Hawaii QUEST Integration

Annual Monitoring Report to CMS

Federal Fiscal Year 2020

Reporting Period:

October 1, 2019 - September 30, 2020

(Demonstration Year 26)

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I. Introduction

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

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

A total of 4 proposals were received for the QI RFP issued in August 2019. On January 22, 2020, MQD awarded to each of the plans that submitted a proposal. The new contract is scheduled to go into effect on July 1, 2020. On May 29, 2020, MQD rescinded the award and cancelled the RFP due to the COVID-19 pandemic. MQD plans to reissue a new QUEST Integration RFP in the first quarter of FFY 2021. MQD will modify the RFP requirements to reflect the new reality of the emerging needs of the Medicaid population in particular during a pandemic period.

This annual report meets the requirements of item *51 Monitoring Reports* in the Special Terms and Conditions (STC) document of Hawaii's section 1115 (a) Demonstration Waiver, as well as, the Managed Care Program report required under 42 CFR 438.66(e). Information on the fourth quarter of Federal Fiscal Year (FFY) 2020, that would ordinarily be provided in a separate report, is provided as distinct information within this annual report as Appendix J.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality spreadsheet for the quarter ending September 30, 2020 was submitted by the November 30, 2020 deadline.

III. Events Affecting Healthcare Delivery

A. Approval & Contracting with New Plans

During the reporting period, QUEST Integration Request For Proposal Supplemental Changes #12, #13, #14 and #15 were sent to CMS for approval on contract content changes, 2019 supplemental rate changes, for 2020 CAP rate and for extension of contract. CMS approved Supplemental Changes #12 and #13.

During this period, no additional or new health plans were contracted with for QI.

B. Benefits & Benefit Changes

Community Integration Services (CIS)

The CIS amendment to the current 1115 Demonstration waiver was approved on October 31, 2018. This amendment will increase access to CIS to individuals who are chronically homeless or in danger of losing public housing with either a physical or behavioral illness. MQD continues to work on provision of these services to eligible beneficiaries with providers and collaborative partners in the community. In March of 2020, MQD issued initial CIS policy guidance around data requirements for the CIS program. In September 2020, MQD shared draft CIS policy guidance around criteria, processes, and service codes with Health Plans and community partners with the intent of gathering feedback.

1115 Demonstration Renewal

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

MQD submitted various documents related to the 1115 waiver during this time frame (October 1, 2019—September 30, 2020):

- On April 8, 2020 CMS approved Hawaii's request to update the Hawaii QUEST Integration (Project No. 11-W-00001/9) with the Emergency Preparedness and Response Attachment K in order to respond to the COVID-19 pandemic.
- On June 25, 2020 CMS approved the State of Hawaii's request for a Section 1115(a) Demonstration project to address the COVID-19 public health emergency. CMS approved expenditures for Retainer Payments, 1915(i)-like Initial Evaluations and Assessments, and Revaluations and Reassessments, and 1915(c) and 1915(c)-like HCBS Waiver Level of Care Determination and Redetermination Timeline**.** CMS also approved flexibilities around HCBS Visitor Requirements.
- On September 1, 2020 CMS approved Project No. 11-W-00001/9 Hawaii Behavioral Health Services Protocol submitted by Hawaii as required by the Special Terms and Conditions (STCs) of the demonstration.
- On September 25, 2020 CMS approved the update to the Hawaii QUEST Integration (Project No. 11-W-00001/9) Emergency Preparedness and Response Attachment K with an Addendum in order to respond to the COVID-19 pandemic.

HOPE initiative

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

Another area of focus is on screening and addressing social risk factors for members with Special Health Care Needs. MQD received technical assistance from the State Health and Value Strategies Program and identified Hawaii-specific needs, priority domains (e.g., food and housing insecurity), and standardized screening questions.

Behavioral health integration across the continuum was also another area of focus. MQD researched best practices and meet with experts in the field with technical assistance support from the Center for Health Care Strategies.

MQD also spent a considerable amount of time identifying ways to streamline care coordination and improve outcomes for Special Health Care Needs and LTSS members receiving care coordination. Additionally, MQD was able to secure funding from the Stupsky Foundation for support to develop a specialized palliative care benefit that is community-based.

Department of Education (DOE) & School Based Services

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

DOE staff has continued to conduct mail outs and telephone calls to inform and receive necessary consent forms from parents to work with Medicaid for medically necessary services during school hours. The process has been more challenging due to multiple and varied barriers encountered along the way. In addition, the requirement for all providers to obtain an NPI be eligible for Medicaid reimbursement has also proven to be difficult. Despite these challenges, DOE successfully began billing for skilled nursing services November 1, 2019 and received their first reimbursement check shortly thereafter. During this period total federal reimbursement was over $500,000. This was the first time DOE received any federal reimbursement for nursing services since 2007. The DOE also increased their administrative support by hiring additional support staff and renewed their contract with UMass for claims processing with Medicaid and to receive assistance to implement Administrative claiming. Prior to the current Public Health Emergency (PHE) DOE was in the process of hiring a physician to assist with medical related issues, but that is now on hold indefinitely. Efforts to increase billing for other school-based services, as well as adding Administrative claiming for federal reimbursement, continue.

State Plan Amendments and Hawaii Administrative Rules

For the reporting period of 10/01/19 to 09/30/20, PPDO completed the following SPAs, and continues to work on other SPAs initiated during this period:

- 19-0004 "Recovery Audit Contractor (RAC) reimbursement increase" was approved by CMS on 10/29/19 which allows the current continency fee rate of 12.5 percent to increase to 17 percent for all RAC claims.

- 20-0001 "Optional State Supplementary Payment" was approved by CMS on 02/11/20 which a yearly required amendment to reflect the increase to the monthly income standards for Domiciliary Care Type I from $1,422.90 to $1,434.90 and for Domiciliary Care Type II from $1,530.90 to $1,542.90.

- 19-0006 “Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patient and Communities Act” was approved 03/04/20 and created a new section (K) to the State Plan that details claims review requirements, program to monitor antipsychotic medications by children, and fraud and abuse identification requirements for Hawaii.

- 19-0007 “Federally Qualified Health Center and Telehealth” was approved 03/07/20 to update the definitions of Spoke/Originating site and Hub/Distant site definitions, how the sites are used to deliver covered medical services through telehealth, health care provider requirements for telehealth and clarifies the payment methodology for these services.

- 20-0002 “COVID 19-Emergency” was approved 04/30/20 to create a new section in the State Plan which modified the public notice and tribal requirements, extends the reasonable opportunity period for immigration status verification and bed hold day allowances during the emergency period.

- 19-0005 “Durable Medical Equipment (DME) Fee For Service (FFS)” approved 07/23/2020 to meet section 1903(i)(27) to the Social Security Act requirements which prohibits federal Medicaid reimbursement to state for certain durable medical equipment (DME expenditures that are in aggregate, in excess of what Medicare would have paid for such items.

PPDO continues to work on amendment drafts for Hawaii Administrative rules.

Medicaid Eligibility Quality Control (MEQC) and Permanent Error Rate Measurement (PERM)

The Review Year (RY)2021 PERM is underway and PPDO is coordinating activities between the Department’s Eligibility staff and Booz Allen Hamilton (BAH), Eligibility Review Contractors (ERC) to meet requirements of the review process. The activity is high with request for clarification of KOLEA system rule processing, case information, and findings. In addition, PPDO has been instrumental in working with the Department’s Quality Control Office for required system data, access, policy updates, and training for the MEQC proposal which has been approved by CMS on December 31, 2020. Together with the KOLEA Project Team, PPDO is coordinating with QC in preparation for MEQC to commence simultaneously with the PERM RY2021. Logistics of the MEQC reviews are in process, however the basis will be on the accuracy and timely determination of current eligibility determinations for the Medicaid/CHIP programs for application, change of circumstances, and renewal approvals (ACTIVE actions). In addition, the MEQC focus includes reviews of denials and terminations (NEGATIVE actions). The required number of samples for the MEQC review year is as follows:

Program/Action Type	Number to Review
CHIP active	210
Medicaid (all others except LTC)	110
LTC only	100
Medicaid negative	210
CHIP negative	210

Policy and Program Directives

Policy and Program Directives (PPDs) are issued to MQD staff for information, clarifications and actions to be taken relative to any policy change ranging from changes in federal rules and policy to changes in state rules and regulations. For the reporting period, nine (9) PPDs were issued:

- **19-005** 10/23/2019
  RETROACTIVE MEDICAL ASSISTANCE FOR INDIVIDUALS UNDER QUEST INTEGRATION
- **19-006** 12/6/2019
  2020 MEDICARE PREMIUMS, DEDUCTIBLES AND CO-INSURANCE AMOUNTS
- **19-007** 12/6/2019
  2020 SSA RSDI, SSI AND VA COST OF LIVING ADJUSTMENT INCREASE
- **19-008** 12/27/2019
  2020 SPOUSAL IMPOVERISHMENT STANDARDS AND HOME EQUITY LIMIT FOR LTC INDIVIDUALS
- **20-001** 1/23/2020
  TREATMENT OF REVOCABLE TRANSFER ON DEATH DEED (TODD)
- **20-002** 2/12/2020
  TREATMENT OF CENSUS WORKER INCOME
- **20-003** 3/16/2020
  2020 INCREASE IN THE RESOURCE LIMITS FOR THE MEDICARE SAVINGS PROGRAMS
- **20-004** 3/17/2020
  MEDICAL MASS CHANGE 03/20 DUE TO THE INCREASE IN THE FEDERAL POVERTY LEVELS FOR 2020
- **20-005** 9/21/2020
  DEATH PAYMENTS PROGRAM UNCLAIMED BODIES (State-only program. Not Medicaid related)

Provider Memos are issued to providers and posted on the Med-QUEST website for information, clarifications and actions to be taken relative to changes ranging from changes in federal rules and policy to changes in state rules and regulations. For the reporting period, forty-four (44) Provider/Health Plan memos were issued. Of note, this is more than what MQD would usually issue however, many were issued to respond to the COVID-19 pandemic.

QI Memos – 2020

QI-2032 - Medicaid Fee-For-Service Hospice Rates - Effective October 1, 2020 through September 30, 2021
QI-2031 - QUEST Integration (QI) Transition of Care (TOC) Files
QI-2030 - Medicaid Fee-For-Service Hospice Nursing Facilities Rates - Effective July 1, 2020
QI-2029 - HOKU COVID-19 Waivers and Policy Reminders
QI-2028 - Clarification on Applied Behavior Analysis (ABA) Services Through Telehealth
QI-2027 - Required Quantity Prescribed Field in Point of Sale Claim Submission for Schedule II Drugs
QI-2026 - Medicaid Rates for Legacy Hilo Rehabilitation and Nursing Center
QI-2025 - Universal Precautions for QUEST Integration Members Receiving At-Risk and Home and Community Based Services (Addendum to FFS-M15-05)
QI-2024 - Subacute Definitions (Replaces QI-2012, QI-2012A)
QI-2023 - Medicaid Rates for Island Skilled Nursing and Rehabilitation
QI-2022 - Medicaid Fee-For-Service Rates - Effective July 1, 2020
QI-2021 - Guidance on SARS-COV-2 Antibody Testing
QI-2020 - Coverage of Services for Autism Spectrum Disorder via Telehealth
QI-2019 - Updated DHS 1145 - Hysterectomy Acknowledgement Form and Rescinding 1146 - Sterilization - Consent Form Change
QI-2018 - Quality Portion of Auto-Assignment Algorithm for Quest Integration (QI) Members
QI-2016 - COVID-19 Pandemic Action Plan for QI Health Plans and Providers - Part IV
QI-2015 - COVID-19 Pandemic Action Plan for QI Health Plans - Part III
QI-2014 - COVID-19 Pandemic Action Plan for QI Health Plans - Part II
QI-2013 - Telehealth Guidance for Public Health Emergency - Telephonic Services and Services Billable by Qualified Non-Physician Health Care Professionals

QI-2012A - Subacute Definitions (Addendum)
QI-2012 - Subacute DefinitionsQI-2011A - Clarification of Items and Services Carved Out from the Long Term Care PPS Rates (Addendum)
QI-2011 - Clarification of Items and Services Carved Out from the Long Term Care PPS Rates
QI-2010 - Telehealth Guidance During Public Health Emergency Related to COVID-19QI-2009 - COVID-19 Pandemic Action Plan for QI Health Plans
QI-2008 - Federally Qualified Health Center Telehealth Guidance During Public Health Emergency Period in Response to COVID-19
QI-2007 - Tele-Health Payment Guidance for Federally Qualified Health Centers (FQHC)
QI-2006B - New Provider Enrollment System - HOKU System Update (Addendum)
QI-2006A - New Provider Enrollment System - HOKU System Update (Addendum)
QI-2006 - New Provider Enrollment System - HOKU System Update
QI-2005 - New State Medicaid ID Card Design
QI-2004 - Revised QUEST Integration Coverage for Our Care, Our Choice Act (End of Life Care Option)
QI-2003 - Community Integration Services (CIS) Data Requirements
QI-2002 - Payment Suspension to Provider (Philip Suh, MD) - Effective January 17, 2020

QI Memos – 2019

QI-1934 - Med-QUEST Guidance Regarding the Coverage of Routine Costs Associated with Qualifying Clinical Trials
QI-1933 - Medicaid Fee-for-Service Federally Qualified Health Center (FQHC) & Rural Health Clinic (RHC) Prospective Payment Rates (PPS) - Effective January 1, 2020 through December 31, 2020
QI-1932A - Medicaid Fee-for-Service REVISED Hospice Nursing Facility Rate for Hospice Hilo - Effective January 1, 2020
QI-1932 - Medicaid Fee-for-Service Hospice Nursing Facility Rate for Hospice Hilo - Effective January 1, 2020
QI-1931 - Medicaid Fee-for-Service Hospice Nursing Facility Rate for St. Francis - Effective January 1, 2020
QI-1930A - Medicaid Fee-for-Service REVISED Hospice Rates - Effective January 1, 2020 through June 30, 2020
QI-1930 - Medicaid Fee-for-Service Hospice Rates - Effective January 1, 2020 through June 30, 2020
QI-1929 - Electronic Visit Verification (EVV) Service Codes and Modifiers
QI-1928 - QUEST Integration (QI) Transition of Care (TOC) Files

C. Enrollment and Disenrollment

The Customer Service Branch (CSB), Eligibility Branch (EB), and Health Care Outreach Branch are committed to assist community members complete their Medicaid application and maintain enrollment. Prior to the public health emergency (PHE), Med-QUEST Division (MQD) administration planned to issue laptops with virtual personal network and install Voice Over Internet Protocol (VoIP) in EB offices on all islands. The enhancement in technology led a smooth transition for staff to work remotely at the onset of the PHE and more notably seamless continuation of service to beneficiaries. The decision proved effective as the State had a 31% increase in enrollment and any of the beneficiaries requiring staff assistance would have been assisted remotely using the new technology.

The application process ends with enrollment. It is the goal of MQD to obtain a QI health plan choice from every applicant. If applicant is not prepared to select a plan, MQD staff provides the names of QI health plans in the service area and encourages the individual contact his or her primary care physician to ask the name of the QI health plan the physician is a participating provider. In the absence of a selection, our system will auto-assign the beneficiary a QI health plan and generate a choice notice. The beneficiary has 90 days to choose another QI Health Plan. Otherwise, the beneficiary will remain enrolled in the auto-assigned QI Health Plan until the next annual plan

change period. Beneficiaries that regain Medicaid eligibility within 180 days from last covered will re-enroll in the last QI Health Plan recorded in HPMMIS.

1. Enrollment Summary

As of September 30, 2020, the following table represents the percentage increase of applications during the PHE.

Count	2019	2020	Percentage Increase in Applications
Honolulu	26,149	33,388	28%
Maui	5,784	9,138	58%
Hawaii	7,610	8,808	16%
Kauai	2,598	4,061	56%
Statewide	42,141	55,395	31%

The 2019 QUEST Integration Annual Plan Change was October 1 through 31, enrollment applied January 1, 2020. A total 321,027 beneficiaries were eligible to participate in annual plan change. Of the total enrollees, 10,626 (3.31%) beneficiaries elected to enroll in a different health plan for the 2020 benefit year (January to December 2020). The table below is a summary of the annual plan change activity by health plan and service area. The numbers reflect new members each plan gained January 1, 2020.

MAGI Excepted	Oahu	Kauai	Hawaii	Maui	Molokai	Lanai	Total
AlohaCare	74	7	24	18	2	0	125
HMSA	254	21	91	34	2	0	527
Kaiser	73	0	0	35	0	0	510
Ohana Health Plan	75	2	28	5	3	0	221
UnitedHealthcare Community Plan	385	5	53	20	0	0	576
Total	**861**	**35**	**196**	**112**	**7**	**0**	**1959**
Beneficiaries w/APC Choice	1.58%	0.06%	0.36%	0.21%	0.01%	0.00%	3.59%
MAGI	Oahu	Kauai	Hawaii	Maui	Molokai	Lanai	Total
AlohaCare	420	67	147	108	34	6	782
HMSA	1411	173	525	194	13	6	3104
Kaiser	598	0	0	288	0	0	3208
Ohana Health Plan	126	14	92	24	3	0	1145
UnitedHealthcare Community Plan	122	8	28	10	1	0	428
Total	2677	262	792	624	51	12	8667
Beneficiaries w/APC Choice	1.00%	0.10%	0.30%	0.23%	0.02%	0.00%	3.25%

[*Member Choice of Health Plan Exercised*, appears in section XII.A.]

2. Disenrollment Summary

There were 226 clients that changed health plans outside the normal change period.

D. Quality of Care

Information related to quality of care can be found in the following sections: IV, *Grievances, Appeals & State Fair Hearings*; XIV, *Quality Assurance and Monitoring Activity*; and XV, *Quality Strategy Impacting the Demonstration*.

E. Access that is Relevant to the Demonstration

The COVID-19 Public Health Emergency (PHE) affected Member ability to access in-person care. To address this, MQD applied for and received federal flexibilities that mitigated some of the impact of COVID-19. Many policy decisions were made to further increase the access to care, including several telehealth adjustments and flexibilities. Provided below are some actions MQD took to meet other challenges affecting Members and access to care presented by the COVID-19 PHE.

Increased Collaboration and Communication with Health Plans

Beginning May 2020, MQD met with all five QI Health Plans on a weekly basis. These meetings were named "COVID Task Force Meetings", and the focus was addressing PHE issues.

Memorandum to Promulgate the Flexibilities Approved by CMS

MQD received approval on Appendix K which allowed the following flexibilities of services delivered during the PHE period.

a. Telehealth
   Instead of face-to-face visits, telehealth played an important role for continuance of service delivery.

b. Administering Level of Care Assessments
   MQD auto-extended 6 months on the level of care assessments without face-to-face visits for those receiving HCBS services residing in their own home. The level of care assessment for Medicaid beneficiaries residing in facilities for other community settings continues to receive face-to-face level of care assessments. Also, levels of care services were maintained and not reduced.

c. CCS Flexibilities
   The face-to-face requirements for CCS level 5 Members remained the same. However, telehealth visits were allowed for CCS Members in levels 1 through 4, and face-to-face visits for those Members were required on an as-needed basis.

d. Adult Day Care Flexibilities
   MQD allowed for the continuation and maintenance of payments to adult day care facilities while services to Members were modified, such as wellness calls and check-ins, delivery of groceries and meals, translation, and family support.

Addressing Prevention of COVID-19

a. Preventative Personal Protection Equipment (PPE) Distribution
   MQD partnered in the early months of the pandemic with State emergency agencies to obtain and distribute scarce PPE for EARCHs, CCFFHs, DD facilities, and CMAs. These congregate settings care for some of the most vulnerable populations in Medicaid who are at the highest risk for mortality from COVID-19. Along with the PPE, webinars and printed handouts were shared with facility owners to

educate and support them on proper PPE usage and disease prevention. Additionally, MQD worked with the State of Hawaii Office of Health Care Assurance (OHCA) to align communications with the facilities that received the PPE. As a result, the State of Hawaii experienced one of the lowest death rates for COVID-19 nationwide.

b. Go-Kits

Similar to the preventative PPE distribution, Go-Kits were specifically designed for the congregate settings when care givers or Members became positive for COVID-19. Each Go-Kit includes a box of gloves, face shields, gowns, surgical masks, booties, and the instructions for proper use. Each Go-Kit was designed for single-Member care and multiple Go-Kits were delivered for settings that had multiple Members. There were 375 Go-Kits created internally by MQD staff and 75 were distributed to 31 congregate settings during the second half of 2020. MQD partnered with CMAs, Health Plans and internal staff to ensure Go-Kit availability on all islands. In the event an individual became positive, the case manager was notified, and immediate actions were taken to deliver appropriate Go-Kits to that setting. As a result of the strategic plan, Go-Kit deliveries were often made within hours of such notification.

Additionally, Health Plans collaborated to design and create additional Go-Kits for HCBS Members that reside in their own homes. Health Plan service coordinators were notified when a Member or in-home care giver became COVID-19 positive and quickly delivered a Go-Kit to that home. There were 652 Go-Kits created by the Health Plans, and 381 were distributed to homes during the second half of 2020.

Equipping Providers to Deliver Telehealth – Laptop Distribution

MQD applied for an emergency Advance Planning Document (APD) and received approval for funding to purchase laptop and surface devices to distribute to targeted Medicaid providers to facilitate and increase services delivered via telehealth, especially in rural areas. MQD distributed 217 devices to 20 providers on the islands of Oahu, Kauai, Maui, Molokai and Hawaii.

F. Pertinent Legislative or Litigation Activity

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

The 2020 Legislative session was cut short because of COVID-19. Major policy initiatives were not addressed by the legislature, as the primary focus was on passing required funding bills.

MQD is pursuing litigation regarding a drug, Plavix, for which MQD believes the manufacturers withheld critical information on drug efficacy as it relates to patient ethnicity. Several key MQD employees were deposed in the 2nd quarter of FFY 2020. This case was scheduled to go to court in the 1st quarter of FFY 2021.

G. Public Forums

Due to the COVID-19 pandemic emergency, there was only one public forum set up during this reporting period. On January 30, 2020, MQD held an award public forum to solicit meaningful comments on the progress of the Federal approval of the State's Section 1115 Waiver Demonstration. The five-year demonstration project, which is administered by the Department of Human Services, Med-QUEST Division (MQD), authorizes Hawaii to continue providing Medicaid benefits through its managed care delivery system, continue providing Home and Community-

Based Services to certain populations, and expand access to and benefits of Community Integration Services for beneficiaries who meet specified needs-based criteria. This demonstration project is approved through July 31, 2024.

IV. Grievances, Appeals and State Fair Hearings

A. Grievance Events that Affected Health Care Delivery

See section IV.B, *Information on and Assessment of Grievances and Appeals for the Managed Care Program*, below.

B. Information on and Assessment of Grievances and Appeals for the Managed Care Program

1. Grievances

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

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

2. Appeals

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

3. State Fair Hearings (Administrative Hearings)

Requests for a State Administrative Hearing are disseminated by the Administrative Appeals Office (AAO) to MQD. Members must first exhaust the appeal system of the Health Plan before they can request a State Administrative Hearing with the AAO. It appears that members have been exercising their appeal rights and have made requests for administrative hearings.

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

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

1. Grievances to MQD Health Care Services Branch (HCSB)

October 2019 – September 2020 Types of Member Grievances to MQD (HCSB)	
Description: The following are grievances received by the HCSB of MQD. These DO NOT include the grievances received by the Health Plans, which are reported in a separate table below.	
Health Plan Policy	3
Provider/Provider Staff Behavior/Services	31
Transportation Customer Service	8
Treatment Plan/Diagnosis	5
Fraud and Abuse of Services	2
Billing/Payments	5
Member Rights	21
Medication	6
General Information	36
Forward to Other Departments	27
Total	**144**

Month	# of Member Grievances Addressed by HCSB
October 2019	9
November 2019	5
December 2019	11
January 2020	8
February 2020	7
March 2020	17
April 2020	15
May 2020	16
June 2020	13
July 2020	15
August 2020	16
September 2020	12
Total	**144**

Status of Member Grievances Addressed by HCSB					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul–Sep 2020	**TOTAL**
Received	7	7	44	43	101
Status					
Referred to Subject Matter Expert	0	0	10	16	26
Health Plan resolved with Members	2	0	17	16	35
Member withdrew grievance	0	1	0	0	1
Resolution in Health Plan favor	0	1	7	7	15
Resolution in Member's favor	1	4	2	2	9
Still awaiting resolution	2	2	0	0	4
Carry-over from previous Quarter	2	6	13	13	34

2. Grievances to Health Plans

Types of Member Grievances Reported to Health Plans					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul–Sep 2020	
Medical					**TOTAL**
Provider Policy	3	7	10	6	26
Health Plan Policy	20	26	23	35	104
Provider/Provider Staff Behavior	74	70	79	72	295
Health Plan Staff Behavior	49	32	35	32	148
Appointment Availability	4	9	10	7	30
Network Adequacy/ Availability	2	1	3	4	10
Waiting Times (office, transportation)	60	90	53	59	262
Condition of Office/ Transportation	2	0	4	4	10
Transportation Customer Service	19	18	11	13	61
Treatment Plan/Diagnosis	14	16	24	34	88
Provider Competency	40	25	13	20	98
Interpreter	0	0	0	0	0
Fraud and Abuse of Services	2	1	4	2	9

Billing/Payments	19	17	22	19	77
Health Plan Information	12	20	10	8	50
Provider Communication	24	22	15	17	78
Member Rights	5	9	19	20	53
Total	349	363	335	352	1399

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

Status of Member Grievances Reported to Health Plans					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Total number filed during the reporting period	325	334	268	287	1,214
Status received from Health Plans					
Total number that received timely acknowledgement from health plan	319	328	262	278	1,187
Total number not receiving timely acknowledgement from health plan	6	6	6	3	21
Total number expected to receive timely acknowledgement during next reporting period	0	2	0	9	11
Total number that received timely decision from health plan	308	324	246	268	1,146
Total number not receiving timely decision from health plan	11	6	16	1	34
Total number expected to receive timely decision during next reporting period	7	6	15	7	35
Total number currently unresolved during the reporting period	13	9	19	18	59

3. Appeals to Health Plans

There was a total of 1,337 appeals submitted for FFY 2020 with the health plans. Of those appeals submitted to the health plans, only 24 appeals were submitted with the Administrative Appeals Office. There were 19 resolved with the health plan or decided in Member's favor prior to going to a hearing. There was 1 resolved in DHS's favor.

Types of Member Appeals to Health Plans					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Service denial	78	76	64	43	261
Service denial due to not a covered benefit	54	45	56	9	164

Service denial due to not medically necessary	211	238	177	241	867
Service reduction, suspension or termination	2	0	2	0	4
Payment denial	18	9	12	8	47
Timeliness of service	0	0	0	0	00
Prior authorization timeliness	0	0	0	0	00
Other	0	10	4	4	18

Status of Member Appeals to Health Plans					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Total number filed during the reporting period	355	374	308	300	1337
Status received from Health Plans					
Total number that received timely acknowledgement from health plan	318	362	304	269	1253
Total number not receiving timely acknowledgement from health plan	37	11	2	9	59
Total number expected to receive timely acknowledgement during next reporting period	24	1	2	22	49
Total number that received timely decision from health plan	321	349	270	265	1205
Total number not receiving timely decision from health plan	30	15	24	2	71
Total number expected to receive timely decision during next reporting period	28	24	32	33	117
Total number currently unresolved during the reporting period	28	24	32	33	117
Total number overturned	205	238	174	168	785

4. Appeals to the State (State Fair Hearings)

Types of Member Appeals to State Administrative Appeals Office (AAO)					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Medical	2	3	5	4	14
Home and Community Based Services (HCBS)	0	2	1	1	4
Van Modification	0	0	0	0	0
Applied Behavioral Analysis (ABA)	0	0	0	0	0
Durable Medical Equipment	0	0	0	0	0
Reimbursement	0	0	0	0	0
Medication	1	0	0	1	2
Miscellaneous	2	1	1	0	4

Status of Member Appeals to State Administrative Appeals Office (AAO)					
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	**TOTAL**
Submitted	5	6	7	6	24
Status received from AAO					
Department of Human Services (DHS) resolved with health plan or Department of Health Developmental Disabilities Division (DOH-DDD) in Member's favor prior to going to hearing	2	5	7	5	19
Dismiss as untimely filing	0	0	0	0	0
Member withdrew hearing request	1	0	0	0	1
Resolution in DHS' favor	0	1	0	0	1
Resolution in Member's favor	0	0	0	0	0

Still awaiting resolution	2	0	0	1	3

V. Adverse Incidents

A. Long Term Services and Supports (LTSS)

In FFY 2020, a total of 1,406 adverse events related to the LTSS population were reported. The top five incident categories were: Fall, Hospital, Death, Emergency Room Visit, and Injury. Falls were the top occurring incident for all quarters. Hospitalization was the second most occurring incident.

There were 52 adverse events from Nursing Facilities. "Fall" remains the top occurring incident for all quarters in Nursing Facilities and "injury" was the second most occurring incident.

In ICF DD/ID there were 43 adverse events. "Emergency Room Visits" were the top occurring incident for all quarters in ICF DD/ID and "injury" was the second most occurring incident.

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

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

Types of Adverse Events												
	Health Plan				**Nursing Facility**				**ICF DD/ID**			
	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020	Oct-Dec 2019	Jan-Mar 2020	Apr-Jun 2020	Jul-Sep 2020
Fall	136	142	120	132	10	10	12	10	0	2	0	1
Hospital	71	90	96	104	0	0	0	0	0	0	0	0
Death	29	35	27	32	0	0	0	0	0	0	1	0
Emergency Room Visit	70	62	51	55	0	0	0	0	9	10	4	5
Injury	31	34	45	44	2	1	4	3	5	1	0	4

Med Error	0	0	0	0	0	0	0	0	0	0	0	1
TOTAL	337	363	339	367	12	11	16	13	14	13	5	11

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

MQD shares an MMIS system with the Arizona Heath Care Cost Containment System (AHCCCS); the encounter intake and validation systems are structured similarly, and enhancements and modifications are generally operationalized simultaneously for both states. However, AHCCCS has achieved better encounter data quality than Hawaii. During FFY 2020, Med-QUEST Division ramped up its efforts related to the improvement of encounter data quality in multiple ways.

First, MQD contracted with Hawaii's EQRO to conduct an Encounter Data Validation (EDV) study. The study continues into FFY2021 and will provide MQD with an environmental scan of best-practices in encounter data quality; a Hawaii-specific analysis of current data quality issues parsed by MCO; and actionable recommendations for improving encounter data quality that MQD will plan to implement in FFY2021. Simultaneously, MQD sought additional funds from CMS within its MMIS OAPD to fortify its ability to address and implement the recommendations from the EDV Study. These funds are expected to strengthen MQD's policy and system documentation, improve facilitation and resolution of ongoing encounter data issues with MCOs, and support the development of an action plan to systematically improve encounter data quality.

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

Third, MQD began work to investigate and address the sources of discrepancies between the MCOs' and MQD's systems. For example, MQD worked with its contracted actuary, Milliman, to refine its reconciliation process to align with the data submission to the actuary, that would enable an apples-to-apples comparison between encounters submitted by the MCOs to Milliman for rate development to those submitted and accepted by MQD. The new aligned encounter reconciliation is expected to be released in FFY2021. Triangulation of the reconciliation process to identify discrepancies found in the three systems (MCOs, Milliman, and MQD), and reconciliation of those differences, will enable improvements in data quality to support the use of data in the State Medicaid encounter system for future rate setting.

Fourth, in addition to encounter data reconciliation, MQD worked closely with Milliman to effectively increase the financial consequences to MCOs associated with poor data quality in the State Medicaid encounter system; specifically, risk sharing for high-cost newborns is exclusively based on encounters found within the State Medicaid encounter system. Beginning in CY2019, risk sharing for high-cost drugs was implemented to be based on

encounters found within the State Medicaid encounter system. In CY2020, Milliman began additional beneficiary-level verifications to ensure that any special services were only offered to those identified to be qualifying for these services by MQD.

VII. Action Plans for Addressing Issues Identified In:

A. Policy

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

B. Administration

MQD's Ombudsman contractor failed to comply with several contract requirements. MQD did not extend the current contract but re-procured and awarded the Ombudsman contract to a new contractor effective October 2020. The new contractor has been complying with the contract requirements.

C. Budget

See section IX, *Financial and Budget Neutrality Development and Issues*, below.

VIII. Expenditure Containment Initiatives

See section XVIII.F (Progress on Implementing Cost Containment Initiatives) below.

IX. Financial and Budget Neutrality Development and Issues

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

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

A. Enrollment Counts

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**10/2019 - 9/2020**	**As of 9/30/20**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	1,411,919	119,705
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	427,328	36,527
Aged	Aged w/Medicare Aged w/o Medicare	343,517	29,523
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	286,914	24,298
Expansion State Adults	Expansion State Adults	1,199,295	107,098
Newly Eligible Adults	Newly Eligible Adults	254,768	22,195
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	6,717	604
CHIP	CHIP (HI01), CHIPRA (HI02)	351,023	27,921
Total		4,953,317	367,871

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	210,657
Title XXI funded State Plan	27,921
Title XIX funded Expansion	129,293
Enrollment current as of	9/30/2020

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total for Year Ending 9/30/20
EG 1 – Children	115,913	115,815	115,048	114,928	114,914	113,974	116,233	123,445	120,131	121,178	123,006	124,051	1,418,636
EG 2 – Adults	34,278	34,127	33,803	33,524	33,662	33,183	34,182	38,758	37,328	37,542	38,316	38,625	427,328
EG 3 – Aged	27,747	27,853	28,269	27,833	27,999	28,138	28,370	29,067	29,493	29,304	29,639	29,805	343,517
EG 4 – Blind/Disabled	23,628	23,782	23,786	23,465	23,647	23,654	22,935	24,340	24,452	24,341	24,348	24,536	286,914
EG 5 – VIII-Like Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
EG 6 – VIII Group Combined	111,838	112,781	113,390	114,025	112,866	111,971	114,440	132,086	129,095	129,978	134,761	136,832	1,454,063

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

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Total for Year Ending 9/30/20
State Plan Children	115,400	115,283	114,513	114,383	114,369	113,413	115,678	122,868	119,563	120,593	122,415	123,441	1,411,919
Sate Plan Adults	34,278	34,127	33,803	33,524	33,662	33,183	34,182	38,758	37,328	37,542	38,316	38,625	427,328
Aged	27,747	27,853	28,269	27,833	27,999	28,138	28,370	29,067	29,493	29,304	29,639	29,805	343,517
Blind or Disabled	23,628	23,782	23,786	23,465	23,647	23,654	22,935	24,340	24,452	24,341	24,348	24,536	286,914
Expansion State Adults	91,755	92,632	92,641	93,149	92,479	91,860	94,837	110,123	107,445	107,967	111,398	113,009	1,199,295
Newly Eligible Adults	20,083	20,149	20,749	20,876	20,387	20,111	19,603	21,963	21,650	22,011	23,363	23,823	254,768
Optional State Plan Children	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Foster Care Children, 19-20 years old	513	532	535	545	545	561	555	577	568	585	591	610	6,717
Medically Needy Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Demonstration Eligible Adults	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Demonstration Eligible Children	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
VIII-Like Group	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Governmental	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Governmental LTC	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
UCC-Private	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

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

C. Enrollment in Behavioral Health Programs

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.	**4,321**	**4,335**	**4,541**	**4,682**
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).	**901**	**837**	**889**	**818**
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.	**1,138**	**1,012**	**955**	**874**

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

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

1st Quarter Health Plan	Oct 2019	Nov 2019	Dec 2019
Aloha Care	442	486	669
HMSA	709	705	720
Kaiser	279	288	311
Ohana	2958	2901	2810
United Healthcare	2226	2196	2473
Total	**6614**	**6576**	**6983**

2nd Quarter Health Plan	Jan 2020	Feb 2020	Mar 2020
Aloha Care	538	525	644
HMSA	712	718	723
Kaiser	301	297	302
Ohana	2795	2708	2674
United Healthcare	2323	2210	2233
Total	**6669**	**6458**	**6576**
3rd Quarter Health Plan	**Apr 2020**	**May 2020**	**Jun 2020**
Aloha Care	645	519	509
HMSA	729	733	728
Kaiser	301	320	312
Ohana	2724	2689	2581
United Healthcare	2216	2191	2040
Total	**6615**	**6452**	**6170**

4th Quarter Health Plan	Jul 2020	Aug 2020	Sep 2020
Aloha Care	541	566	507
HMSA	744	759	680
Kaiser	301	307	306
Ohana	2717	2611	1874
United Healthcare	2209	2177	2089
Total	**6512**	**6420**	**5456**

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

XI. Outreach and Innovative Activities

The Health Care Outreach Branch (HCOB) actively planned and prepared for the Annual Medicaid Enrollment system (KOLEA) and Health Insurance Marketplace training to approximately 120 "Kōkua" (outreach/enrollment assisters), in-person assisters from Federally Qualified Health Centers (FQHC's), Med-QUEST Kōkua Services Contractors, and other community health centers statewide. Trainings occurred on all islands, and covered details on how to submit online applications and upload documents in our KOLEA system via their Navigator Portal along with review of the Federal Health Insurance Marketplace application details.

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

2020 was a challenging year with the Covid-19 Public Health Emergency, Hawaii's stay at home orders in March and all of the business within our State which closed permanently or laid off employees due to the pandemic. HCOB had to think outside the box and do outreach in creative ways while following stay-at-home orders and still being able to assist the community and get the work out. HCOB reached out to all food distribution entities, Department of Education Grab-N-Go breakfast and lunch programs, local labor unions, churches, etc. to distribute either hard or soft copy flyers so the community would know where to get help if they lost their health coverage, due to loss of work and employer sponsored health coverage. Our team arranged with unions, hotels, airlines, restaurants and other business to hold online informational sessions to educate employees on how to obtain health coverage for Medicaid and/or the Federal Health Insurance Marketplace for those who would be losing the employment and health coverage.

HCOB also noted, due to the Covid-19 pandemic, an uptick in those transitioning in and out of the Hawaii State Hospital along with justice-involved populations and experienced an increase of suspension/unsuspension requests from members for their Medicaid coverage.

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

A. Member Choice of Health Plan Exercised

Number of Members	Oct – Dec 2019	Jan – Mar 2020	Apr – Jun 2020	Jul – Sep 2020	Total
Individuals who chose a health plan when they became eligible	741	922	2,127	2,251	6,341
Individuals who were auto-assigned when they became eligible	7,406	6,850	10,717	9,641	34,614
Individuals who changed their health plan after being auto-assigned	2,611	2,395	5,027	3,869	13,902
Individuals who changed their health plan outside of choice period	65	76	43	42	226
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	18	6	9	13	46

During this reporting period, 6,341 individuals chose their health plan when they became eligible, and 13,902 changed their health plan after being auto-assigned. Also, 34,614 individuals had an initial enrollment which fell within this reporting period.

In addition, 46 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

XIII. Demonstration Evaluation and Interim Findings

During FFY2020, MQD prioritized revisions to the 1115 demonstration evaluation design to satisfy CMS requirements. MQD's 1115 demonstration evaluation design was approved by CMS on 10/15/2020. Upon approval, MQD's work with the UH Evaluation Team has transitioned to planning for data collection. The planning work and orientation of the UH Evaluation Team to MQD data will continue into FFY2021.

MQD submitted the "Hawaii COVID-19 Public Health Emergency Demonstration - Draft Evaluation Design - September 2020" on September 24, 2020 to the CMS Submission Portal and is currently awaiting feedback.

XIV. Quality Assurance and Monitoring Activity

A. Quality Activities

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

1. Validation of Performance Improvement Projects (PIPs)

Per Hawaii's Quality Strategy, each health plan was required by the MQD to conduct PIPs in accordance with 42 CFR 438.330(b)(1) and §438.330(d)(2)(i-iv). 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 2019, the EQRO initiated validation activities for the following 12 new PIPs to be submitted by the Hawaii Medicaid health plans:

1. For three QI health plans (AlohaCare, HMSA and KFHP)
    - Improving Adolescent WellCare Visits
    - Follow-Up After Hospitalization for Mental Illness.

2. For one QI health plan (Ohana)
    - Improving Rates for Adolescent Well-Child Visits
    - Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge

3. For one QI health plan (UnitedHealthcare)
    - Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center
    - Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64

4. For CCS
    - Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge
    - Follow–Up After Emergency Department Visit for Mental Illness.

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

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

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

HSAG evaluations were for the 2020 validation cycle. The core components of this standard approach involve testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.

Health Plan PIP results are provided in section XVIII.M, *Summary of Performance Improvement Projects (PIPs) Conducted by the State & Outcomes Associated with the Interventions*, below.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

Validation of performance measures (PMs).

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the HEDIS 2020 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.1- The audit procedures were also consistent with the CMS protocol for performance measure validation: CMS External Quality Review (EQR) Protocols.1- The health plans that contracted with the MQD

during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit incorporated a detailed assessment of the health plans' 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 2019 (January 1, 2019, through December 31, 2019), and the audit activities were conducted concurrently with HEDIS 2020 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 17 measures, yielding a total of 52 measure indicators, for the QI population. 'Ohana CCS was required to report on 8 measures, yielding a total of 20 measure indicators, for the CCS program. The measures were organized into the following five categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services.

- Access and Risk-Utilization
- Children's Preventive Health
- Women's Health
- Care for Chronic Conditions
- Behavioral Health

HSAG evaluated each QI health plan's compliance with NCQA IS standards during the 2020 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. Overall, the health plans followed the NCQA HEDIS 2020 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of Reportable. Summarized results can be found on the MQD website under the tabs "Resources", and then "Quality Strategy".

3. Compliance Monitoring Review

COVID-19 Impact

Due to guidelines outlined by President Trump's declaration of a national emergency in March 2020 in response to the coronavirus disease 2019 (COVID-19) outbreak in the United States and travel restrictions in the State of Hawaii, the on-site portion of the EQRO's review of the health plan's compliance with standards was changed to a virtual site review utilizing the Webex meeting platform.

2020 is the second year of the three-year review cycle of EQR compliance reviews. HSAG performed a desk review of documents, file reviews, and a virtual site visit that included reviewing additional documents and conducting interviews with the QI health plans and the CCS program.

HSAG evaluated the degree to which QI health plans and CCS program complied with federal Medicaid managed care regulations and associated State contract requirements in performance categories (i.e., standards) that related to eight selected standard areas.

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

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

The standardized survey instrument selected was the CAHPS 5.0H Adult Medicaid Health Plan Survey. Adult members completed the surveys from February to May 2020. All sampled members received an English version of the survey with the option to request a survey in one of the four alternate, non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.

5. Provider Survey

Due to COVID-19 and HSAG's findings of other states receiving only 2% Response Rate on this survey, MQD decided to postpone this activity this year and to resume in January 2021 with the hope of getting a higher response rate and more meaningful results.

XV. Quality Strategy Impacting the Demonstration

During this reporting period, MQD contracted with a vendor, Myers Stauffer, to assist with updating MQD's quality strategy. MQD's quality strategy will follow the pillars outlined in the HOPE Vision document. In September 2020, MQD issued the quality strategy for public comment. Feedback indicated overall acceptance of the quality strategy. MQD was on track to present a revised quality strategy to CMS in the 1st quarter of FFY 2021.

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

Please see Attachment C: Schedule C, Quarter Ending September 30, 2020.

XVII. Expenditures for Uncompensated Care Costs

Please see Attachment C: Schedule C, Quarter Ending September 30, 2020.

XVIII. Managed Care Delivery System

A. Accomplishments

Due to all of the interventions for the COVID-19 pandemic (some examples are provided above in section III.E, *Access that is Relevant to the Demonstration*), Hawaii experienced a decrease in the death rate of the elderly population. Factors contributing to this were, heightened infection control, PPE direct distribution and limiting community contact within the HCBS settings.

B. Status of Projects

During this reporting period, MQD completed the following projects.

1. National Take Back Initiative to receive unused or expired medications.
2. The new QI RFP scope of services

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

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

C. Findings and Outcomes of Quantitative Studies, Case Studies, Focused Studies, or On-Site Reviews Conducted by the State or Contractor of the State

Due to the COVID-19 pandemic, on-site audits were restricted. Any issues identified were addressed by desk-review and on an as-needed basis. Case studies were conducted virtually. There were no major outstanding findings to remediate.

D. Findings of Interim Evaluations

See section XIII, *Demonstration Evaluation and Interim Findings*.

E. Utilization Data

Calendar Year (CY) 2019 incurred aggregated health care expense data produced by our actuaries for our QI program is included as Attachment I. This data is aggregated for all of the MCOs. It is broken out by family and children, expansion, and the Adult, Blind and Disabled (ABD) population groups.

F. Progress on Implementing Cost Containment Initiatives

Discharge Planning for Difficult-to-Place Members

MQD continues to work with Hawaii Queen's Hospital on placement of difficult to discharge members. Such members often have substance abuse issues, behavioral health issues, non-compliance issues, morbid obesity, and homelessness. So far, Queen's Hospital expanded their coalition working with the Department of Public Safety, Honolulu police department, homeless shelters and agencies, and managed care organizations. The Queen's Coalition project is ongoing and continues to be successful in stabilizing members medical conditions as well as housing issues.

One Key Question

One Key Question is an on-going screening program to address pregnancy options for women of child-bearing age. The goal is to both reduce unwanted pregnancies and promote healthy newborn outcomes. The One Key Question is: "Would you like to become pregnant in the next year?"

Community Integration Services (CIS)

MQD continues to work with health plans on implementing the beginning stages of CIS services to their members. MQD also works with providers and collaborative partners in the community on providing these services to eligible beneficiaries. More CIS information can be found in III.B, *Benefits and Benefit Changes.*

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

See sections III.B, *Benefits and Benefit Changes*, and III.E, *Access that is Relevant to the Demonstration*.

H. CAHPS Survey

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

Summary of Statewide Comparisons Results

Comparison of the QI health plans' scores to the 2019 NCQA adult Medicaid national averages revealed the following summary results:

- AlohaCare QI did not score at or above the 90th percentile on any of the measures. Conversely, AlohaCare QI scored below the 25th percentile on two measures: Getting Needed Care and Getting Care Quickly.

- HMSA QI did not score at or above the 90th percentile on any of the measures. Conversely, HMSA QI scored below the 25th percentile on seven measures: Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, Customer Service, and Coordination of Care.
- Kaiser QI scored at or above the 90th percentile on five measures: Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, How Well Doctors Communicate, and Coordination of Care. Also, KFHP QI did not score below the 25th percentile on any of the measures.
- 'Ohana QI did not score at or above the 90th percentile on any of the measures. Conversely, 'Ohana QI scored below the 25th percentile on one measure, Customer Service
- UHC CP QI scored at or above the 90th percentile on one measure, Coordination of Care. Conversely, UHC CP QI scored below the 25th percentile on two measures: Getting Needed Care and Getting Care Quickly.

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

Summary of Trend Analysis Results

The trend analysis revealed the following summary results:

- The 2020 QI Program aggregate scored statistically significantly lower than the 2018 scores in one measure, Getting Needed Care, Getting Care Quickly. Conversely, the 2020 QI Program aggregate scored statistically significantly higher than the 2018 scores in Coordination of Care.
- AlohaCare QI's 2020 scores were not statistically significantly higher or lower than the 2018 scores in any measure.
- HMSA QI's 2020 scores were statistically significantly lower than the 2018 scores in one measure, Customer Service
- Kaiser QI: This health plan's 2020 scores were statistically significantly higher than the 2018 score on two measures, Rating of All Health Care and Coordination of Care.
- 'Ohana QI's 2020 score was not statistically significantly higher or lower than the 2018 score on any measure.
- UHCCP QI's 2020 scores were statistically lower than the 2018 scores in one measure, Getting Care Quickly.

The QI Program's scores were at or above the national averages on six measures: How Well Doctors Communicate, Coordination of Care, Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor and Rating of Specialist Seen Most Often.

Conversely, the QI Program's scores were below the national averages on three measures: Getting Needed Care, Getting Care Quickly and Customer Service.

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

- Members' perceptions of not always easily getting the care, tests, or treatment they thought they needed.
- Members' perceptions of not easily obtaining appointments with specialists.
- Members' perceptions of not receiving care as soon as they needed it when they needed care right away.

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 they are not always getting the information or help they needed from their health plan's customer service.
- Respondents' personal doctor not always seeming informed and up-to-date about the care they received from other doctors or health providers.
- Respondents reported that the forms from the health plan are often not easy to fill out.

I. Outcomes of any Focused Studies Conducted

See section XVIII.C, *Findings and Outcomes of Quantitative Studies, Case Studies, Focused Studies, or On-Site Reviews Conducted by the State or Contractor of the State*.

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

During this reporting period, there were no complaints or investigations regarding such disparities.

K. Annual Summary of Network Adequacy by Plan

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

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

L. Summary of Outcomes of On-Site Reviews

1. EQRO

[Information on EQRO activities performed during the reporting period, is provided above in section XIV, *Quality Assurance and Monitoring Activity*.]

COVID-19 Impact

Due to guidelines outlined by President Trump's declaration of a national emergency in March 2020 in response to the coronavirus disease 2019 (COVID-19) outbreak in the United States and travel restrictions in the State of Hawaii, the on-site portion of the EQRO's review of the health plan's compliance with standards was changed to a virtual site review utilizing the Webex meeting platform.
Findings for the 2020 compliance review were determined from its:

- Desk review of the documents submitted by Health Plans to HSAG prior to the virtual site review.
- Credentialing, recredentialing, and organizational credentialing file reviews conducted prior to the virtual site review.
- Virtual site review activities that included reviewing additional documents and records, interviewing Health Plans' key administrative and program staff members, and viewing health plan presentations and system demonstrations.

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 eight standards and an overall percentage-of-compliance score across the eight 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	6	5	4	1	0	1	90%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	39	32	32	0	0	7	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**93**	**91**	**2**	**0**	**8**	**99%**

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	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	10	0	0	0	100%
III	Credentialing	39	37	36	1	0	2	99%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	10	1	0	0	95%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**96**	**2**	**0**	**3**	**99%**

	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	6	5	4	1	0	1	90%
II	Subcontracts and Delegation	10	10	4	6	0	0	70%
III	Credentialing	39	37	36	1	0	2	99%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	9	2	0	0	91%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**88**	**10**	**0**	**3**	**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- '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	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	39	38	38	0	0	1	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**99**	**98**	**1**	**0**	**2**	**99%**

	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	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	10	0	0	0	100%
III	Credentialing	39	37	37	0	0	2	100%
IV	Quality Assessment and Performance Improvement	8	8	8	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	9	2	0	0	91%
VIII	Enrollment and Disenrollment	6	6	6	0	0	0	100%
	Totals	**101**	**98**	**96**	**2**	**0**	**3**	**99%**

	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	6	5	5	0	0	1	100%
II	Subcontracts and Delegation	10	10	9	1	0	0	95%
III	Credentialing	38	31	31	0	0	7	100%
IV	Quality Assessment and Performance Improvement	10	10	10	0	0	0	100%
V	Health Information Systems	17	17	17	0	0	0	100%
VI	Practice Guidelines	4	4	4	0	0	0	100%
VII	Program Integrity	11	11	11	0	0	0	100%
VIII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**101**	**93**	**92**	**1**	**0**	**8**	**99%**
	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.							

2. Financial

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

Due to the COVID-19 Public Health Emergency, this investigation is still on-going.

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

See section XVIII.C, *Findings and Outcomes of Quantitative Studies, Case Studies, Focused Studies, or On-Site Reviews Conducted by the State or Contractor of the State*.

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

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

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

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

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

The following are summaries of this year's **Module 3** progress:

1. AlohaCare

Intervention Determination Summary for Improving Adolescent WellCare Visits PIP

Failure Modes	Potential Interventions
Member believes that he/she only needs to visit a provider when sick/injured.	• Provide the member educational material on adolescent well care (AWC) using technology (HealthCrowd), bilingual and interactive audio recordings, or texts. The message will describe who to schedule an AWC appointment with (primary care provider [PCP] or obstetrician/gynecologist [OB/GYN]) and why it is important. • Contact members who attended a sick visit but did not have an AWC visit within the measurement year and assist members with establishing care with their PCP. • Provide provider education on "max-packing" acute sick/injured visit with an AWC visit.
Member does not schedule AWC visit with assigned PCP.	• Incentivize lead care managers (LCMs) who have successfully assisted with scheduling an appointment with a parent/guardian or member, and for the member who has completed an AWC visit during the measurement year. • Incentivize providers, office staff, and community health workers who have successfully assisted with scheduling an appointment with a parent/guardian or member, and the member who has completed an AWC visit during the measurement year.

Provider schedules visit with member, but member fails to attend.	• LCM and providers will use 1:1 text messaging capability/outreach calls to assist with appointment reminders to members. • Incentivize members who have successfully completed an AWC visit during the measurement year (e.g., gift cards, coupons, movie tickets, monthly raffles).

Intervention Determination Summary for Follow-Up After Hospitalization for Mental Illness PIP

Failure Modes	Potential Interventions
Behavioral health practitioner (BHP) noted on list may be unavailable during critical 7-day follow-up window.	• Collaborate with clinics, organizations, and/or individuals statewide who could provide face-to-face (F2F) or telehealth follow-up visits within 7 days after discharge for members hospitalized with mental illness or intentional self-harm. • Establish secure methods for providing telehealth, such as ZOOM. For example, ZOOM via Transition of Care Behavioral Health Care Coordinator (ToC BH CC) laptop at the time of ToC BH CC prearranged post-discharge visit, who could then contact the BHP for a telehealth visit.
Member may not prioritize contacting BHP from list.	• ToC BH CC and facility case managers take a more active role with the member in discharge planning during inpatient hospitalization, assisting the member in making an appointment with established BHPs (if discharge date is known), instead of providing the member a list of BHPs (current process). • Include in the inpatient discharge plan establishing with the member a definite date/time/place and method of contact within 24 hours of discharge to activate intervention #1 above (if discharge date is unknown).
Member may not call ToC BH CC at discharge.	• Include in the inpatient discharge plan ToC BH CC taking a more active role in establishing contact at discharge, such as confirming the member's address, telephone number, or other method of contact during the inpatient F2F visit (the current process is that the ToC BH CC gives the member a card containing his/her name and telephone number and instructs the member to contact the ToC BH CC at discharge, which puts the responsibility on the member to initiate contact). • Provide or assist in providing transportation for the member from the facility at discharge to the member's place of residence. This helps to ensure contact at discharge, as well as to confirm the member's contact information.

Member may not be aware of the importance of follow-up with a BHP within 7 days of discharge.	Include in the inpatient discharge plan providing education to the member regarding the importance of the 7-day follow-up visit with BHP, emphasizing that during the visit, the BHP can help the member address any concerns or need for further assistance, including but not limited to the following: • Assistance in obtaining medications as prescribed at the time of discharge, as well as assistance in meeting other current needs the member may have. • Assessment of the member's mental health status post-discharge. • Linking the member with case management or other services, as appropriate.

Conclusions

The validation findings suggest that AlohaCare successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. AlohaCare further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. AlohaCare has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

2. HMSA

Intervention Determination Summary for Adolescent Well-Care Visits PIP

Failure Modes	Potential Interventions
Member is not aware of the annual adolescent well-care visit benefit.	Targeted member education and incentives for completed adolescent wellcare visits.
Value of the visit is not understood by the parent, guardian, or adolescent.	Improve adolescent well-care visit messaging in Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mailings.
Member is not aware of the transportation benefit.	Develop and distribute member educational material that describes the EPSDT transportation benefit and how to access transportation services.
Member is not aware of how to access the transportation benefit.	Develop and distribute member educational material that describes the EPSDT transportation benefit and how to access transportation services.

Intervention Determination Summary for Follow-Up After Hospitalization for Mental Illness PIP

Failure Modes	Potential Interventions
Members are scheduled for appointments greater than 7 days post-discharge.	• Educate facilities about the *FUH* measure and encourage them to set up an additional appointment within 7 days of discharge. • Assist members with obtaining telehealth appointments. • Perform transition of care activities with members within 2 business days of discharge.
Members are readmitted within 30 days of discharge.	• Assist members post-discharge through service coordination. • Connect members with community resources for crisis management.

Conclusions

The validation findings suggest that HMSA successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. HMSA further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. HMSA has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

3. Kaiser

Intervention Determination Summary for Adolescent Well-Care Visits PIP

Failure Modes	Potential Interventions
Staff do not know how to use the "Well-Child Visit" tool.	Educate staff on how to use the 'Well-Child Visit" tool to identify members who are due for a visit.
Member is not routinely placed on the wait list.	Use the "Well-Child Visit" tool to identify members and place them on the wait list for an appropriate due date.
Unable to contact member via a telephone call.	Use text messaging to confirm the appointment.
Demographic information is incorrect or outdated.	Educate staff to assure information is updated with each contact.

Intervention Determination Summary for Follow-Up After Hospitalization for Mental Illness PIP

Failure Modes	Potential Interventions
Member does not keep follow-up appointment.	Provide live reminder calls two days after discharge.
Unable to contact the member to reschedule a missed appointment or the member does not respond to messages/letter.	• Update member contact information prior to discharge. • Provide appointment information at discharge (i.e., "you will receive a reminder call two days after discharge about your follow-up appointment").
Member is not engaged or interested.	Provide education about the importance of a follow-up appointment during the live reminder call.

Conclusions

The validation findings suggest that KFHP successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. KFHP further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. KFHP has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

4. Ohana QI

Intervention Determination Summary for Improving Rates for Adolescent Well-Child Visits PIP

Failure Modes	Potential Interventions
Adolescent/parent/guardian cannot be reached by provider or health plan for assistance with scheduling an appointment.	Explore claims to see if members have any claims for providers not assigned to them. Reach out to those providers to see if the health plan can obtain the correct demographic information to contact members. Research other systems (e.g., Hawaii Health Information Exchange—Health eNet) to locate updated member demographic information.
Adolescent member and/or parents/guardians do not think they need a well-child visit and immunizations.	Patient care advocates (PCAs) and/or care gap coordinators (CGCs) emphasizing and educating on the importance of a well visit to members and their parents/guardians over the phone. Incentives for members (gift cards) to keep scheduled well-child visits (healthy rewards 2020).
Adolescent goes in for a sick visit, birth control, or a sport physical and not for a well-child visit.	Educating providers, members, and parents/guardians to do a well-child visit at the same time as a sick visit, OB/GYN visit, or physical.

Intervention Determination Summary for Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge PIP

Failure Modes	Potential Interventions
Member does not have an adequate discharge plan before inpatient discharge.	Identify qualified BH provider who can focus on all the health plan members to briefly follow up with them post-discharge within 7 days. Conduct a short-term case management service to identify member needs the health plan can assist with such as housing, food assistance, etc.
CGC adds all members admitted for mental illness to the tracker but is unaware that the treating diagnosis could change during the course of the treatment.	Educate CGCs on the facility process and review the specifications of the measure to have them identify only the members who had a primary diagnosis of mental illness. Track the correct members for timely followup to be completed, within 7 days post-hospital discharge. Add the members to the tracker for follow-up. The CGC will mark the encounters with diagnoses that changed through the course of the treatment as changed diagnoses at discharge.
CGC does not see the importance of the process being completed in a timely manner.	Educate CGCs on the importance of completing member outreach soon after discharge to assure a timely follow-up appointment is scheduled. Add the process in the tracker to assure the CGC conducts timely member outreach and monitors the process.

Conclusions

The validation findings suggest that 'Ohana successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. 'Ohana further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. 'Ohana has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

5. UnitedHealthcare CP QI

Intervention Determination Summary for the Improving Adolescent Well-Care Visit Rates Among UHC CP HI Membership at Waianae Coast Comprehensive Health Center PIP

Failure Modes	Potential Interventions
Member/guardian does not initiate contact with Waianae Coast Comprehensive Health Center (WCCHC) to establish care.	UHC CP Member Services conducts telephonic outreach to members/guardians assigned to WCCHC who have not established care and are due for an AWC visit. Assist as needed and schedule a visit or update the member's PCP if care has been established elsewhere.

Member/guardian is unaware of the member's assignment to WCCHC.	UHC CP Member Services conducts telephonic outreach to members/guardians auto-assigned to WCCHC who have not established care and are due for an AWC visit. Inform auto-assigned PCP and assist as needed to schedule a visit with WCCHC or update the member's PCP if care has been established elsewhere.
Member/guardian's contact information is not current.	Collaborate with WCCHC and schools (if member is school-aged) on the data exchange process for member contact information. With updated contact information, UHC CP Member Services conducts outreach to members/guardians due for an AWC visit to assist as needed/schedule a visit.
Member/guardian does not feel the need to see WCCHC unless sick.	Develop and implement educational materials targeted toward adolescents about the importance of preventive care. Leverage social media to deliver message.
Member/guardian does not have transportation to the visit.	Collaborate with a community-based organization, like Hawaii Keiki, to expand reach of school-based clinics where members can complete AWC visits.

Intervention Determination Summary for the Improving 7-Day Follow-Up After Hospitalization for Mental Illness Among UHC CP HI Members Ages 18–64 PIP

Failure Modes	Potential Interventions
Member lacks motivation to attend a follow-up appointment within seven days after discharge.	Modify the existing workflow to increase behavioral health field care advocate (BH FCA) face-to-face (FTF) visits with the member while still inpatient to increase trust. Educate on the importance of follow-up. Incorporate member incentives (e.g., food, gift card).
Member is a no-show at the scheduled FTF follow-up visit with the BH FCA after discharge.	Modify the existing workflow to increase BH FCA FTF visits with the member while still inpatient to increase trust. Educate on the importance of follow-up. Incorporate member incentives (e.g., food, gift card).
Member is unfamiliar with or lacks trust in the mental health practitioner (MHP).	If scheduling with previously seen MHPs is not possible, use BH FCA FTF visits to educate the member on the MHP and set up an introductory call between the member and MHP.
The follow-up appointment was scheduled with limited notice to the MHP.	Incentivize MHPs to see members within seven days after discharge.
There is a shortage of MHPs, especially with prescribing authority (i.e., psychiatrists).	Incentivize MHPs with prescribing authority to see members within seven days after discharge.

Conclusions

The validation findings suggest that UHC CP successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. UHC CP further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. UHC CP has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

6. Ohana CCS

Intervention Determination Summary for the Follow-Up After Hospitalization for Mental Illness Within 7 Days of Discharge PIP

Failure Modes	Potential Interventions
Case manager (CM) does not contact the facility to arrange for the visit while the member is inpatient.	Care coordinator notifies CM liaison of the member's admission. CM liaison will track members from the time they admit as inpatient, up to two to three days post-discharge, and communicate with the assigned CM at the CBCM agency until the member is scheduled a follow-up appointment with a behavioral health (BH) provider within seven days of discharge.
CM does not arrange an in-person visit with the member during facility admission, prior to discharge.	Send a reminder notification to the CBCM agency if the visit during the member's inpatient admission is not captured in CellTrak (electronic health record [EHR]) within 24 hours. The reminder to the CBCM agency is to notify the agency that the visit had not been captured in CellTrak (if the visit had occurred). If the visit has not occurred and the member has not been discharged, it will be a reminder to visit the member.
CM is not trained and is unaware of the importance of meeting with the member prior to discharge and lacks supervision in initiating the next steps to meet with the member at the facility.	Work with the selected CBCM agencies and learn the process of new staff onboarding and training to identify the gaps in training. Then, work with these agencies to incorporate the CM to meet with the member at the facility while inpatient and plan for the member's care after discharge to ensure the follow-up appointment is made within seven days postdischarge. The health plan will monitor the FUH rates monthly.

Intervention Determination Summary for Follow-Up After Emergency Department Visit for Mental Illness PIP

Failure Modes	Potential Interventions
No real-time ED census data.	CMs at the health plan and IHS will receive real-time ED discharge notifications for members so they are aware that the members need followup appointments within seven days post-ED discharge. The CM liaison will receive the real-time census from a contracted vendor, Hawaii Health Information Exchange (HHIE)—Notify reporting system. CM liaisons assigned to the health plan—Acuity Level 5 team and IHS will send their assigned members' real-time ED visit notifications to the CMs.
Facility is busy and it is not a priority to notify the health plan of a member's visit to the ED.	Work with EDs across the State to provide the health plan's customer service number. The EDs should inform the health plan when a member visits the ED.
Member does not attend the scheduled visit on the date of the appointment due to transportation not having been set up to attend the visit.	Work with the CBCM agencies to identify the gaps in helping to arrange the follow-up visit for members and educate the agencies on how they can arrange transportation for members to attend the follow-up appointment.
Member does not see the value in attending the appointment.	Work with the CBCM agencies to identify that CMs are educating members on the importance of engaging in care to improve their health.
Member has other priorities.	Work with the CBCM agencies to ensure that CMs are working closely with members to identify issues and priorities. Assist members in eliminating barriers, put their health first as a priority, and engage in care.

Conclusions

The validation findings suggest that CCS successfully completed Module 1 and Module 2 and designed a methodologically sound project for both PIPs. The health plan also successfully completed Module 3 and identified opportunities for improvement. CCS further analyzed opportunities for improvement in Module 3 and considered potential interventions to address the identified process flaws or gaps. CCS has initiated Module 4 by selecting an intervention to test and documenting a plan for evaluating the impact of the intervention through PDSA cycles for both PIPs. HSAG will report final Module 4 and Module 5 review findings in the CY 2021 PIP validation report.

N. Outcomes of Performance Measure Monitoring

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

Please see Attachment H for the Hawaii Calendar Year 2019 HEDIS 2020 Rate Spreadsheet.

O. Summary of Plan Financial Performance

The MLR experience for calendar year 2019 for each of the five MCOs is as follows:

- AlohaCare – 96.4%
- HMSA – 97.1%
- Kaiser – 94.7%
- Ohana – 100.7%
- UHC – 91.4%

XIX. Managed Care Organization and Program

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

There were no service area expansions during the reporting period.

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

The primary changes to the benefits were made due to the pandemic that required the State to abide by lockdown orders issued by the Governor. This necessitated looking at efforts the Division could implement to continue access to care by Medicaid recipients. The Division issued QUEST Integration memoranda that allowed services to be delivered using telehealth modalities. This included allowing telephonic-only services, clarification on FQHC services, coverage of EPSDT visits, and other evaluation and management codes not previously covered. The expansion of services are applicable only during the federal PHE.

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

See section IV, *Grievances, Appeals & State Fair Hearings*, above.

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

See sections XVIII.L, *Summary of Outcomes of On-Site Reviews* and XVIII.M, *Summary of Performance Improvement Projects (PIPs) Conducted by the State & Outcomes Associated with the Interventions*.

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 is an on-going corrective action plan with a provider, which is continuing due to the PHE.

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.

For details, see section XI, *Outreach and Innovative Activities* above.

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. LTSS continued to be provided without interruption, and reassessments were extended by 6 months due to the PHE.

XX. Other

Final Rules

In continuous compliance of MCO Final Rules, Hawaii incorporated required provision in QUEST Integration Supplemental Changes #11 and the capitation rate for calendar year 2019. CMS approved on August 19, 2019. During the reporting period, MQD continued to work with CMS on the QI RFP Supplemental Changes #12 which includes more MCO Final Rules provisions and capitation rate for January to June 2020. CMS approved Supplemental Changes #12.

HOKU (Hawaii Online Kahu Utility)

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 FFY 2018 quarter three, and we received approval of this vendor contract in FFY 2019 quarter one. The Internal Verification & Validation (IVV) vendor was selected in FFY 2018 quarter four, to monitor the PMSU project. The initial go-live date of August 26, 2019 was postponed until March 2, 2020, to account for unforeseen complexities in business rules development and software coding and implementation. The go-live date was then postponed to April 13, 2020 to ensure thorough testing of the system. As we approached April 13, MQD and AHCCCS decided to postpone the go-live date due to the COVID-19 public health emergency (PHE). The official go-live date was August 3, 2020.

MQD named the PMSU project, Hawaii's Online Kahu Utility (HOKU). Hoku, in Hawaiian means guiding star. Kahu, in Hawaiian means caretaker or pastor, one who looks after their flock. Med-QUEST providers are caretakers looking after and taking care of members.

MQD communicated memos QI-2006, QI-2006A and QI-2006B to the MCOs and providers that included information and updates on the go-live date, registration rollout in HOKU by waves, information about training materials and schedule and what an Application ID is.

MQD issued a request for proposal in 2019 to secure a vendor for our Provider Enrollment and Revalidation contract. MQD awarded the contract to Koan, with an effective contract date of January 1, 2020. With the Provider Enrollment and Revalidation contract, Koan is responsible with managing MQD's provider hotline, imaging (scanning) provider applications and assisting with screening and inputting provider enrollment and revalidation applications into the previous mainframe enrollment system, HPMMIS. Now that HOKU is live, Koan staff have been assisting with reviewing provider enrollment applications in HOKU and addressing provider questions related to enrollment and revalidation.

MQD hired a tech writer in Q1 of FFY 2020, however, that contractor resigned end of January 2020. MQD was then able to hire a new tech writer in June 2020 to continue the previous tech writer's work. The new tech writer worked on the provider training videos that will be available on MQD's HOKU webpage. There are training videos for each HOKU enrollment type (Group Biller, Individual Provider, Atypical Provider, Facility/Agency/Organization and Atypical Agency).

Due to the PHE, MQD faced a challenge where our provider enrollment applications were paper based only and majority of our staff began tele-working. Our clerical staff worked hard to scan our paper applications to a SharePoint site so that MQD and Koan staff could access them from home. MQD and Koan prioritized applications by working on new providers first. The reasoning for this is so that a provider ID number will be generated for new providers and they will be able to convert to the HOKU system and continue their re-registration.

MQD is continued to work in partnership with AHCCCS to identify and clean-up any conversion errors the defects that are detected in the system. MQD and AHCCCS met daily with CNSI to discuss and fix the system's defects. A goal for MQD and AHCCCS was to have very little to none priority 1 defects found.

As MQD approached Q4, we continued our efforts to process new paper applications, continued to work on HOKU conversion error clean-ups and prepare for HOKU's new launch date of August 3rd. MQD will worked on provider communications and updated the website. In preparation of the new launch date, MQD will hosted HOKU refresher courses for provider training session trainers (MCO staff) and MQD/Koan internal staff.

New Hawaii Medicaid providers were able to access once the system went live. The first two weeks were dedicated to our Wave 0 group, these were two organizations that we could work with directly as they inputted applications and we could identify any issues or recommended changes to HOKU. On August 17th, Wave 1 providers were able to access HOKU, which are our Group Billers. On September 14th, Wave 2 providers were able to access HOKU, which were all of our individual providers excluding MDs (Physicians).

The break-down for each wave, is the following.

HOKU Go-Live	
Wave 0	Hawaii Pacific Health and Kaiser Permanente Medical Group
Wave 1	Group billers (PT-01)
Wave 2	All individuals, excluding MDs (PT-C1, 27, 62, 51, BC, 34, 86, 09, 12, 16, 50, 07, D1, D2, D3, 31, 24, 21, 75, 48, 13, 69, 14, 18, 10, 11, 47, 19, 15)

In the first few months of HOKU's launch, MQD had a slow start on applications that were submitted by providers. However, as the applications began to roll in, we began to work on our process to review applications. We've also encounter issues along the way and worked with CNSI to log/track and resolve them. HI and AHCCCS met with CNSI daily to discuss our status and go over questions and issues.

Electronic Visit Verification (EVV)

In accordance with the 21st Century Cures Act, Med-QUEST Division (MQD) prepared to execute an Electronic Visit Verification (EVV) soft launch in early October. In the federal fiscal year (FFY) 2020, development, configuration, implementation, training and support of EVV was accomplished with the assistance of a statewide EVV vendor. MQD submitted the Good Faith Letter to CMS and received approval for implementation for the calendar year 2020.

FFY2020 continued with EVV requirements gathering, aligning EVV design with State policy, EVV systems and user interface development and configuration, and developing the training program with a statewide EVV vendor, as well as conducting statewide information forums throughout Hawai'i. Throughout FFY2020, MQD communicated progress to stakeholders via several modes of communication including email, face-to-face meetings, virtual meetings, virtual town halls, and EVV webpage updates.

MQD's future work will include, regular communications with stakeholders, working with the IV&V vendor, and working with the EVV vendor towards solution implementation and support.

FFY2020 summary:

In October, demonstrated the EVV solution to over 150 representatives from the Health Plans and Provider agencies. Reviewed the proposed HCPCS table for EVV services with the MCOs. Completed the Business Rules Workbook review with the EVV vendor. Many questions were raised because of the review. Three-quarters of the questions were addressed by the end of October. EVV vendor held the Outreach and Training Kick-off meeting for MQD and established reoccurring meetings to build the communications plan. Reviewed the EVV vendor device proposal with AHCCCS to ensure deliverable alignment.

In November, started engaging with the shared resources in Arizona to discuss the pre-payment visit validation and for data extraction. The EVV vendor held the Support Workstream kick-off to initiate the reoccurring meetings. Completed the MQD EVV Business Rules Workbook. Submitted the CMS Good Faith Effort request. The EVV vendor delivered final Technical Specification documents for MQD review. Delivered EVV content for Health Plans to include in their member quarterly newsletters.

In December, released the MQD EVV HCPCS service codes and modifiers memo and table to the Health Plans and providers. Hosted meetings with the MCOs, Provider Agencies, and DDD to review the HCPCS memo in early December. Reviewed CMS KPIs (key performance indicators) deliverables with the IV&V vendor. Attended multiple Technical Specification documentation reviews with the EVV Vendor.

In January, during the month of January 2020, the AZ and HI EVV Project Teams continued to focus on finalizing the Technical Specifications, participating in focused workstreams that address training, outreach, support, device management, and certification. Additionally, the team finalized the update to the Change Management Plan and facilitated their first Change Advisory Board (CAB). One of the critical tasks addressed in January was working towards an Integrated Master Schedule that includes Sandata, Arizona, Hawaii, ISD Development and Testing tasks. The team worked to refine and sync the schedules between the states and Sandata to ensure all of the dependencies are coordinated and the goal is to baseline the schedule in February. Weekly Technical Review meetings were held with the MCOs and EVV vendor to ensure a smooth implementation. The Provider, Member, Authorization, Claims Validation, Alt EVV, OpenEVV-EVV, Data Warehouse Export, and Plan of Care EVV Technical

Specifications documents were approved. The EVV Training Plan was reviewed and approved with the EVV vendor.

In February, during the month of February 2020, the EVV Project Teams focused on participating in focused workstreams that address training, outreach, support, device management, and certification. A critical task that the teams continue to focus on is updating an Integrated Master Schedule (IMS) that includes both the Sandata and States tasks. Med-QUEST continued to actively work with health plans/MCOs and other key stakeholders to provide updates on the project and provide technical insights as appropriate. Held final review of the Master Test Plan in preparation for approval. Continued engagement with the shared resources in Arizona to design the pre-payment visit validation and for data extraction.

In March, the EVV Project Team was actively involved in the Sandata Workstreams and reviewing applicable documentation from each workstream team. The current workstreams include Training, Outreach, Support, Device Management, Testing, and Certification. Med-QUEST continued to actively work with health plans/MCOs and other key stakeholders to provide updates on the project and provide technical insights as appropriate. Finalized the EVV Device Guide document that will be distributed in the EVV Welcome Kit to Provider Agencies and Self-Directed Members. Incorporated final feedback into the Project Management Plan for review and approval.

In April, During the month of April 2020, the AZ and HI EVV Project Teams baselined the project schedule, participated in focused workstreams that address training, outreach, support, device management, and certification. The baselined project schedule includes the Sandata, Arizona, Hawaii, ISD Development and Testing tasks. The baselined project schedule adjusted the systems Go-Live from June to October with mandatory EVV use on December 30th, 2020. Received and reviewed the User Acceptance Test Cases from Sandata in preparation for testing. Completed the Staging Testing for the Provider and Member file formats & structure. Aligning with the Open Model approach, Alternate EVV vendor outreach materials were distributed to provider agencies and 3rd party vendors. Weekly Technical Review meetings were held with the MCOs and EVV vendor to ensure a smooth implementation.

In May, during the month of May 2020, the EVV Project Teams focused on participating in focused workstreams that address training, outreach, support, device management, and certification. Systems Integration Test cases given to HI MCOs in preparation for testing with Sandata. Addressed many inquiries by the MCOs regarding the SIT/UAT testing approach. MCOs continued to progress with Authorization file testing with Sandata. Meetings were hosted with the MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV baseline. Med-QUEST continued to actively work with health plans/MCOs and other key stakeholders to provide updates on the project and provide technical insights as appropriate.

In June, the EVV Project Team was actively involved in the Sandata Workstreams and reviewing applicable documentation from each workstream team. The current workstreams include Training, Outreach, Support, Device Management, Testing, and Certification. Med-QUEST continued to actively work with health plans/MCOs and other key stakeholders to provide updates on the project and provide technical insights as appropriate. 100% of User Acceptance Test Cases were executed for Hawaii. 97% test cases passed with the remaining pending fixes from Sandata. Cycle 2 of User Acceptance Test was scheduled for August to address the testing of the outstanding issues. Most of the health plan test cases were completed with Sandata in June.

In July, during the month of July 2020, the AZ and HI EVV Project Teams continued to work the project schedule, participated in focused workstreams that address training, outreach, support, device management, and certification. Demonstrated the EVV system to the provider agencies and MCOs. Meetings were hosted with the

MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV timeline and project. Confirmed and approved the change in training approach from face-to-face to virtual due to COVID-19. The MCOs completed the authorization test cases with Sandata. Aligning with the Open Model approach, Alternate EVV vendor testing with Sandata began.

In August, during the month of August 2020, the EVV Project Teams focused on participating in focused workstreams that address training, outreach, support, device management, and certification.
Meetings were hosted with the MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV project. Coordinated and developed a standardized provider EVV communication with the MCOs that was sent to the EVV providers. Collaborated with the MCOs to align provider contract renewals with the mandated EVV service codes and modifiers. Finalized and approved the EVV training schedule. Met with the provider agencies to review the training schedule, authorization cutover and 3rd party EVV vendor requirements.

In September, hosted two virtual EVV town hall meetings open to the public. Med-QUEST completed the Provider and Member file uploads into the EVV system. The MCOs completed the authorization file uploads into the EVV system. MCO claims validation testing began that compares a claim from a provider agency against the EVV database. 100% of the UAT test cases passed and the UAT approval was granted. Prepared the evidence packets for the Operational Readiness Review with CMS/MITRE. Identified and mitigated a catastrophic service code mapping error through execution of extensive end-to-end testing.

Clinical Care Guidelines

The COVID-19 pandemic and resulting public health emergency (PHE) declared by the Department of Health and Human Services influenced much of the work for the Division during the 2020 FFY.

Telehealth utilization was encouraged through the issuance of multiple provider memoranda. Through the memos, guidance on the provision of services and coverage of allowable codes during the PHE have been issued. The provision of services through the use of telehealth modalities will continue into the new year and beyond. The health plans have begun to look at how they can continue to provide support to their providers and members to use telehealth to expand access to care for children, individuals living in remote areas, and elderly.

The pandemic also highlighted the need to further support Medicaid recipients, who are a nursing facility level of care, but residing and receiving home and community-based services. Planning and collaboration ensured that the recipients and their caregivers receiving special support with personal protective equipment that included distribution and support on the proper use and infection precautions. Special attention was also given to the care of residents in the residential group home who became infected with SARS-CoV-2.

Another effort by the Division included working with the long term care and Hawaii hospital association to engage stakeholders to update the criteria for the sub-acute level of care to address hospital waitlist issues and adjusting criteria to aid in the transfer of patients occupying acute care beds but at a lower level of care. This adjustment helps to open up acute care beds to address potential surges in cases of SARS CoV-2 patients needing inpatient care and to ensure recipients receive care at the appropriate setting.

XXI. MQD Contact

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