3	1	1	0	1	1	1	2	1	0	3	16
Van Modification	0	0	0	0	0	0	0	1	0	0	0	0	1
ABA	0	0	0	0	0	0	0	0	1	0	0	0	1
DME	0	1	0	2	0	0	1	0	0	2	0	0	6
Reimbursement	1	0	0	0	0	0	0	0	0	0	1	0	2
Out of Network Service	2	0	0	0	0	0	0	1	0	0	0	0	3
Medication	0	0	0	0	0	1	0	0	0	0	0	0	1

X. Evaluation Activities and Interim Findings

(Annual Summary)

A. Evaluation Activities

(Annual Summary - of the progress of evaluation activities, including key milestones accomplished, plus challenges encountered and how they were addressed.)

QUEST Integration (QI) RFP

During the reporting period, MQD continued to work with CMS on the QI RFP Supplemental Changes #9 regarding 2018 rates and scope. Progress was also made on the behavioral health parity report sent to CMS. Final approval from CMS was received on December 17, 2018.

Provider Management System Upgrade (PMSU)

In partnership with Arizona Health Care Cost Containment System (AHCCCS), MQD has moved forward with upgrading existing provider management software. A PMSU vendor was selected in the prior quarter, and we are currently waiting for CMS approval of this vendor contract. The Internal Verification & Validation (IVV) vendor was selected in this year, to monitor the PMSU project.

Electronic Visit Verification (EVV)

In accordance with the 21st Century Cures Act, Med-QUEST Division (MQD) is working towards the implementation of Electronic Visit Verification (EVV). In the federal fiscal year (FFY) 2018, plans for EVV were developed and work was accomplished towards system model design and preparation work to procure a statewide EVV vendor.

FFY2018 started with EVV information gathering, including research about EVV vendors and other State EVV implementations, as well as conducting statewide information forums throughout Hawai'i. It was also determined early on that MQD would collaborate with Arizona Health Care Cost Containment System (AHCCCS) for an EVV solution. Work in the middle of the FFY was primarily in shaping the state plan, working on required documentation for CMS (including preparations for procuring an Independent Verification and Validation (IV&V) vendor) and preparing for procurement for an EVV vendor. FFY 2018 ended with procurement for a statewide EVV vendor well underway. Throughout FFY2018, MQD communicated progress to stakeholders via several modes of communication including email, face-to-face meetings, and EVV webpage updates.

MQD's future work will include selecting and awarding a statewide EVV vendor, working with the IV&V vendor, hiring a dedicated MQD EVV Project Manager, and working with the EVV vendor towards an implementation date in the winter of 2019.

Q1

Conducted EVV research, including implementation in other states and follow ups from the Home and Community Based Conference in September 2017. Started drafting an EVV implementation plan. Began monthly discussions with Arizona Health Care Cost Containment System (AHCCCS) to explore possible collaboration for implementation. The relationship with AHCCCS for the EVV project was formalized.

Q2

Created a dedicated EVV webpage within the Med-QUEST website in January (https://medquest.hawaii.gov/en/plans-providers/electronic-visit-verification.html). Created a dedicated EVV mailbox and email address (EVV-MQD@dhs.hawaii.gov) in April in response to numerous email inquiries and to more effectively communicate and track communication with stakeholders. In February and March, conducted fourteen statewide in-person forums with video conferencing to inform stakeholders about EVV and to solicit feedback. In February, a provider survey was distributed to obtain information about current EVV practices in addition to stakeholder implementation feedback. The open vendor model was selected.

Q3

Worked with AHCCCS to create the request for proposal for an EVV vendor. Worked with AHCCCS to submit additional documentation to CMS such as the project partnership understanding and the planning advanced planning document. Worked with AHCCCS towards the release of a request for proposal for an IV&V provider in order to meet the Medicaid Enterprise Certification Lifecycle requirement for successful implementation and certification of the EVV solution. Working in parallel tracks, MQD met with QUEST Integration Managed Care Organizations and the Department of Health Developmental Disabilities Division to plan possible interim solutions to meet the January 1, 2019 implementation deadline while also preparing a letter for CMS requesting an exemption from the Federal medical assistance percentage reduction if the deadline was not met because of good faith efforts.

Q4

System model design and project timelines were developed with AHCCCS and distributed to stakeholders via email, face-to-face and an update to the EVV webpage. A request for procurement for an EVV vendor was released in September.

B. Interim Findings

During the reporting period, no interim findings were identified for any initiatives or corrective action plans.

XI. Quality Assurance and Monitoring Activity

(Annual Summary - Identify any quality assurance/monitoring activity in the year.)

Quality Activities During 2018

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

1. Validation of Performance Improvement Projects (PIPS)
   Per Hawaii's Quality Strategy, each health plan was required by the MQD to conduct PIPs in accordance with 42 CFR 438.240. The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. For such projects to achieve meaningful and sustained improvements in care, and for interested parties to have

confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

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

The primary objective of the PIP validation was to determine the health plans' achievement of PIP module criteria, including:
• Integration of quality improvement science.
• Formation of teams.
• Setting aims.
• Establishing measures.

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

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

2. For one QI health plan-
    - Medication Management for People with Asthma (ages 5-64) and
    - Getting Needed Care

3. For CCS-

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

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

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

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

The goal of HSAG's PIP validation is to ensure that the health plan and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP.

HSAG obtained the data needed to conduct the PIP validations from the health plans' PIP module submission forms. These forms provided detailed information about each health plan's PIPs related to the criteria completed, and HSAG evaluated for the 2017 validation cycle.

HSAG, along with some of its contracted states, has identified that, while MCOs have designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few MCOs have achieved real and sustained improvement. In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement.

To illustrate how the rapid-cycle PIP framework continued to meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. HSAG presented the crosswalk and new PIP framework components to CMS, and CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within healthcare settings, a new approach was reasonable, approving HSAG's rapid-cycle PIP framework for validation of PIPs for the State of Hawaii.
The key concepts of the PIP framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. The core component of the approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the health plan with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings.
Each module consists of validation criteria necessary for successful completion of a valid PIP. Each evaluation element is scored as either Achieved or Not Achieved. Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as high confidence, confidence or low confidence.

HSAG continued to provide guidance, training, and oversight of the PIPs during the current validation cycle. HSAG has been involved from the onset of the PIPs to determine their methodological soundness and to ensure the health plans have the knowledge and guidance needed to be successful, not only in documentation of their approach but also in the application of the rapid-cycle quality improvement methods that are central to achieving improved outcomes. HSAG provided written feedback to the health plans after each module was completed and submitted for review. HSAG also offered technical assistance phone conferences to each health plan to provide further clarification on the recommendations for each module. HSAG's rapid-cycle PIP validation process facilitated frequent technical assistance for the health plans throughout the process, as requested.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

Validation of performance measures (PMs). HSAG validated the HEDIS and non-HEDIS state-defined measure rates required by the MQD to evaluate the accuracy of the results. HSAG assessed the PM results and their impact on improving the health outcomes of members. HSAG conducted validation of the PM rates following the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) 1-3 Compliance Audit™ 1-4 timeline, typically from January 2017 through July 2017. The final PM validation results generally reflect the measurement period of January 1, 2016, through December 31, 2016. HSAG provided final audit reports to the health plans and the MQD in July 2017.

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the *2016 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5.* The audit procedures were also consistent with the CMS protocol for performance measure validation: *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.1-7 The health plans that contracted with the MQD during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health. The measurement period was CY 2016 (January 1, 2016, through December 31, 2016), and the audit activities were conducted concurrently with HEDIS 2017 reporting.

During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 33 measures, yielding a total of 96 measure indicators, for the QI population. 'Ohana CCS was required to report on 10 measures, yielding a total of 27 measure indicators, for the CCS program. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services. These domains included:

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

HSAG evaluated each QI health plan's compliance with NCQA information system (IS) standards during the 2017 NCQA HEDIS Compliance Audit. All QI health plans were *Fully Compliant* with the IS standards applicable to the measures under the scope of the audit except for AlohaCare QI (IS 5.0 = *Partially Compliant*). Overall, the health plans followed the NCQA HEDIS 2016 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of *Reportable* except for two measures reported by UHC CP QI, which received a *Biased Rate* designation for the *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence* measures.

3. Compliance Monitoring

The Balanced Budget Act of 1997 (BBA), as set forth in 42 CFR §438.358, requires that the state or its designee conduct a review within the previous three-year period to determine the MCO's, PIHP's, PAHP's, or PCCM

entity's compliance with the standards established by the state for access to care, structure and operations, and quality measurement and improvement. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)
   The primary objective of the Child Medicaid CAHPS survey was to effectively and efficiently obtain information on the levels of satisfaction of the Hawaii Medicaid child members with their health plan and healthcare experiences. Results were provided at both plan-specific and statewide aggregate levels.
   The primary objective of the CHIP CAHPS survey was to obtain satisfaction information from the Hawaii CHIP population to provide to the MQD and to meet the State's obligation for CHIP CAHPS measure reporting to CMS. Results were provided to the MQD in a statewide aggregate report.

   Data collection for the Child CAHPS survey and the CHIP CAHPS survey was accomplished through administration of the CAHPS 5.0H Child Medicaid Health Plan Survey instrument (without the Children with Chronic Conditions [CCC] measurement set) to child Medicaid and CHIP members of the QI health plans. Child members included as eligible for the survey were 17 years of age or younger as of December 31, 2016. All parents or caretakers of sampled child Medicaid and CHIP members completed the surveys from February to May 2015 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese. The CAHPS 5.0H Health Plan Survey process allows for two methods by which members can complete a survey: mail and telephone. During the mail phase, the cover letters provided with the English version of the CAHPS survey questionnaire included additional text in Chinese, Ilocano, Korean, and Vietnamese informing parents/caretakers of sampled members that they could call a toll-free number to request to complete the survey in one of these designated alternate languages. The toll-free line for alternate survey language requests directed callers to select their preferred language for completing the survey (i.e., Chinese, Ilocano, Korean, or Vietnamese) and leave a voice message for an interpreter service that would return their call and subsequently schedule an appointment to complete the survey via computer-assisted telephone interviewing (CATI). A reminder postcard was sent to all non-respondents, followed by a second survey mailing and reminder postcard. The second phase, or telephone phase, consisted of CATI of sampled members who had not mailed in a completed survey or requested the option to complete the survey in an alternate language (i.e., Chinese, Ilocano, Korean, or Vietnamese). It is important to note that the CAHPS 5.0H Child Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. Therefore, prior to the start of the CAHPS survey process and in following NCQA HEDIS specifications, a request for a survey protocol enhancement was submitted to NCQA to allow QI health plan members the option to complete the CAHPS survey in the designated alternate languages (i.e., Chinese, Ilocano, Korean, and Vietnamese).

   The Child CAHPS survey included a set of standardized items (48 questions) that assessed parents'/caretakers' perspectives on their child's care. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed to select the child members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. An analysis of the CAHPS 5.0H Child Medicaid Health Plan Survey results was conducted using NCQA HEDIS Specifications for Survey Measures A-3.NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS survey result; however, for this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

The survey questions were categorized into 11 measures of satisfaction. These measures included four global rating questions, five composite measures, and two individual item measures. The global measures (also referred to as global ratings) reflect overall satisfaction with the health plan, healthcare, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* or *Getting Care Quickly*). The individual item measures are individual questions that consider a specific area of care (i.e., *Coordination of Care* and *Health Promotion and Education*).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction rating (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate. In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (i.e., 1, 2, or 3) divided by the total number of responses to the global rating question.
For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite measure questions' response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always"; or (2) "No" and "Yes." A positive or top-box response for the composite measures was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures.
In addition to the global proportions, a three-point mean was calculated for four of the composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*).A-4 Scoring was based on a three-point scale. Responses of "Usually/Always" were given a score of 3, responses of "Sometimes" were given a score of 2, and all other responses were given a score of 1. The three-point mean was the average of the mean score for each question included in the composite.
For the individual item measures, the percentage of respondents who chose a positive response was calculated. Response choices for CAHPS individual items fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always"; or (2) "No" and "Yes." A positive or top-box response for the individual items was defined as a response of "Usually/Always" for *Coordination of Care* and "Yes" for *Health Promotion and Education*. The percentage of top-box responses is referred to as a question summary rate for the individual item measures.

For each CAHPS measure, the resulting three-point mean scores were compared to published NCQA Benchmarks and Thresholds to derive the overall member satisfaction rating (i.e., star rating), except for the *Shared Decision Making* composite measure and the *Health Promotion and Education* individual item.A-5 NCQA does not publish benchmarks and thresholds for these CAHPS measures; therefore, star ratings could not be derived. Based on this comparison, ratings of one to five stars were
Determined for each CAHPS measure, with one being the lowest possible rating and five being the highest possible rating.

For purposes of the Statewide Comparisons analysis, HSAG calculated question summary rates for each global rating and individual item measure, and global proportions for each composite measure. Both the question summary rates and global proportions were calculated in accordance with NCQA HEDIS Specifications for Survey Measures.A-6 Additionally, HSAG performed a trend analysis of the child and CHIP results. For the 2017 Child CAHPS scores, scores were compared to their corresponding 2015 CAHPS scores to determine whether there were statistically significant differences, while CHIP 2017 CAHPS scores were compared to their corresponding 2016 CAHPS scores. A test was performed to determine whether results in 2017 were statistically significantly different from results in 2015. In addition to the trend analysis, results were compared to NCQA national averages. These comparisons were performed for the four global ratings, five composite measures, and two individual item measures.

5. Provider Survey
   In 2016 the EQRO administered the provider survey, which is done biennial.
   The provider survey revealed opportunities to improve provider satisfaction. Based on these results, the EQRO provided general quality improvement recommendations that plans should consider to increase or maintain a high level of provider satisfaction.

   - Providers consistently expressed concerns in getting adequate specialty care due to the lack of specialists. The process to refer patients to specialists was noted as especially difficult. The shortage of specialists on the island requires patients to travel to get care, but limitations related to availability and travel arrangements prevent many patients from being seen in a timely manner. Providers are becoming overwhelmed by the growing demand, while many members are being left with nowhere to go. HSAG recommends the QI health plans work with the MQD on a solution to this issue, such as provider recruitment and retention, and focus on the patient-centered medical home (PCMH) model of care.
   - Some providers indicated that the prior authorization process has a negative impact on their ability to provide quality care. QI health plans could work toward programming medical services and drugs that require prior authorization into their systems and workflows to automate the process (e.g., expand availability and interoperability of health information technology). The QI health plans can work with the MQD to support the simplification and standardization of the preauthorization forms and process.
   - Providers' feedback indicated that opportunities still exist to ensure that QI health plans have adequate access to non-formulary drugs. QI health plans typically choose which drugs to include in the formulary. The QI health plans should consider working with the MQD to establish standard policies and procedures to ensure adequate access to non-formulary drugs.
   - Periodic provider focus groups could be implemented to gain further valuable information and insight into areas of poor performance as described in the survey feedback. Hearing about specific scenarios and examples of provider issues may help the QI health plans in understanding and targeting areas needing performance improvement. QI health plans could then use a performance improvement project approach to determine interventions and perform a targeted remeasurement of provider satisfaction at a later date.

6. Annual Technical Report
   The EQRO produces the Hawaii External Quality Review Report of Results for the QI Health Plans and the Community Care Services program to comply with the CFR at 42 CFR 438.364. The report describes how data from activities conducted in accordance with 42 CFR 438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of and access to, care furnished to Medicaid recipients by the five QI health plans and the CCS program.

   Purpose of the Report
   The Code of Federal Regulations requires that states use an EQRO to prepare an annual technical report that describes how data from activities conducted, in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that managed care organizations provide.
   To comply with these requirements, the MQD contracted with HSAG to aggregate and analyze the health plans' performance data across mandatory and optional activities and prepare an annual technical report. HSAG used the Centers for Medicare & Medicaid Services' (CMS') November 9, 2012, update of its External Quality Review Toolkit for States when preparing this report.1-2
   This report provides:

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

Scope of EQR Activities

This report includes HSAG's analysis of the following EQR activities.

- *Review of compliance with federal and state-specified operational standards. HSAG evaluated the health plans' compliance with State and federal requirements for organizational and structural performance. The MQD contracts with the EQRO to conduct a review of one-half of the full set of standards in Year 1 and Year 2 to complete the cycle within a three-year period. HSAG conducted on-site compliance reviews in May and June 2017. The health plans submitted documentation that covered a review period of April 1, 2016, through March 31, 2017. HSAG provided detailed, final audit reports to the health plans and the MQD in September 2017.*
- *Validation of performance improvement projects (PIPs)*. HSAG validated PIPs for each health plan to ensure the health plans designed, conducted, and reported projects in a methodologically sound manner consistent with the CMS protocol for validating PIPs. Each health plan submitted two state-mandated PIPs for validation. All PIPs were based on the rapid-cycle PIP framework, which includes five modules that were submitted by the health plans for each PIP, reviewed by HSAG, and used to provide feedback from HSAG to the health plans throughout the 12-month PIP cycle. HSAG assessed all PIPs for real improvements in care and services to validate the reported improvements. In addition, HSAG assessed the health plans' PIP outcomes and impacts on improving care and services provided to members. The CMOs submitted Modules 4 and 5 for each PIP at varying times throughout calendar year (CY) 2017. HSAG provided final, CMO-specific PIP reports to the health plans and the MQD in September 2017. A new round of rapid-cycle PIPs began in 2017 focused on completion of Module 1 through Module 3; however, these results will not be ready until CY 2018.
- *Validation of performance measures (PMs). HSAG validated the HEDIS and non-HEDIS state-defined measure rates required by the MQD to evaluate the accuracy of the results. HSAG assessed the PM results and their impact on improving the health outcomes of members. HSAG conducted validation of the PM rates following the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) 1-3 Compliance Audit™ 1-4 timeline, typically from January 2017 through July 2017. The final PM validation results generally reflect the measurement period of January 1, 2016, through December 31, 2016. HSAG provided final audit reports to the health plans and the MQD in July 2017.*
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys.1-5. The MQD conducted the CAHPS surveys of the QI child and Children's Health Insurance Program (CHIP) populations to learn more about member satisfaction and experiences with care. The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with chronic conditions [CCC] measurement set). The parents and caretakers of child members enrolled in the QI and CHIP program completed the surveys from February to May 2017. HSAG aggregated and produced a final report in September 2017.*

Overall Summary of Health Plan Performance

Compliance Monitoring Review

CY 2017 began the second year of a three-year cycle of compliance reviews for all the QI health plans and the CCS program that included two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs, using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the CFR for six areas of review, or standards.1-6 A pre-on-site desk review, on-site review with interview sessions, system and process demonstrations, and record reviews were conducted.

The second compliance review activity in 2017 involved HSAG's and the MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to its 2016 compliance review, which were all addressed by the end of 2016 or early 2017.

Findings, Conclusions, and Recommendations

Table 1-1 summarizes the results from the 2017 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

7. Technical Assistance

   At the State's direction, the EQRO provided technical guidance to groups to the State and the QI health plans and CCS as described at 42 CFR 438.358(d).

   The following are technical assistance by the EQRO:

- In January, the EQRO notified MQD that development of Successful Transitions measure not possible due to insufficient time and data; recommended alternative measures. MQD selected CMS' *Emergency Department Use without Hospitalization During the First 60 Days of Home Health* measure as a replacement measure.
- In February, HSAG submitted final *Emergency Department Use without Hospitalization During the First 60 Days of Home Health* (EDUH) measure specifications for review and approval on 02/21/18. They also addressed questions from the health plans regarding state-specific measures.
- In the next month, they drafted updates to the *Emergency Department Use without Hospitalization During the First 60 Days of Home Health* (EDUH) measure specifications in collaboration with the MQD and submitted updated documentation to health plans on 03/19/18 and 03/29/18. Also, they conducted a technical assistance call with health plans regarding EDUH measure on 03/28/18, and continued addressing questions from the health plans regarding state-specific measures.
- Upon MQD's request, HSAG also validated the 2017 P4P results and submitted findings on 03/21/18.
- The EQRO also assisted MQD to address the *Seek More Information (SMI)* questions regarding the MQD's Adult and Child core quality measure MACPro submission. Submitted responses to the MQD on 03/25/18. Updated responses submitted on 03/29/18.
- In April, HSAG continued technical assistance calls and email updates with the health plans regarding EDUH measure. Received request from the MQD to discuss sampling recommendations for conducting audit of CCS care management oversight on 04/10/18. Met with the MQD on 04/18/18. Received request from the MQD to assist in presenting CMS State Health Plan Performance scorecard data; submitted preliminary and final charts on 04/27/18.

- May through June, the EQRO continued technical assistance calls and email updates with the health plans regarding EDUH measure. Received request to calculate remaining funds in Technical Assistance funding; submitted response to the MQD and confirmed dollars could be used to support Provider Survey enhancements. And, continued technical assistance calls and email updates with the health plans regarding EDUH measure.
- In July, HSAG met with the MQD on 7/31/18 to discuss structure of the 2018 technical report. Technical report to mirror layout of the 2017 report. Continued technical assistance calls and email updates with the health plans regarding EDUH measure.
- Closing out the year, in August and September, HSAG continued technical assistance calls and email updates with the health plans regarding the EDUH measure.

XII. Quality Strategy Impacting the Demonstration

(Annual Summary - A report on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the Demonstration.)

MQD is currently working on updating its comprehensive Quality Strategy.

XIII. Demonstration Evaluation

(Annual Summary - Discuss the progress of evaluation design and planning.)

After an extensive, collaborative approach between CMS and MQD between 2014 and 2018, CMS approved the evaluation design on February 23, 2018. MQD completed a draft interim evaluation on June 29, 2018 and shared it with CMS for comments. CMS returned comments in July 2018. MQD adopted those comments and finalized the interim evaluation in late July 2018. The final interim evaluation was submitted to CMS alongside our Section 1115 renewal on July, 27 2018.

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

(Administrative costs reported separately.)

Please see *Attachment D: Schedule C, Quarter Ending September 30, 2018*.

XV. Expenditures for Uncompensated Care Costs

Please see *Attachment D: Schedule C, Quarter Ending September 30, 2018*.

XVI. Managed Care Delivery System

A. Accomplishments

During this report period, State procured and awarded the Medicaid Ombudsman and Community Care Services contracts.

Hawaii also received approval for the 1115 Waiver to include Community Integrated Services.

Additionally during this period, the 1915(c) I/DD Waiver amendment was approved with a June 1, 2018 effective date. Significant updates to the waiver included the following: phase out skilled nursing service; add private duty nursing service; implementation of supports budget to enable participants' choice and flexibility in services; expands the eligibility group to include blind or disabled under the Section 1634(c) of the Act; and revisions and refinement in service specifications and rates for existing services.

B. Status of Projects

During this report period, State completed the following projects:

1. Electronic PASRR portal
2. Hawaii Medicaid website
3. National Take Back Initiative to receive unused or expired medications.
4. My Choice My Way outreach and training
5. Hurricane and volcano eruption disaster planning and management
6. QI RFP supplemental changes to comply with 42 CFR 438 MCO Final Rules

On-going projects:

1. Electronic Visit Verification (EVV)
2. Medicaid Provider Management System Upgrade (PMSU)
3. Five-year 1115 Demonstration Waiver extension
4. Additional My Choice My Way outreach and training
5. Collaborating with DOH and revising the Hawaii Administrative Rules for HCBS settings to comply with the HCBS Final Rules
6. Medicaid provider revalidation
7. Medicaid Information Technology Architecture (MITA) update

C. Findings of Quantitative Studies

See section D below.

D. Findings of Case Studies

MQD performed an audit on the 5 MCOs to see how services were being provided to the Medicaid LTSS population. MQD pulled random member files and reviewed them for quality of service, member-driven service planning, thoroughness, and contract compliance. In general, MQD found that the health plans had some deficits regarding service plans, timeliness of assessments, lack of documentation, lack of person-centeredness, etc.

MQD followed-up with the findings of the above audit, by having the MCOs conduct their own internal audit with the same LTSS population utilizing MQD's audit tool and evaluate their findings. This report had to be submitted to MQD in one month. The purpose of this internal audit was to evaluate trending in the same deficit areas.

Also, the MCOs are to change policies and re-train staff in documentation and service planning and provide MQD with the results of the training with staff. Periodic auditing will continue to measure improvements in the deficit areas.

E. Findings of Interim Evaluations

As noted in Section XIII, MQD submitted its final interim evaluation to CMS alongside the Section 1115 renewal on July, 27 2018. A copy of that interim evaluation can be found at: https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/ATT_B_-_Interim_Eval_Report.pdf.

In the evaluation, MQD found that the QI program achieved success on the goals outlined in the STCs, but there may be room for improvement in some areas. The QI program demonstrated success in meeting the following demonstration goals:

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

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

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

The evaluation showed mixed results as it pertains the following demonstration goals:

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

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

For Child Core Set measures, the QI program experienced variation across the domains. The program notably experienced strong performance on the Follow-Up Care for Children Prescribed ADHD Medication measure. QI performance in the measures in the P4P Program similarly showed mixed results. While the state aggregate score

improved on 7 out of 9 measures, the State only met the target for 2 out of 9 measures from CY2014 through CY2016.

Finally, there were mixed results for the following demonstration goals:

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

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

The QI program will continue to monitor performance on the measures found in the evaluation and in other quality monitoring activities and use them to inform policy and operations.

F. Utilization Data

Calendar Year (CY) 2017 incurred cost model data produced by our actuaries for our QI program is included as Attachment I. This data is aggregated for all of our MCOs (excluding Kaiser), and has claims run out through February 2019. It is broken out by non-expansion, expansion, and ABD population groups.

G. Progress on Implementing Cost Containment Initiatives

Hepatitis C Approved Drug Treatment

MQD expanded coverage to include members with Level 0 Hepatitis score. In the calendar year 2017, MQD implemented a Hep-C cost corridor to limit the financial exposure for the state.

Orphan Drugs

In the calendar year 2018, MQD expanded the Hep-C cost corridor to include all high-cost orphan drugs. This was done to proactively include any new orphan drugs unknown when the 2018 rates were being calculated.

Discharge Planning for Difficult-to-Place Members

MQD has been working with Queen's Hospital on placement of difficult to discharge members. Such members often have substance abuse issues, behavioral health issues, non-compliance issues, morbid obesity, and homelessness.

One Key Question

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

Long Acting Reversible Contraceptives (LARC)

Associated with One Key Question, LARC's goal is to prevent unwanted pregnancies. MQD set policy that required MCOs to pay for the LARC as an additional billable charge in the hospital setting, to promote pre-discharge LARC

insertion post-delivery. Additionally, MQD also removed prior authorization for utilization controls in the inpatient setting.

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

At this time, MQD has no update.

I. CAHPS Survey

Summary of Statewide Comparisons Results

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

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

Summary of Plan Comparisons Results

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

- AlohaCare QI did not score statistically significantly lower or higher than the QI Program aggregate on any of the measures.

- HMSA QI scored statistically significantly lower than the QI Program aggregate on one measure, Rating of Health Plan.
- Kaiser QI scored statistically significantly higher than the QI Program aggregate on one measure, Rating of Health Plan.
- 'Ohana QI scored statistically significantly lower than the QI Program aggregate on one measure, Rating of Health Plan.
- UHC CP QI did not score statistically significantly lower or higher than the QI Program aggregate on any of the measures.

Summary of Trend Analysis Results

The trend analysis revealed the following summary results:

- The 2018 QI Program aggregate scores were statistically significantly higher than the 2016 scores on three measures: Rating of Health Plan, How Well Doctors Communicate, and Customer Service.
- AlohaCare QI's 2018 scores were statistically significantly higher than the 2016 scores on two measures: How Well Doctors Communicate and Customer Service.
- HMSA QI: For Customer Service, the 2018 score was statistically significantly higher than the 2016 score.
- Kaiser QI: This health plan's results were not statistically significantly higher or lower than the 2016 score on any measure.
- 'Ohana QI's 2018 score was not statistically significantly higher or lower than the 2016 score on any measure.
- UHCCP QI's 2018 score was statistically significantly higher than the 2016 score on one measure, Getting Care Quickly.

The QI Program scored at or above the 2017 NCQA adult Medicaid national averages on 10 measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, How Well Doctors Communicate, Customer Service, Shared Decision Making, Coordination of Care, and Health Promotion and Education. Additionally, the 2018 QI Program aggregate scores were statistically significantly higher than the 2016 scores on three measures: Rating of Health Plan, How Well Doctors Communicate, and Customer Service. The QI Program scored at or above the 90th percentile (i.e., five stars) compared to the 2018 NCQA HEDIS Benchmarks and Thresholds for Accreditation for the Rating of Personal Doctor, Rating of Specialist Seen Most Often, and How Well Doctors Communicate measures. Furthermore, the star ratings for the QI Program increased from 2016 to 2018 for four of the nine measures: Rating of Health Plan, Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Customer Service. Overall, members report being satisfied with their health plan and their doctors, as well as the customer service they are receiving from their health plan.

Conversely, the QI Program scored below the 2017 NCQA adult Medicaid national average on one measure, Getting Care Quickly. Also, the QI Program scored at or between the 25th and 49th percentiles (i.e., two stars) compared to the 2018 NCQA HEDIS Benchmarks and Thresholds for Accreditation for the Getting Needed Care, Getting Care Quickly, and Coordination of Care measures. Furthermore, the QI Program scored at or between the 25th and 49th percentiles in 2016 for the Getting Needed Care and Getting Care Quickly measures, showing that these measures are not only high priority assignments for the QI Program in 2018 but have not significantly improved over time compared to national benchmarks. These findings indicate opportunities for improvement in member satisfaction related to access to care and timeliness of care, which aligns with the results from the key drivers of satisfaction analysis.

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

- Respondents reported that it was often not easy for them to obtain appointments with specialists.
- Respondents reported that when they did not need care right away, they did not obtain an appointment for health care as soon as they thought they needed.

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

- Respondents reported that their personal doctor did not always spend enough time with them.

J. Outcomes of any Focused Studies Conducted

(Including what the State intends to do with the results.)

No focus studies were done during this reporting period.

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

There were a few internal civil rights investigations conducted, but all the findings were negative.

L. Annual Summary of Network Adequacy by Plan

(Including the following:

- *Assessment of the provider network pre- and post-implementation;*
- *MCO compliance with provider 24/7 availability; and*
- *Information on, and assessment of, the operation of the managed care program in regard to availability and accessibility of covered services within the MCO, PIHP, or PAHP contracts, including network adequacy standards.)*

MQD continues to review the Network Adequacy reports from all the health plans and communicate with the health plans that have issues on meeting the provider ratios. Due to the shortage of the providers, especially the emergency department, MQD asks the MCOs to educate their members to use Urgent Care or After-hour Care before going to the hospitals.

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

M. Summary of Outcomes of On-Site Reviews

EQRO

Findings for the 2017 compliance review were determined from its:

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

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

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

The following tables present a summary of the performance results.

Standards and Compliance Scores- AlohaCare QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	8	1	0	0	94%
III	Credentialing	45	34	30	4	0	11	94%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**68**	**63**	**5**	**0**	**11**	**96%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- HMSA QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	9	0	0	0	100%
III	Credentialing	45	40	36	4	0	5	95%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**74**	**70**	**4**	**0**	**5**	**97%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- Kaiser Foundation QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	3	4	2	0	56%
III	Credentialing	45	34	27	6	1	11	88%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**68**	**55**	**10**	**3**	**11**	**88%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- ‘Ohana QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	9	0	0	0	100%
III	Credentialing	45	41	35	6	0	4	93%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**75**	**69**	**6**	**0**	**4**	**96%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- UHC QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	9	0	0	0	100%
III	Credentialing	45	41	34	7	0	4	91%
IV	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**79**	**75**	**68**	**7**	**0**	**4**	**95%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standards and Compliance Scores- CCS

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	8	8	8	0	0	0	100%
II	Subcontracts and Delegation	9	9	9	0	0	0	100%
III	Credentialing	44	40	35	5	0	4	94%
IV	Quality Assessment and Performance Improvement	8	8	7	1	0	0	94%
V	Health Information Systems	7	7	7	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
	Totals	**80**	**76**	**70**	**6**	**0**	**4**	**96%**

Total # of Elements: The total number of elements in each standard.

Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a score of *NA*.

Total Compliance Score: The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

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

Financial

The Hawaii Medicaid Fraud Control Unit (MFCU), is currently conducting an audit on HMSA billing practices around palliative care and hospice services. The audit is in its final stages.

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

CCS On-Site Audit by MQD Nurses

In 2018, record reviews were conducted to assist appropriate level of care to receive CCS services. Service plans were reviewed to evaluate success of interventions and appropriate movement between levels of acuity.

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

As part of the State's quality strategy, each health plan is required by the MQD to conduct performance improvement projects (PIPs) in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the Balanced Budget Act of 1997 (BBA), HSAG, as the State's EQRO, validated the PIPs through an independent review process. The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. For such projects to achieve meaningful and sustained improvements in care, and for interested parties to have confidence in the reported improvements, PIPs must be designed,

conducted, and reported in a methodologically sound manner. To ensure methodological soundness while meeting all state and federal requirements, HSAG follows guidelines established in the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.1-1
HSAG's validation of rapid-cycle PIPs includes the following two key components of the quality improvement process:

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

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

The goal of HSAG's PIP validation is to ensure that the health plan and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP.

Rapid-Cycle PIP Methodology

HSAG, along with some of its contracted states, identified that, while managed care organizations (MCOs) have designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few MCOs have achieved real and sustained improvement. In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to health care quality activities by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of health care by way of continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement.
To illustrate how the rapid-cycle PIP framework continued to meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012.* HSAG presented the crosswalk and new PIP framework components to CMS and CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within health care settings, a new approach was reasonable, approving HSAG's rapid-cycle PIP framework for validation of PIPs for the State of Hawaii.
The key concepts of the PIP framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. The core component of the approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.
For this PIP framework, HSAG developed five modules with an accompanying companion guide:

- Module 1—PIP Initiation: Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data; building a PIP team; setting aims (Global and SMART [specific, measureable, attainable, relevant, and time-bound]); and completing a key driver diagram.

- Module 2—SMART Aim Data Collection: In Module 2, the SMART Aim measure is outlined, and the data collection methodology is described. The data for the SMART Aim will be displayed using a run chart.

- Module 3—Intervention Determination: In Module 3, the quality improvement activities that can impact the SMART Aim are identified. Using process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, interventions are selected to test in Module 4.

- Module 4—Plan-Do-Study-Act: The interventions selected in Module 3 are tested and evaluated through a series of thoughtful and incremental PDSA cycles.

- Module 5—PIP Conclusions: Module 5 summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

PIP Validation Overview

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the health plan with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings. Each module consists of validation criteria necessary for successful completion of a valid PIP. Each evaluation element is scored as either *Achieved* or *Not Achieved*. Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

- High confidence
- High confidence = the PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- Confidence
- Confidence = the PIP was methodologically sound, the SMART Aim goal was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention (s) tested were clearly linked to the demonstrated improvement.
- Low confidence
- Low confidence = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- **Reported PIP results were not credible** = the PIP methodology was not executed as approved.

Technical Assistance

HSAG's rapid-cycle PIP validation process facilitates frequent technical assistance for the health plans. HSAG is involved from the onset of the PIPs to determine their methodological soundness and to ensure the health plans have the knowledge and guidance needed to be successful, not only in documentation of their approach but also in the application of the rapid-cycle quality improvement methods that are central to achieving improved outcomes.

HSAG provides written feedback to the health plans after each module is submitted for review and offers technical assistance phone conferences to provide further clarification on the recommendations for each module. HSAG conducts webinar trainings prior to each module submission and periodic Module 4 progress check-ins while health plans are testing interventions, to inquire about progress made and any challenges that may have arisen that could necessitate technical assistance.

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

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

The following are summaries of this year's progress:

AlohaCare:

PIP Topic	SMART Aim Statement
Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services	By December 31, 2018, **AlohaCare** will increase the mean score by 5% using the third question of the member survey as it relates to the ease of access to ophthalmology services reported by members paneled to the five (5) CHCs.
Improving Timeliness of Prenatal Care and Postpartum Care	By December 31, 2018, **AlohaCare** aims to increase the timeliness of prenatal care from 73% to 87% and timeliness of postpartum care from 46% to 56% among women seen at Kalihi-Palama Health Center.

Table 2-2—Status of the *Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act (PDSA)	Initiated in March 2018
5. PIP Conclusions	Targeted for February 2019

Table 2-3—Status of the *Improving Timeliness of Prenatal Care and Postpartum Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. PDSA	Initiated in March 2018
5. PIP Conclusions	Targeted for February 2019

Conclusions

AlohaCare was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the ***Improving Members' Satisfaction for Remote Access to Care for Specialty Ophthalmology Services Diabetes Care*** and ***Improving Timeliness of Prenatal Care and Postpartum Care*** rapid-cycle PIPs. The health plan successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. **AlohaCare** provided an update on intervention testing (Module 4) in May 2018.

HMSA:

PIP Topic	SMART Aim Statement
Getting Needed Care	By December 31, 2018, for QUEST members under the age of 18 who had a specialty office visit of dermatology, ophthalmology, or psychiatry, increase the percentage of "yes" responses to the 2017 Specialist Satisfaction Survey question, "Did your child get an appointment to see Dr.<Name> as soon as you needed?" from 93% to 98%.
Improving Timeliness of Prenatal Care and Postpartum Care	By December 31, 2018, for members attributed to either Kokua Kalihi Valley, Waikiki Health Center, or Waimanalo Health Center, increase the overall percentage of deliveries that received a prenatal visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment, from 64.8% to 68.0%. By December 31, 2018, for members attributed to either Kokua Kalihi Valley, Waikiki Health Center, or Waimanalo Health Center, increase the overall percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery from 28.1% to 30.9%.

Table 2-2—Status of the *Getting Needed Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act (PDSA)	Initiated in February 2018
5. PIP Conclusions	Targeted for February 2019

Table 2-3—Status of the *Improving Timeliness of Prenatal Care and Postpartum Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. PDSA	Initiated in March 2018
5. PIP Conclusions	Targeted for February 2019

Conclusions

HMSA was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the ***Getting Needed Care*** and ***Improving Timeliness of Prenatal Care and Postpartum Care*** rapid-cycle PIPs. The health plan successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. **HMSA** provided updates on intervention testing (Module 4) in May 2018 and July 2018.

Kaiser:

PIP Topic	SMART Aim Statement
Getting Needed Care	By December 31, 2018, increase the percentage rate at which Adult QUEST Integration members are seen within 21 days of the initial request for an initial routine outpatient Behavioral Health evaluation, by internal providers on Oahu from 50% to 55%.
Medication Management for People With Asthma, Ages 5–64	By December 31, 2018, decrease the rate of QUEST Integration members, ages 5–64 years old with home clinic locations of Honolulu, Waipio, and Maui Lani, with an Asthma Medication Ratio [AMR] of less than 0.5 from 26.3% to 24.3%.

Table 2-2—Status of the *Getting Needed Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act (PDSA)	Initiated in February 2018
5. PIP Conclusions	Targeted for February 2019

Table 2-3—Status of the *Medication Management for People With Asthma, Ages 5–64* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. PDSA	Initiated in February 2018
5. PIP Conclusions	Targeted for February 2019

Conclusions

KFHP was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the ***Getting Needed Care*** and ***Medication Management for People With Asthma, Ages 5–64*** rapid-cycle PIPs. The health plan successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. **KFHP** provided an update on intervention testing (Module 4) in May 2018 and August 2018.

Ohana CCS:

PIP Topic	SMART Aim Statement
Improving Behavioral Health Assessment Completion Rates	By December 31, 2018, improve BHA compliance rates of newly enrolled CCS members assigned in four CBCM agencies (Community Empowerment Resources, Institute of Human Services, North Shore Mental Health, Aloha House, Mental Health Kokua on Oahu and Kauai) from 16% to 50%.
Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge	By December 31, 2018, increase mental health 7-day follow-up compliance rates of CCS members in four CBCM agencies (Community Empowerment Resources, Helping Hands Hawaii, North Shore Mental Health, and State of Hawaii Department of Health—Adult Mental Health Division) from 53% to 61%.

Table 2-2—Status of the *Improving Behavioral Health Assessment Completion Rates* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act (PDSA)	Initiated in February 2018
5. PIP Conclusions	Targeted for February 2019

Table 2-3—Status of the *Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. PDSA	Initiated in February 2018
5. PIP Conclusions	Targeted for February 2019

Conclusions

CCS was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the ***Improving Behavioral Health Assessment Completion Rates*** and ***Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge*** rapid-cycle PIPs. The health plan successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. **CCS** provided an update on intervention testing (Module 4) in June 2018.

Ohana:

PIP Topic	SMART Aim Statement
Getting Needed Care	By December 31, 2018, increase the rate of Getting Needed Care among members residing in Ewa Beach, Hilo, Honolulu, Waianae, and Waipahu from 75.8% to 84.2%.
Improving Timeliness of Prenatal Care and Postpartum Care	By December 31, 2018, **'Ohana** aims to increase the timeliness of prenatal care from 63% to 73% for pregnant members residing in Honolulu, Waianae, Waipahu, Ewa Beach, Kailua Kona, and Hilo. By December 31, 2018, **'Ohana** aims to increase timeliness of postpartum care from 37% to 47% for members who delivered and reside in Honolulu, Waianae, Waipahu, Kailua Kona, Hilo, and Ewa Beach.

Table 2-2—Status of the *Getting Needed Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act (PDSA)	Initiated in February 2018
5. PIP Conclusions	Targeted for February 2019

Table 2-3—Status of the *Improving Timeliness of Prenatal Care and Postpartum Care* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. PDSA	Initiated in February 2018
5. PIP Conclusions	Targeted for February 2019

Conclusions

'Ohana was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the ***Getting Needed Care*** and ***Improving Timeliness of Prenatal Care and Postpartum Care*** rapid-cycle PIPs. The health plan successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. **'Ohana** provided an update on intervention testing (Module 4) in June 2018.

UHC:

PIP Topic	SMART Aim Statement
Getting Needed Care: Improving Access to Behavioral Health Services	By December 31, 2018, increase the rate of ease of access to a mental health specialist appointment as soon as the member felt they [he or she] needed, from 57.46% to 61.46%.
Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County	By December 31, 2018, **UHC CP** aims to increase the timeliness of prenatal care hybrid rates from 76.6% to 79.6% and timeliness of postpartum care hybrid rates from 46.8% to 49.8% among members located in Hawai'i County.

Table 2-2—Status of the *Getting Needed Care: Improving Access to Behavioral Health Services* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. Plan-Do-Study-Act (PDSA)	Initiated in March 2018
5. PIP Conclusions	Targeted for February 2019

Table 2-3—Status of the *Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County* PIP

Module	Status
1. PIP Initiation	Completed and achieved all validation criteria
2. SMART Aim Data Collection	Completed and achieved all validation criteria
3. Intervention Determination	Completed and achieved all validation criteria
4. PDSA	Initiated in March 2018
5. PIP Conclusions	Targeted for February 2019

Conclusions

UHC CP was successful in documenting appropriate methodologies, quality improvement processes, and potential interventions in Modules 1 through 3 for the ***Getting Needed Care: Improving Access to Behavioral Health Services*** and ***Improving Timeliness of Prenatal Care and Postpartum Care in Hawai'i County*** rapid-cycle PIPs. The health plan successfully achieved all validation criteria in Modules 1 and 3 for both PIPs, addressing all recommendations. **UHC CP** provided an update on intervention testing (Module 4) in May 2018 and June 2018.

O. Outcomes of Performance Measure Monitoring

Summaries of the HEDIS 2018 Compliance Audit Final Report of Findings will be included for review in the 2018 External Quality Review Report of Results for the QUEST Integration Health Plans and the Community Care Services Program. This report is projected to be finalized before April 2019 and posted to the MedQUEST website.

Please Attachment C for the Graphs of HEDIS 2015-2018 results of pay for performance measures and see Attachment D for the Hawaii Calendar Year 2017 HEDIS 2018 Rate Spreadsheet.

P. Summary of Plan Financial Performance

(Including information on, and assessment of, the operation of the managed care program in regard to financial performance of each MCO, PIHP, and PAHP, including MLR experience.)

The MLR experience for CY 2017 for our five MCOs are as follows:

- AlohaCare – 90.45%
- HMSA – 89.36%
- Kaiser – 94.89%
- Ohana – 92.52%
- UHC – 91.32%

As this is the first year for MCOs to report MLR, MQD is in the process of analyzing the different MLRs by MCO.

XVII. Managed Care Organization and Program

(Information on, and assessment of, the operation of the managed care program in regard to the following areas.)

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

There were no service area expansions during the reporting period.

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

The Division has been working with the State Department of Education and managed care plans to continue ensure coverage and provision of EPSDT services. Emphasis has been on ensuring that children receive medically necessary services even though in school during the day. The Department of Education does not allow non-contracted individuals on to school campuses during the day. While children can also receive medically necessary services from DOE during the school day, the health plans need to ensure that there is better coordination with DOE. This will ensure that children and getting the hours of medically necessary services during and after school hours.

The Division also issued a Memorandum related to Applied Behavioral Analysis (ABA) services to pilot a report collecting more detailed information on denials or reduction in services for ABA services for children with an autism spectrum disorder. With the passage of a Hawaii law that requires ABA providers to be licensed, the State experienced a backlog in the provision of services. The backlog has been steadily decreasing as the availability of licensed providers increases. The pilot report should allow the Division to more closely monitor the provision and availability of services.

The Division also moved to lower the eligibility criteria for individuals with Hepatitis C to access direct-acting antiviral curative medications. The criteria was that an individual had to have fibrosis stage 1 but Hawaii has lowered it to stage 0-essentially there is no longer a fibrosis restriction. Edits for drug testing toxicology screens has also been removed. This is in keeping with national trends.

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

Grievances

It appears that members have been exercising their grievance rights and have been filing grievances with the health plans. Whenever a member is not satisfied with the health plan's grievance decision, the member may ask for a grievance review with DHS/MQD. The grievance review determination made by DHS/MQD is final.

Appeals

It appears that members have been exercising their appeal rights and have been filing appeals with the health plans.

State Fair Hearings

It appears that members have been exercising their appeal rights and have made requests for fair hearings by submitting letters to the Administrative Appeals Office.

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

(Including consumer report cards, surveys, or other reasonable measures of performance.)

Please see sections XV (I), (M) and (N).

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

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

F. Activities and Performance of the Beneficiary Support System

The MQD Beneficiary Support System is a combination of internal staff support along with an external contracted vendor. The Health Care Outreach Branch (HCOB) within MQD is the internal staff who identifies and assists hard to reach populations and those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers, justice-involved populations and those who are admitted to and discharged from public institutions.

HCOB is present on all major islands, and also assists beneficiaries with submitting applications and enrollment into health plans for Medicaid and the Federal Health Insurance Marketplace. The MQD contracts with Hilopa'a to provide Ombudsman services for Medicaid beneficiaries, including member education, member advocacy, and fulfillment of person-centered goals. Hilopa'a uses both traditional and unconventional communication modalities to communicate and interact with beneficiaries, including the use of webinars, Ted Talks, social media, face-to-face meetings, text messaging and phone/fax.

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

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

XVIII. MQD Contact

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