

Hawaii QUEST Integration
1115 Waiver
Quarterly CMS Monitoring Report

Federal Fiscal Year (FFY) 2024 2nd Quarter
Demonstration Year (DY) 30 Q2

Date Submitted: May 25, 2024	Reporting Period: January 2024 – March 2024	
	Federal Fiscal Quarter:	2nd Quarter 2024
	State Fiscal Quarter:	3rd Quarter 2024
	Calendar Year Quarter:	1st Quarter 2024
	Demonstration Year:	30th Year (10/1/23 – 9/30/24)
		<p>This reporting period includes the:</p> <ul style="list-style-type: none"> • last month of 2nd Q. DY 30; and the • 1st & 2nd months of 3rd Q. DY 30 <p>when applying a DY of August 1st – July 31st.</p>

Table of Contents

I. Introduction 3

II. Operational Updates 4

 A. Key Achievements and Challenges Related to the 1115 Waiver 4

 1. Managed Care 4

 2. Home and Community Based Services (HCBS) and Personal Care 5

 3. Other 6

 B. Issues or Complaints Identified by Beneficiaries 6

C. Audits, Investigations, Lawsuits, and Legal Actions	7
D. Unusual or Unanticipated Trends	9
E. Legislative Updates	10
F. Descriptions of any Public Forums Held.....	10
III. Enrollment and Disenrollment.....	11
A. Member Choice of Health Plan.....	11
IV. Performance Metrics	11
A. Impact of the Demonstration	11
1. Providing Insurance Coverage to Beneficiaries and the Uninsured Population	11
2. Outcomes of Care, Quality of Care, Cost of Care, and Access to Care.....	12
B. Results of Beneficiary Satisfaction Surveys (if conducted)	12
C. Results of Grievances and Appeals (from Health Plans)	12
V. Budget Neutrality and Financial Reporting Requirements.....	12
A. Financial Performance of the Demonstration	12
B. Updated Budget Neutrality Workbook.....	12
C. Quarterly and Annual Expenditures.....	13
D. Administrative Costs.....	13
VI. Evaluation Activities and Interim Findings.....	13
A. Current Results of the Demonstration per the Evaluation Hypotheses	13
B. Progress Summary of Evaluation Activities	13
1. Key Milestones Accomplished.....	13
2. Challenges Encountered and How They Were Addressed.....	14
3. Interim Findings (when available).....	14
4. Status of Contracts with Independent Evaluators (if applicable)	16
5. Status of Institutional Review Board Approval (if applicable)	16
6. Status of Study Participant Recruitment (if applicable).....	16
7. Result or Impact of the Demonstration Programmatic Area Defined by CMS that is Unique to the Demonstration Design or Evaluation Hypotheses	16
VII. Med-QUEST Division Contact.....	18

Attachments

Attachment A: Up-To-Date Budget Neutrality Summary

The Budget Neutrality Summary (worksheet) for the quarter ending 12/31/2023 is attached. The Budget Neutrality Summary for the quarter ending 3/31/2024 will be submitted by the 5/31/2024 deadline.

Attachment B: Budget Neutrality Workbook

The Budget Neutrality Workbook for the quarter ending 12/31/2023 is attached. The Budget Neutrality Workbook for the quarter ending 3/31/2024 will be submitted by the 5/31/2024 deadline.

Attachment C: Schedule C

Schedule C for the quarter ending 3/31/2024 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 or Managed Care Organizations (MCOs)). Med-QUEST Division works closely with the Health Plans to facilitate contract implementation and improve healthcare access and services to members.

MQD continued the eligibility redetermination during this quarter and launched its automated telephonic campaign on February 16, 2024. The campaign aims to remind members to stay well and stay covered. Messages were sent prior to, and shortly following, member renewal dates.

The section 1115 Demonstration renewal application was submitted to CMS in January 2024, deemed complete by CMS by the February 1st deadline, and was put out for public comment by CMS from February 5th – March 6th, 2024. New items in the renewal include various health related social needs such as nutrition and housing supports, continuity of coverage, and integration of behavioral health. Negotiations are anticipated to start the next quarter.

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. 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 mis-formatted 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)

January 2024 marks a new beginning for Hawaii residents eligible for both Medicaid and Medicare. This is the first year that Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) are offered in the state. The three Medicare Advantage Organizations (MAOs) offering FIDE SNPs are AlohaCare, Kaiser, and Ohana. This accomplishment is the result of much planning, hard work, and collaboration for nearly 2 years of: various staff at MQD; its consultants, ATI Advisory and Speire Healthcare Strategies, LLC (collectively, Consultants); the Health Plans; contacts at the Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO); and other interested parties.

FIDE SNPs must meet organizational design and other integration requirements, intended to facilitate and elevate the partnership and coalescence of managing and delivering both a member's Medicare services and Medicaid services. The objective is a more positive, seamless, and integrated health care experience for individuals receiving both Medicare and Medicaid which in turn, supports better access to care and better health outcomes. For many individuals, Medicare and Medicaid services are provided by two completely different organizations. However, a key feature of Hawaii's 2024 FIDE SNPs is that they are required to have Exclusively Aligned Enrollment (EAE). In essence, this means that all enrollees in the FIDE SNP receive both their Medicare and Medicaid services under a single organization. Alternatively, membership in Hawaii's Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) may or may not be aligned under a single organization.

By the end of the first quarter, enrollment numbers from CMS were the following: D-SNP (HIDE SNP and FIDE SNP) membership = 36,029; HIDE SNP membership = 29,788; and FIDE SNP membership = 6,241. This indicates that for the first few months of operation, Hawaii's FIDE SNPs have acquired about 17% of the state's D-SNP membership. The hope is that this share continues to grow as the FIDE SNP program and policies develop.

Also, during this quarter MQD and Consultants worked through details for initial drafts of the 2025 State Medicaid Agency Contract (SMAC), continued discussions regarding the direction for Hawaii D-SNPs beyond 2025, began joint reviews and updates with CMS on 2025 integrated materials, and held one-on-one meetings with Health Plans preparing to stand up either an EAE FIDE SNP or EAE HIDE SNP in 2025. All such efforts helping movement toward increased integration of Medicare and Medicaid services for the state's dual eligible individuals.

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

HCBS Settings Rule

MQD's efforts to bring settings into compliance with the federal home and community-based services (HCBS) regulations found at 42 CFR §§441.301(c)(4)-(5) and 441.710(a)(1) is ongoing.

As of the end of this quarter, MQD has completed site visits to 154 providers on the island of Oahu, and 27 providers on the neighbor islands, including the island of Maui, which was devastated by wildfires in the town of Lahaina.

MQD continues to deliver technical assistance to ensure that all providers will achieve and maintain compliance through capacity building activities.

MQD is on-target to complete its revised Final Settings Rule CMS corrective action plan by the due date of July 1, 2024.

Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS®) Survey

Med-QUEST Division assesses the perceptions and experiences of members enrolled in the QUEST Integration (QI) health plans as part of its process for evaluating the quality of health care services provided to eligible adult members. The MQD contracted with Health Services Advisory Group, Inc. (HSAG) to administer and report the results of the Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services (HCBS CAHPS®) survey for members that received a qualifying HCBS service.

MQD is in the late stages of planning the next HCBS CAHPS® survey to be implemented in 2024.

Investment in Tools and Technology for Residential Alternative Providers

MQD received funding from the American Rescue Plan Act of 2021 (ARPA) to support HCBS residential provider capacity for technology. Activities to continue distribution of surface and laptop devices to residential providers state-wide continued during this quarter. The distribution of surface devices to date, has increased provider capacity to interact electronically with health plans and medical providers and supports members' receipt of virtual services (where applicable).

3. Other

Member Outreach

Mid-January marked the conclusion of the Federal Marketplace open enrollment. Thus, outreach efforts were more focused on assisting with the renewal activities, especially since this marked the restarting of all renewal activities that had been paused since September, 2023.

Data Quality Strategy

In late 2023 MQD kicked off its 2023-4 Encounter Data Validation (EDV) project which conducts a comparative analysis between the encounter data health plans submit to our MMIS system, HPMMIS, and the encounter data health plans report to our actuaries for various actuarial activities. This comparative analysis will identify differences in these two data sources at both the record level—whether encounters exist in both data sources or just one—and the field level to compare completeness and accuracy. Based on the findings of the EDV project, MQD will be opening Corrective Action Plans with each health plan to resolve uncovered discrepancies that impact the usability of HPMMIS encounter data for actuarial activities. Throughout the reporting period, MQD continued meeting with the EDV vendor. The findings will be available in April 2024.

B. Issues or Complaints Identified by Beneficiaries

No new issues or complaints were identified during this quarter.

C. Audits, Investigations, Lawsuits, and Legal Actions

Administrative Hearings

1. **Coastal Medical Supply v. DHS** – Audit of Coastal Medical Supply, a Medicaid Provider, conducted by Unified Program Integrity Contractor Qlarant, found overpayments for Continuous Positive Airway Pressure (CPAP) devices and supplies that were not medically necessary. DHS sent an overpayment notice to recover the \$647,648.00 overpayment. Coastal Medical Supply requested an administrative hearing on the overpayment. A scheduling conference is set for April 5, 2024.
2. **Kawasakis v. DHS** - The Kawasakis are appealing the denial of their applications for Medicaid long-term care benefits based on DHS' decision that the entire value of their irrevocable trust is available to them. The Trust currently contains the cash proceeds from the sale of the Kawasakis personal residence. The Kawasakis previously owned outright a life estate in an undivided one-ten thousandth of an interest in the property, with the Trust owning the remainder. The property was sold in May 2020 and the Kawasakis argued that the Trust reacquired its status as an irrevocable trust with no benefits to them after the life estate on a fractional interest was dissolved. The administrative hearing is scheduled for April 11, 2024.
3. **LaPorte v. DHS** – On January 12, 2023, DHS 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 two-day hearing was held on December 4 and 5, 2023. On February 23, 2024, the DHS Administrative Appeals Office issued a decision finding that the DHS correctly imposed a suspension of payments on Dr. LaPorte, and properly referred the matter to the State's Medicaid Fraud Control Unit.
4. **In the Matter of Petitioner J.M.** - Petitioner failed to timely file a request for administrative hearing regarding 3 Resolution of Appeal letters denying coverage. Petitioner's Request for Hearing was denied as untimely, i.e. past 210 days. Petitioner filed "Emergency Motion for Director's Time Extension Approving Action After Specified Period, Or, In the Alternative, Reconsideration" (Emergency Motion). The Emergency Motion was heard on January 12, 2024 and the order was issued on February 8, 2024. The order denied the Emergency Motion as the Hearing Officer found Petitioner failed to show "good cause" in this matter and there was no other legal basis on which to grant Petitioner's Emergency Motion.
5. **In the Matter of Petitioner J.M. (Appeal #15)** – Petitioner requested approval of ongoing 24/7 care of Delegated Personal Assistance Service Level II services. The Petitioner's health plan denied this request, and the Petitioner requested an administrative hearing on the denial. An administrative hearing is scheduled for April 15, 2024.

6. **In the Matter of Petitioner J.M. (Appeal #16)** - Petitioner requested approval of 24/7 care of Delegated Personal Assistance Service Level II services while the Petitioner was out of the State for almost three weeks. The Petitioner's health plan denied this request, and the Petitioner requested an administrative hearing on the denial. An administrative hearing is scheduled for April 23, 2024.
7. **In the Matter of Petitioner J.M. (Appeal #17)** – Petitioner requested an electroencephalogram to be administered by a specific physician. The Petitioner's health plan denied this request because the physician was not a Medicaid provider, and the Petitioner requested an administrative hearing on the denial. An administrative hearing has not been scheduled yet.

Hawaii Courts

1. **Bekkum v. DHS** – DHS appeals the administrative hearing decision in favor of Curtis Bekkum, M.D. DHS had sought to terminate Bekkum's provider participation in the Medicaid program based on a criminal complaint and conviction of sexual assault, which occurred in his provision of medical services to a patient. The administrative hearing decision found in favor of Bekkum because the Hearing Officer believed that the services Bekkum provided were not Medicaid services. DHS filed its opening brief and is awaiting the answering brief.
2. **Jason Murbach and Kaili Murbach, for and on behalf of J.M. v. Director DHS** – Appellants appeal DHS' decision to deny his request for an administrative hearing regarding 3 Resolution of Appeal letters denying coverage for durable medical equipment. The request for administrative hearing was denied as untimely, i.e. past 210 days. Appellant filed the Notice of Appeal to the Circuit Court to: 1) request vacating dismissal of administrative hearing request; 2) remand matter to Director to vacate dismissal; 3) Order DHS to review motion for hearing and allow filing of request for hearing after the deadline; and 4) order DHS to hold a contested case hearing on the Request for Hearing.
3. **Jason Murbach and Kaili Murbach for and on behalf of J.M. v. Director of State of Hawaii Department of Human Services** – Appellants appeals denial of additional delegated Personal Assistance Service Level II (PAII) services for Member for the duration of an 18-day trip to a Colorado hospital. Appellants allege the additional PAII services, which would equate to 24 hours day/7 days a week services, are medically necessary and must be covered under Member's Medicaid and QUEST-Integration coverage. The Opening brief is due on or about May 3, 2024, the answering brief due on or about June 12, 2024, and the Oral Argument is scheduled for July 17, 2024.
4. **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 her mental impairment makes her unable to stand trial in the criminal case. The parties have reached a settlement. The parties are in the process of signing, and have begun implementing, the written settlement agreement.

5. **In re F.T., by and through Aloha Nursing Rehab Centre (Aloha Nursing)** – Aloha Nursing requested an administrative fair hearing on behalf of deceased former patient regarding the patient's Medicaid eligibility. Aloha Nursing is seeking payment for services rendered to F.T. at a time when patient was ineligible for Medicaid coverage. The hearing officer determined that Aloha Nursing had no standing as an authorized representative of the former patient because it lacked the proper legal documentation providing authority to act on behalf of the deceased patient. Circuit Court affirmed in favor of DHS. Aloha Nursing appealed to the Intermediate Court of Appeals. Decision is pending.
6. **In re F.W.H., by and through Aloha Nursing Rehab Centre (Aloha Nursing)** – Aloha Nursing requested an administrative fair hearing on behalf of deceased former patient regarding the patient's Medicaid eligibility. Aloha Nursing is seeking payment for services rendered to F.W.H. at a time when patient was ineligible for Medicaid coverage. The hearing officer determined that Aloha Nursing had no standing as an authorized representative of the former patient because it lacked the proper legal documentation providing authority to act on behalf of the deceased patient. Circuit Court affirmed in favor of DHS. Aloha Nursing appealed to the Intermediate Court of Appeals. Decision is pending.

9th Circuit Court of Appeals

1. **HDRC 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. HDRC filed an Opening Brief and the State of Hawaii filed an Answering Brief. HDRC's Reply Brief was filed on July 14, 2023. Oral argument before a panel of the Ninth Circuit Court of Appeals occurred on October 4, 2023. We are awaiting the decision.

D. Unusual or Unanticipated Trends

As noted above, eligibility renewal processes that had been paused for three months due in part to the impact of the Maui wildfires as well as the need to make updates to the eligibility systems/processes were restarted. The *ex parte* processes were started in December 2023, and the first terminations since the pause were at the end of January 2024. Due to the pause in renewal terminations, a record number of individuals are currently covered by QUEST (over half of all children and 1/3rd of Hawaii's residents).

Outreach and recovery efforts continued in response to the wildfires. Health clinics that had burned down or displaced continued their relocation activities; families and individuals receiving HCBS/NF services who had been displaced by the fires continued to receive services from wherever they were temporarily residing.

E. Legislative Updates

The Hawaii legislature was in session this quarter. The primary areas of focus affecting the Demonstration has been strengthening the long-term care, particularly home and community-based services. Key legislators along with Medicaid leaders, Executive Office on Aging, Department of Health's licensing, LTSS and health care providers participated in a two-day LTSS Summit with support from the Council on State Governments. Additionally, several bills and agency budget asks were for HCBS rate increases. These were being positively considered as of the end of March.

The other areas of focus for the legislature have been funding Maui wildfire recovery efforts, and addressing the ongoing concerns of increasingly unaffordability of living in Hawaii, particularly the housing costs. These are also related to the high rates of homelessness, the latter as a third, but related focus that has an impact on Hawaii's Demonstration. There are several overlapping efforts to invest in MH crisis, justice-involved, and homeless services. All three of these areas, Med-QUEST is focused on either as part of the current Demonstration, or included in the 1115 Renewal application.

F. Descriptions of any Public Forums Held

Hawaii held one Public Forum during this time period. MHAC comments and questions were received from this meeting and summarized below.

MHAC meeting, February 21, 2024

Med-QUEST Division presented information and updates on the Stay Well Stay Covered campaign for the restart of renewals for all Medicaid members, the Section 1115 Demonstration Renewal for 2024, an overview of the Hawaii Child Wellness Incentive Program, and State Plan Amendments and updates. In addition, MQD is having all five of its managed care organizations present on their Health Plan Member Communications with their Medicaid population. Aloha Care (AC) was the first health plan to present their information on this issue to the MHAC. There were no questions from the MHAC or the public on the first two items. Questions were asked by the MHAC on the three remaining items and are summarized below.

One MHAC member asked if there is a tool kit or any other basic information, they can share to promote the Hawaii Child Wellness Incentive Program. MQD responded that they do not have any additional printed flyers to distribute at this time as they have been focusing on the Stay Well Stay Covered campaign but that they would take this comment back and have conversations with the Managed Care Organizations to help promote this program. Another MHAC member commented that she appreciated the clarification that the parent must be on Med-QUEST in order to claim the \$50.00 Visa/Master Card for having their child complete a well-child examination annually and that the child does not have to be receiving Medicaid for the parent to receive this benefit.

A MHAC member had a question for AC regarding their presentation on their Member Communication for the Medicaid population. She asked how Aloha Care was able to get the staff on board to understand where the Medicaid families are at and how to meet their needs given the diversity of the Medicaid population. AC responded that there is a strong focus on developing a company culture where everyone is onboard with their goals. AC conducts one on one meetings, all staff meetings,

engages their employees to participate in volunteer work, teaches their employees to listen, be empathetic, and learn to work with community leaders and partners so they can develop their capacity to better understand the community they serve. Another MHAC member commented that AC did a great presentation on their Member Communication.

Another MHAC member had comments regarding the State Plan presentation. She stated that MQD is doing a lot of exciting work and thanked MQD for persevering on the palliative care issue.

The public had no comments or questions for any of the topics raised and discussed by MQD.

III. Enrollment and Disenrollment

A. Member Choice of Health Plan

January 2024 – March 2024	# of Members
Individuals who chose a health plan when they became eligible	4092
Individuals who were auto-assigned when they became eligible	2867
Individuals who changed health plan after being auto-assigned	621
Individuals in the ABD program that changed health plan within days 61 to 90 after confirmation notice was issued	13

IV. Performance Metrics

A. Impact of the Demonstration

1. Providing Insurance Coverage to Beneficiaries and the Uninsured Population

Total enrollment as of 3/25/24: 470,211

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

No data to report as of this quarter. Ongoing work to improve data quality will result in data in future quarters.

B. Results of Beneficiary Satisfaction Surveys (if conducted)

None to report this quarter.

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

Type	Total	Timely Resolved* # (%)	Resolved in Favor of Beneficiaries** # (%)
Grievances	499	457 (91.6%)	263 (52.7%)
Appeals	332	275 (91.4%)	97 (42.2%)**

*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).

**only contains data from 4/5 health plans.

V. Budget Neutrality and Financial Reporting Requirements

A. Financial Performance of the Demonstration

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 3/31/2024 will be submitted by the 5/31/2024 deadline. The Budget Neutrality Workbook for the quarter ending 9/30/2023 is attached (Attachment B).

C. Quarterly and Annual Expenditures

Expenditures for the quarter ending 3/31/2024 were reported on the CMS-64 and certified on 4/30/2024. A summary of expenditures is shown on the attached Schedule C for the quarter ending 3/31/2024.

D. Administrative Costs

There have been no significant increases in Hawaii's administrative costs for the quarter ending 3/31/2024. 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. Additionally, MQD is working on improving data collecting on members receiving health coordination services and released a new health coordination services report to better understand the comprehensive health coordination services provided to Medicaid members. 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.
- UH completed the interim evaluation report which was submitted to CMS.
- The UH Evaluation Team held a Rapid Cycle Assessment presentation for Health Plans, providers, and MQD on Q2 2023 on February 23rd, 2024. 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

Data quality among evaluation reports remained a challenge for Health Plans. During this quarter many reports moved into production meaning the Health Plans consistently met data quality standards. These have informed ongoing monitoring of demonstration populations as well as inform the development of the 1115 waiver interim evaluation report.

3. Interim Findings (when available)

Subject	Successes in Implementation	Barriers in implementation
CIS	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 to bundled payments to make billing easier; and to pay for outreach services regardless of if member ends up consenting to compensate providers for time	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	Updated SHCN report was released to more comprehensively identify services and populations MQD is in the process of working with health plans to submit plan services, such as health coordination, as encounters. This will make reporting more automated and assist with evaluation and ongoing monitoring.	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: 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> <p>Support strategies and interventions implemented (or to be implemented) include: 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.</p>	
<p>Primary Care</p>	<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: 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</p>	<p>Health Plans had challenges with reporting on primary care</p>

	<p>Utilizing vendors to assist in contacting and returning members back into the PCP s practice</p> <p>Regular member communication to keep PC services and benefits top of mind</p> <p>Directly addressing and assisting PCPs on the gaps in care</p> <p>Actively recruiting and hiring PCPs</p>	
VBP	<p>Several VBC and APM initiatives were implemented at MCO and provider level respectively</p> <p>VBC arrangements were mostly aimed at primary care providers, FQHCs and CHCs.</p> <p>Independently, plans report positive results from implementation of VBC arrangements</p>	<p>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.</p>

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

Contract with University of Hawaii Evaluation team has been extended into CY2024.

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	<p>CIS was implemented and demonstrates that Medicaid can develop innovative programs to address SDOH.</p> <p>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.</p> <p>Of those members who received tenancy services, the majority remained housed at exit.</p>

	<p>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.</p> <p>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.</p>
HCBS/LTSS	Data is available in the interim evaluation report.
SHCN	Data is available in the interim evaluation report.
SDOH	<p>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.</p> <p>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.</p> <p>Few Health Plans have some plan on collaborating with other parties and utilizing measurement and progress during these quality activities.</p>
PC	So far, Health Plans have some changes in primary care spending over time. Report documents small changes in spending over time
VBP	<p>Impact of the implemented models is being evaluated</p> <p>Current evaluation opens up avenues for new research questions for further investigation into implementation of VBC arrangements and APM by health plans.</p> <p>Future investigation needs to include qualitative analyses of the implementation, barriers and facilitators and expansion of initiatives currently in place</p>

VII. Med-QUEST Division Contact

Jon D. Fujii
Health Care Services Branch (HCSB) Administrator
601 Kamokila Blvd., Suite 506A
Kapolei, HI 96707
Phone: 808-692-8083
Fax: 808-692-8087