

Hawaii QUEST Integration

1115 Waiver

Quarterly CMS Monitoring Report

Federal Fiscal Year 2023 2nd Quarter (DY29 Q2)

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	Demonstration Year:	29th Year (10/1/22 – 9/30/23)
		<p>This reporting period includes the:</p> <ul style="list-style-type: none"> • last month of 2nd Q. DY 29; and the • 1st & 2nd months of 3rd Q. DY 29 <p>when applying a DY of August 1st – July 31st.</p>

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Attachments

Attachment A: Up-To-Date Budget Neutrality Summary

The Budget Neutrality Summary (worksheet) for the quarter ending 12/31/2022 is attached. The Budget Neutrality Summary for the quarter ending 3/31/2023 will be submitted by the 5/31/2023 deadline.

Attachment B: Budget Neutrality Workbook

The Budget Neutrality Workbook for the quarter ending 12/31/2022 is attached. The Budget Neutrality Workbook for the quarter ending 3/31/2023 will be submitted by the 5/31/2023 deadline.

Attachment C: Schedule C

Schedule C for the quarter ending 3/31/2023 is attached. Schedule C includes a summary of expenditures for the reporting period.

I. Introduction

Hawaii's QUEST Integration (QI) program is a state of Hawaii (State) Department of Human Services (DHS) and Med-QUEST Division (MQD) comprehensive section 1115(a) Demonstration waiver (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.

Med-QUEST Division continues to focus on a comprehensive health care delivery system transformation, called the HOPE Initiative. "HOPE" stands for Hawaii-Medicaid Ohana-Nui Project Expansion. The goal of the initiative is to achieve the Triple Aim of better health, better care, and sustainable costs for our community using a whole person, whole Family and whole community approach to health and well-being. Med-QUEST Division 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 a continued sustainable growth rate in healthcare spending from reductions in unnecessary care and shifts of care to appropriate settings. Med-QUEST Division also focuses on the integration of behavioral health and health-related social risk factors taking a whole-person health approach.

HOPE Strategies:

- Invest in primary care, prevention, and health promotion
- Improve outcomes for high-need, high-cost individuals
- Payment reform and financial alignment
- Support community driven initiatives

The current QI contracts are held by five health plans. Those five health plans are AlohaCare, Hawaii Medical Service Association (HMSA), Kaiser Permanente, Ohana Health Plan, and UnitedHealthcare Community Plan (collectively, Health Plans). Med-QUEST Division works closely with the Health Plans to facilitate contract implementation and improve healthcare access and services to members.

During this quarter, MQD and the Health Plans ramped up preparations for the Public Health Emergency (PHE) end and unwinding activities. In particular, MQD launched its communication campaign which included ads in movie theaters across the State. Med-QUEST Division also mailed to all Medicaid beneficiaries, a letter informing them of their eligibility redetermination date and notifying them to watch for the arrival of a pink envelope in the mail that will contain the eligibility review form. More on this topic is provided below in section A.3 *Outreach*.

II. Operational Updates

A. Key Achievements and Challenges Related to the 1115 Waiver

1. Managed Care

Health Plan Reporting

During this quarter, MQD continued to work with the Health Plans to improve report quality and data submission.

Health Plans continued to submit newly designed reports as part of the QI contract. Health Plans have submitted nearly all remaining reports with the last one submitted on 10/31/2022. Embedded in these reports is a framework to consolidate reporting information into specific focus areas and to analyze performance based on Key Performance Indicators (KPIs) which will be reported in the Performance Metrics section of this 1115 quarterly report once data quality is adequate. Additional strategies for improving data quality have been developed including report templates with built in quality assurance flags that alert Health Plans of inappropriate or misformatted data. Report tools for these reports have been updated based on feedback from the Health Plans, and such updates are incorporated into the Health Plan Manual. Med-QUEST Division is looking at ways to streamline reporting and reduce administrative burden on Health Plans and MQD staff. These include combined data files and working toward more automated reporting.

Dual Eligible Special Needs Plans (D-SNPs)

During this quarter, MQD and its consultants ATI Advisory and Speire Healthcare Strategies, LLC (collectively, Consultants), met regularly with members of the Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO) and its partnering organizations, to discuss details, processes, and options surrounding MQD's new policy considerations for 2024. Such policy considerations included, but were not limited to, integrated member materials, unified grievances and appeals, alignment of D-SNP Health Risk Assessment (HRA) with MQD's QI Health and Functional Assessment (HFA), exclusively aligned enrollment, and default enrollment. Medicare Advantage Organization (MAO) review, feedback, and meetings were also included in the process to fine tune such policies and related requirements.

Regarding integrated member materials, MQD and Consultants worked with CMS to produce templates for an integrated provider and pharmacy directory, and an integrated formulary. The Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) will use these to present its provider and pharmacy networks, and its formularies, in a single document (one for the combined provider and pharmacy directory, and another for the integrated formulary) for its members, that compiles and organizes detailed information across the FIDE-SNP's Medicare and Medicaid programs, in one convenient place. MAOs were given the opportunity to review these templates and to provide feedback, which was taken into consideration before the final versions were set.

Regarding Unified Grievances and Appeals (UGA), MMCO representatives and CMS subject matter experts assisted MQD and Consultants on matters pertaining to the optional UGA forms and the UGA process. The optional UGA forms include the *Letter about Member Right to Make a Fast Complaint*, and the *Appeal Decision Letter*. Beginning the calendar year 2024, FIDE-SNPs will be required under Hawaii's 2024 State Medicaid Agency Contract (SMAC), to use those optional CMS UGA forms in addition to the CMS-required *Coverage Decision Letter*. The intent is to simplify and standardize UGA member communications and processes at the plan level. Whether the issue is Medicare or Medicaid coverage, the member need only file member's claim through a single integrated process at the plan level.

In the area of default enrollment, MQD and Consultants finalized language to update existing approved MAO default enrollment process applications with CMS. These updates reflect the process changes to occur beginning November 2023, that MAOs will use to identify MAGI-excepted individuals eligible for default enrollment. Default enrollment has been running smoothly by all 5 MAOs through calendar year 2022. A preliminary review of 2022 default enrollment data indicate that 96% of individuals default enrolled into a D-SNP of the individual's QI health plan, remained enrolled in such, 90 days post default enrollment. This is a success, as it appears some indication of member satisfaction and it runs in harmony with expectations that aligned enrollment into a plan that provides both an individual's Medicare and Medicaid services under one roof, is positive, beneficial, and consumer friendly. This also made it more evident and important to invest time in the State's exclusively aligned enrollment policy.

The largest lift during this period, involved work on the State's exclusively aligned enrollment (EAE) policy. MQD and Consultants met with CMS to comb through numerous and detailed enrollment and disenrollment scenarios to map and provide guidance for Hawaii FIDE-SNP implementation and operationalization of EAE. The Consultants were key to this success and

worked tirelessly to comprehensively and clearly spell out, organize, and document about 20 different EAE scenarios. These scenarios described actions for each of the following parties involved: Beneficiary; FIDE-SNP; CMS; State; and QI Plan. The information was shared with the MAOs for feedback, and one-on-one meetings with the MAOs were scheduled for the next quarter.

All of the above work is helping to prepare MQD and Consultants for the next quarter's focus on the 2024 SMAC.

2. Home and Community Based Services (HCBS) and Personal Care

The completion of phase one of the Home and Community Based Services (HCBS) rate study was documented through the rate study report delivered by Milliman to MQD on December 30, 2022, and a closing all-stakeholder meeting to communicate these findings was held on February 14, 2023. These two events officially ended phase one of the HCBS rate study.

Building on the rate study for HCBS that was completed on December 31, 2022, the phase two HCBS rate study commenced on March 8, 2023. Phase two is a study of HCBS rates paid for Adult Day Care (ADC), Adult Day Health (ADH), Assisted Living Facilities (ALF), home delivered meals, respite care and in-home services, Level 3 Residential Services provided by Community Care Foster Family Homes (CCFFHs) and Expanded – Adult Residential Care Homes (E-ARCHs), and Level 3 Community Case Management Agency (CCMA) services. The phase two rate study is being done by Milliman, an actuarial firm contracted with MQD for a wide range of actuarial consulting services.

A unique element of phase two is the study of Level 3 residential and CCMA services. Part of this approach will be to standardize Level 3 criteria that is based on current Level 1 and Level 2 criteria. The different levels are factored by the level of assistance needed for the member to perform activities of daily living (ADLs) and/or behaviors that require increased supervision or (re)direction to maintain their safety. The levels are progressive and meet Nursing Facility (NF) level of care, with Level 3 requiring the highest level of care.

Through stakeholder engagement, there will be opportunities to collaborate on strategies to better address the needs of members, identify resources, and facilitate their transition of care more efficiently and appropriately. One strategy is to identify and contract with a community partner(s) that can provide a robust curriculum and training to enhance the skills of residential providers and CCMA's. Additionally, reinforcing provider awareness and accessibility of existing community resources will help provide ongoing supports for both the member and the providers.

3. Other

Member Outreach

Multiple outreach sessions were held with Kokua (community-based organizations providing enrollment and eligibility outreach), provider groups, community organizations, and community health centers to discuss the upcoming restart of the renewal process. Additionally, MQD worked very closely with the Health Plans to develop new processes and reporting tools that will enable the Health Plans to provide better, more targeted outreach to their members.

A media campaign called “Stay Well Stay Covered” was launched in movie theaters, with community-based organizations, QI Health Plans, legislators, and other related entities and parties. Key messages of the media campaign are to update contact information, to be on the lookout for a pink envelope and pink letter in the mail that will have important renewal information, and to know that this renewal activity will begin in April for the upcoming year. As part of this campaign, in March MQD mailed an updated member handbook and a letter to each member household informing them about the restart of renewals and assigned renewal dates. A Stay Well Stay Covered toolkit is available on the MQD website. Toolkit information has been translated into 20 languages.

Data Quality Strategy

This quarter MQD began working with Health Plans to identify gaps in encounter data completeness as a representation of all services our members receive. For example, the Health Plans do not currently submit encounters for any services Health Plan staff render directly to members, including care coordination or housing counseling. In this quarter MQD developed a framework for Health Plans to submit these services as encounters starting in late 2023. Med-QUEST Division will continue to issue guidance for encounter data submission for other services that are not currently “encountered” in coming quarters.

B. Issues or Complaints Identified by Beneficiaries

No new issues or complaints have stood out during this quarter.

C. Audits, Investigations, Lawsuits, or Legal Actions

Audits and Investigations

1. Allergy preparation without injections (Healthcare Fraud Prevention Partnership study)
2. Lab billing of presumptive and confirmatory drug screens
3. Sleep center and Durable Medical Equipment (DME) billing of Continuous Positive Airway Pressure (CPAP) machines
4. Podiatry provider various coding and documentation deficiencies

Lawsuits and Legal Actions

Administrative Hearings:

Waianae Coast Comprehensive Health Center (WCCHC) v. DHS. WCCHC is a federally qualified health center and receives reimbursement under the Prospective Payment System (PPS) of reimbursement created under Hawaii Revised Statutes §§346-53.62, et seq. In February 2019, WCCHC requested a rate change for its medical PPS and dental PPS rates.

MQD ultimately denied the request for a rate change for the dental PPS rate because the services actually began in 2010 and WCCHC did not provide documentation to support the change in an increased type, intensity, duration, or amount of services for the 2019 year.

As for the medical PPS rate change request, after extensive discussion, requests for data, and review of their data, MQD issued a projected adjusted medical PPS rate in September 2019. MQD then provided payments on that projected adjusted medical PPS rate, requested data, and reviewed data until a final adjusted PPS rate was determined in November 2020. MQD provided final settlements based on the final medical PPS rate. All required notices were sent by certified mail in compliance with Hawaii Administrative Rules.

Years after these decisions, around October 2022, WCCHC requested an administrative hearing to contest the final settlement for 2019 (notice dated September 10, 2021), final adjusted medical PPS rate (notice dated November 19, 2020), the denial of the request for a dental PPS rate change (notice dated November 19, 2020), and check payments that were provided to WCCHC checks (dated December 18, 2020). MQD moved to dismiss the hearing for failure to timely request an administrative hearing pursuant to Hawaii Administrative Rule (HAR) §§17-1736-58 and 59. These rules required WCCHC to request an administrative hearing 90 days after the decisions were issued and limit its right to a hearing when the request is not timely made. The Hearing Officer granted MQD's motion to dismiss. On February 22, 2023, the Order granting MQD's motion was issued. On March 20, 2023, WCCHC requested review by the Department of Human Services Director Cathy Betts. On March 23, 2023, WCCHC appealed the decision to the Circuit Court.

Bekkum v. DHS. Curtis Bekkum, M.D. appeals MQD's decision to terminate him based on a criminal complaint and conviction of sexual assault, which occurred in his provision of medical services to a patient. Bekkum is represented by counsel. Bekkum moved to delay the administrative proceedings until his appeal to the Intermediate Court of Appeals was complete. MQD submitted arguments in opposition. The Hearing Officer denied Bekkum's motion and set the hearing for April 2023. Bekkum then filed motions to compel the DHS' Adult Protective Services (APS) to produce documents, which APS objected due to Bekkum's lack of legal authority and because the return for the subpoena was the date of the April hearing, which had not passed. Bekkum ultimately withdrew the motion. Bekkum then brought a motion to dismiss for lack of jurisdiction, which was denied on a procedural basis. The administrative hearing is set for May 2023.

LaPorte v. DHS. On January 12, 2023, MQD suspended Medicaid payments to Bryant LaPorte, DDS, based on credible allegations of fraud as follows: (1) billing for services not rendered, including x-rays, and (2) billing services not medically necessary, including oral evaluations and palliative emergency treatment. Dr. LaPorte requested for an administrative hearing after receiving the Notice of Suspension of Medicaid Payments dated January 18, 2023. The hearing is scheduled for April 26, 2023.

Hawaii Courts:

Soleil Feinberg v. Cathy Betts, et al. This is a federal district court challenge alleging a failure to provide adequate treatment, as required by EPSDT, to a young adult. The allegation is that the failure to provide adequate treatment led to the young person's eventual criminal case and her placement in the Hawaii State Hospital because their mental impairment makes unable to stand trial in the criminal case. The cross motions for summary judgment were denied on May 6, 2022. The Case is set for bench trial in April 2023.

Waianae Coast Comprehensive Health Center (WCCHC) v. State of Hawaii, DHS. WCCHC appeals the order by the administrative hearing officer granting DHS' motion to dismiss for failure to timely request a hearing. The record on appeal is being compiled and will be filed. No briefs have been filed yet.

9th Circuit of Appeals:

HRDC v. Kishimoto. This was a challenge to the State of Hawaii's provision of Medicaid funded Applied Behavioral Analysis (ABA) therapy for children on the autism spectrum attending public schools. The State of Hawaii won a Motion for Summary Judgment in the federal district court on August 31, 2022 and the Plaintiffs appealed to the 9th Circuit Court of Appeals on September 30, 2022. The case remains on appeal to the 9th circuit. The due date for HRDC's opening brief was March 30, 2023.

D. Unusual or Unanticipated Trends

There were no unusual or unanticipated trends impacting the Demonstration this quarter other than the continuation of the continuous coverage requirements leading to an over 42% increase in Medicaid beneficiaries covered since March 2020.

E. Legislative Updates

The 2023 legislative session began mid-January 2023. At the start of the legislative session, there were over 100 bills that MQD was tracking, although many did not receive a hearing by the required deadlines. While there are a wide variety of subject matters, a few themes are increasing rates for various providers, including home and community-based providers, for physician/professional fees, behavioral health services, applied behavioral analysis services as well as the "sustainability" or provider fee bills that outline how the nursing facility and hospital provider fee program will operate. Several bills seek to clarify Hawaii's telehealth law in relation to audio-only care once the federal PHE expires. Hawaii's legislative session ended the first week of May 2023.

F. Descriptions of any Public Forums Held

1. Public Forum for Section 1115 Demonstration Project

Hawaii held one MQD Healthcare Advisory Committee (MHAC) meeting during this reporting period on February 15, 2023. Public comments and questions were received from the meeting and summarized below.

MHAC meeting, February 15, 2023

Med-QUEST Division presented information and updates on the Restart of Renewals & Member Communications (related to the Consolidated Appropriations Act of 2023 passed by Congress and signed by President Biden on December 29, 2022, which restarts Medicaid eligibility renewals),

Advancing Medicare and Medicaid Integration, Adult Dental, Social Determinant Transformation Plan, and the State Plan Amendments. Comments and questions were received by both the MHAC members and the public regarding in certain areas as discussed below.

For the Restart of Renewals & Member Communications, an Advisory Committee member commented that they are excited about what MQD is doing in this area and wanted to know if it was consistent with how other states are handling this matter. MQD explained that we are using the tool kit that was assembled to address these issues for our state and it contains all the information needed to be consistent for how MQD is managing the renewals.

A member of the public asked if the meeting is recorded so she can watch the beginning of the presentation later as she was late to the meeting. MQD confirmed that the recording of the MHAC meeting will be on MQD website under the “About” section for her to view.

For the Adult Dental update, an Advisory Committee member asked what services will be covered under the Adult Dental program and how will the services be implemented. MQD explained that the adult dental services are based on medical necessity, the dental provider will make this decision if the service is needed and the service request will be submitted to the prior authorization process as needed.

For the Advancing Medicare and Medicaid update a member of the public asked for clarification on whether a member can choose a different health plan for the both the Medicare and Medicaid plan. MQD confirmed that this is an option, however MQD strongly urges that the member be in an aligned plan. The same member of the public had questions and issues with her son’s Medicare coverage. MQD explained that we do not have oversight over the Medicare benefits. However, if she has any questions regarding the Medicaid benefit, she can contact the Medicaid office and directed her to the MQD website for the contact information.

For the State Plan Amendments (SPAs) update a member of the public asked that when MQD meets with CMS for SPAs if Medicare is included. MQD confirmed that the CMS team MQD meets with is only for Medicaid and CHIP issues not Medicare issues. The same member of the public asked if the EPSDT benefit is covered under private insurance and MQD clarified that EPSDT is only covered by Medicaid.

III. Enrollment and Disenrollment

A. Member Choice of Health Plan

January 2023 – March 2023	# of Members
Individuals who chose a health plan when they became eligible	2,888
Individuals who were auto-assigned when they became eligible	3,859
Individuals who changed health plan after being auto-assigned	1,252
Individuals in the ABD program that changed health plan within days 61 to 90 after confirmation notice was issued	8

IV. Performance Metrics

A. Impact of the Demonstration

1. Providing Insurance Coverage to Beneficiaries and the Uninsured Population

Total enrollment as of 3/27/2023: 468,233

2. Outcomes of Care, Quality of Care, Cost of Care, and Access to Care

There is no reporting on the above for this quarter.

B. Results of Beneficiary Satisfaction Surveys (if conducted)

N/A

C. Results of Grievances and Appeals (from Health Plans)

Type	Total	Timely Resolved* # (%)	Resolved in Favor of Beneficiaries** # (%)
Grievances	428	419 (99.2%)	24 (23.5%)*
Appeals	314	212 (97.2%)	51 (23.4%)

*Timely is defined as within 30 days for standard grievances and appeals, within 14 days for expedited appeals, and within the approved extension time period for grievances and appeals with approved extensions. Denominator excludes grievances and appeals received within 30 days of the end of the reporting period with no resolution (or 3 days for expedited appeals).

**Denominator excludes appeals for which no decision has been made.

***This quarter only one Health Plan provided this data.

V. Budget Neutrality and Financial Reporting Requirements

A. Financial Performance of the Demonstration

For the quarter ending 12/31/2022, Hawaii has continued to accrue budget neutrality savings, which is shown in the Budget Neutrality Summary attached to this report. In addition, the Hypothetical Expansion eligibility category has continued to accrue budget neutrality savings. The Demonstration continues to project budget neutrality savings in future years.

B. Updated Budget Neutrality Workbook

The Budget Neutrality Workbook for the quarter ending 3/31/2023 will be submitted by the 5/31/2023 deadline. The Budget Neutrality Workbook for the quarter ending 12/31/2023 is attached (Attachment B).

C. Quarterly and Annual Expenditures

Expenditures for the quarter ending 3/31/2023 were reported on the CMS-64 and certified on 4/28/2023. A summary of expenditures is shown on the attached Schedule C for the quarter ending 3/31/2023.

D. Administrative Costs

Despite continued record highs in enrollment, there have not been significant increases in Hawaii's administrative costs for the quarter ending 3/31/2023. Cumulative administrative expenditures can be found on the attached Schedule C.

VI. Evaluation Activities and Interim Findings

A. Current Results of the Demonstration per the Evaluation Hypotheses

See B.3 for results and findings.

B. Progress Summary of Evaluation Activities

1. Key Milestones Accomplished

- Med-QUEST Division released a new reporting package which will assist with monitoring evaluation goals for the 1115 waiver. Health Plans submitted another round of Community Integration Services (CIS), Long-Term Services and Supports (LTSS), Special Health Care Needs, Value-Driven Health Care, and Primary Care reports with data quality improving compared to previous quarters. However, MQD and the University of Hawaii (UH) Evaluation team are still providing targeted technical assistance and engaging with the Health Plans to improve data quality across all reports.
- The UH Evaluation Team held a Rapid Cycle Assessment presentation for Health Plans, providers, and MQD on 2022 Q4 on February 24, 2023. A corresponding report was submitted to MQD. The team also submitted feedback on individual Health Plan reports using the Review Tool.

2. Challenges Encountered and How They Were Addressed

- Acceptable data quality of the reports still remains a challenge. Med-QUEST Division and the UH Evaluation Team are continuing to meet with Health Plans at a greater frequency to better understand how the Health Plans are pulling this information and assisting the Health Plans with mapping the right data to specific fields in the report. Med-QUEST Division developed an aggressive schedule and strategy to ensure that the reports will be submitted with acceptable data quality standards in the near future. MQD expects that several reports including the value driven healthcare report, health disparities, and primary care plan to be of sufficient data quality starting Q2 of 2023.

- In lieu of MQD reports, MQD and UH are working with Health Plans to extract information out of their care coordination reports for analysis over the demonstration period.

3. Interim Findings (when available)

Subject	Successes in Implementation	Barriers in implementation
CIS	<ul style="list-style-type: none"> • Data quality continues to slowly improve. • MQD restructured its “Core Team” to discuss and launch a CIS 2.0 that responded to the challenges raised by the providers, HPs, and Evaluation Team. Daily meetings often include members of the Eval Team, local government, and other homelessness experts. • MQD restructured CIS payments <ul style="list-style-type: none"> ○ to pay for outreach services regardless of if member ends up consenting to compensate providers for time ○ Bundled payments to make billing easier 	<ul style="list-style-type: none"> • Challenges to enrolling members is largely due to provider capacity, limited affordable housing, and lack of coordination between HPs and providers.
LTSS	The analysis shows that the level of care (LOC) scores for LTSS members in the home setting are stable as they progress during the years in the program suggesting effectiveness of HCBS.	The analysis shows that the level of care (LOC) scores for LTSS in the nursing home or foster homes deteriorate over the years they stay in the program.
SHCN	Through individualized meetings and technical assistance, MQD and UH are now receiving health care services data extracts directly from HP care coordination system to help identify the breadth and depth of services provided to waiver target populations and other populations of members.	Unstandardized documentation across Health Plans makes it difficult to integrate data of all members and determine the impact of care coordination services for SHCN member
SDOH	Qualitative analyses were conducted on the Health Disparity reports submitted by Health Plans and preliminary results are shown below:	Shortage of Health Plans staff and community health workers to address SDOH and social needs

	<p>Health Plans identified racial/ethnic or geographical disparities on the utilization of several health service</p> <p>Health Plans conducted root cause analyses and found many drivers including but not limited to:</p> <ul style="list-style-type: none"> • lack of transportation • language barriers and health literacy skills • unstable housing and homelessness • unemployment or having to work multiple jobs or jobs with unreliable schedules, • differences in cultural health practices (belief, mistrust) • healthcare access and quality. <p>Support strategies and interventions implemented (or to be implemented) include:</p> <ul style="list-style-type: none"> • patient engagement and outreach • community engagement • improving health care coordination and access to health care, such as providing transportation or relieving travel burden and scheduling access to services outside of the regular weekday clinic hours. 	
Primary Care	<p>A key early success was development of first and second year report that provides a picture of primary care spend. This helps us get a better picture of the baseline spending</p> <p>Some of the Health Plan's strategy for increasing the percent spend on primary care have included:</p> <ul style="list-style-type: none"> • Increasing P4P incentives that reward patient engagement and PC visits • Changes to P4P measures that reward both correct coding and reducing gaps in coding • Increasing VBP arrangements that reward increasing patient engagement • Increasing the number of member outreach activities through telephonic, text, and face-to-face from their care navigation and care coordination staff that will increase PC visits and beneficial services 	Health Plans had challenges with reporting on primary care

	<ul style="list-style-type: none"> Utilizing vendors to assist in contacting and returning members back into the PCP s practice Regular member communication to keep PC services and benefits top of mind Directly addressing and assisting PCPs on the gaps in care Actively recruiting and hiring PCPs 	
VBP	<ul style="list-style-type: none"> Several VBC and APM initiatives were implemented at MCO and provider level respectively VBC arrangements were mostly aimed at primary care providers, FQHCs and CHCs. Independently, plans report positive results from implementation of VBC arrangements 	<ul style="list-style-type: none"> Many pilot arrangements make directly testing relationship between VBC / APM arrangements and system changes in quality of care at the state level difficult. UH Team is exploring case studies to demonstrate impact at facility and provider level.

4. Status of Contracts with Independent Evaluators (if applicable)

Contract with University of Hawaii Evaluation team has been extended into CY2023.

5. Status of Institutional Review Board Approval (if applicable)

N/A

6. Status of Study Participant Recruitment (if applicable)

N/A

7. Result or Impact of the Demonstration Programmatic Area Defined by CMS that is Unique to the Demonstration Design or Evaluation Hypotheses

Subject	Result or Impact
CIS	<ul style="list-style-type: none"> • CIS was implemented and demonstrates that Medicaid can develop innovative programs to address SDOH. <ul style="list-style-type: none"> ○ Two hundred fifty-five members were in pre-tenancy at some point during the waiver period and so far 33% (n=100) had transitioned to tenancy at exit. ○ Of those members who received tenancy services, the majority remained housed at exit. • The UH Evaluation Team is currently assessing ER visits, hospitalizations, and total cost of care data for CIS members. This analysis will be completed and available in the upcoming interim evaluation report. • The RCAs have proven to be an effective evaluation tool to assist MQD, Health Plans, and service providers with identifying successes and barriers in real time to allow for the development of solutions or shared lessons learned. The MQD Core Team continues to meet weekly with members of the State and City governments, housing service providers, and other housing experts to ensure integration with existing housing services.
LTSS	<ul style="list-style-type: none"> • The UH team is still analyzing data to identify impact of “At Risk” and LTSS populations.
SHCN	<ul style="list-style-type: none"> • The UH team is currently analyzing data extracts from Health Plans’ care coordination systems.
SDOH	<ul style="list-style-type: none"> • In the Social Determinants of Health (SDOH) work plan, Health Plans proposed or implemented quality activities focusing on reducing emergency room visits, improving maternal health, improving patients’ education, reducing isolation, and expanding alternative medicine practice. Other quality activities focusing on addressing COVID-19 recovery, homeless, and food insecurity. • At a higher level, Health Plans also proposed or implemented quality activities that aim to improve SDOH understanding and SDOH screening and documentation of SDOH data. • Few Health Plans have some plan on collaborating with other parties and utilizing measurement and progress during these quality activities.

PC	So far, Health Plans have some changes in primary care spending over time. report documents small changes in spending over time
VBP	<ul style="list-style-type: none"> • Impact of the implemented models is being evaluated • Current evaluation opens up avenues for new research questions for further investigation into implementation of VBC arrangements and APM by health plans. • Future investigation needs to include qualitative analyses of the implementation, barriers and facilitators and expansion of initiatives currently in place

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