Hawaii QUEST Integration

1115 Waiver

Quarterly CMS Monitoring Report

Federal Fiscal Year (FFY) 2024 3rd Quarter
Demonstration Year (DY) 30 Q3

Date Submitted: September 11, 2024 [Approved extended due date to September 13, 2024]	**Reporting Period:** **April 2024 – June 2024**	
	Federal Fiscal Quarter:	3rd Quarter 2024
	State Fiscal Quarter:	4th Quarter 2024
	Calendar Year Quarter:	2nd Quarter 2024
	Demonstration Year:	30th Year (10/1/23 – 9/30/24) This reporting period includes the: • last month of 3rd Q. DY 30; and the • 1st & 2nd months of 4th Q. DY 30 when applying a DY of August 1st – July 31st.

Table of Contents

Attachments

Attachment A: Up-To-Date Budget Neutrality Summary

The Budget Neutrality Summary (worksheet) for the quarter ending 3/31/2024 is attached. The Budget Neutrality Summary for the quarter ending 6/30/2024 will be submitted by the 8/31/2024 deadline.

Attachment B: Budget Neutrality Workbook

The Budget Neutrality Workbook for the quarter ending 3/31/2024 is attached. The Budget Neutrality Workbook for the quarter ending 6/30/2024 will be submitted by the 8/31/2024 deadline.

Attachment C: Schedule C

Schedule C for the quarter ending 6/30/2024 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 wavier (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.

Highlights from this quarter: MQD received approval of a community palliative care benefit state plan amendment. It is the very first in the nation, and will improve the continuum of care for individuals with serious illness. Also, MQD issued a Native Hawaiian Community Improvement Request For Information (RFI) in May 2024 to help MQD draft a Request For Proposal (RFP) to seek information and comments to contract a Third Party Administrator to pursue a contractor capable of providing community grants to invest and support the health and well-being of the Native Hawaiian community. Although this would not use Medicaid funding, it supports the state's health equity goals. Finally, the legislature supported rate increases for home and community based alternative residential settings.

II. Operational Updates

A. Key Challenges and Achievements Related to the 1115 Waiver

DSNP

Through April and May, MQD and its consultants, ATI Advisory and Speire Healthcare Strategies, LLC (collectively, Consultants), combed through multiple drafts of the 2025 State Medicaid Agency Contract (SMAC) for Hawaii's D-SNPs, to finalize provisions, language, and attachments. Also during this time, MQD provided the 2025 SMAC draft for Hawaii state Attorney General review and feedback. By the end of May, the final 2025 SMAC was complete and handed over to the Medicare Advantage Organizations (MAOs) for final review and signatures. The SMAC timely completion was a key accomplishment as the MAOs needed these fully executed and ready for upload on the Centers for Medicare and Medicaid Services (CMS) Health Plan Management System (HPMS) by July 1st.

Additionally, during this quarter MQD worked with its contractor, Public Consulting Group (PCG), on preparing its D-SNP Default Enrollment (DDE) reporting package for official release to the MAOs. On April 30th, the official release occurred triggering the MAO's 90-day launch period to review it and move forward with any internal preparations necessary before the first report under this revised reporting package was due to the State. The first report under this revised DDE reporting package would be due on July 31st. The reporting package included a Q&A Tracker answering questions

received previously from the MAOs as a result of an initial sharing of drafts and request for feedback opportunity provided to them in late 2023. However, to assist the MAOs and to address any remaining MAO questions or concerns regarding the released reporting package, MQD and PCG held a meeting with the MAOs on June 5th. The meeting went very well and indicated the MAOs were prepared and ready to produce the first report by its deadline.

Finally, during this quarter MQD staff continued its work toward obtaining CMS approval to include individuals from the Medicaid Low Income Adult (LIA) category and aging into Medicare, within the default enrollment process. To obtain CMS approval, Hawaii's D-SNPs must submit to CMS updated default enrollment application language describing the proposed process to identify such individuals. Med-QUEST Division assists in preparing the updated language for the Hawaii D-SNPs, and in doing so works with CMS for prior language review and approval. By the end of June, MQD had completed all revisions in accordance with CMS feedback received, and moved forward on next steps with the Hawaii D-SNPs to coordinate and plan for scheduled and timed uploads to the CMS Health Plan Management System (HPMS), with CMS. This latter phase can present challenges as the D-SNPs are only allowed a 48-hour window of time to complete its upload, and such window of time can only be opened by CMS. Upload dates were planned to occur during the next quarter.

Community Palliative Care

On May 7, 2024, CMS approved Hawaii's state plan amendment (SPA) to establish palliative care services provided in non-hospital settings as a Medicaid covered service. It defines palliative care and the required services and details the composition of the palliative care team—including scope and minimum qualifications, as well as relevance to adult and/or pediatric palliative care. Hawaii is the first state to be able to comprehensively cover these palliative care services for its Medicaid beneficiaries.

The SPA adds "Community Palliative Care" to the list of services in the "Preventive Services" benefit covered by Medicaid in Hawaii. Because Hawaii Medicaid (Med-QUEST) added palliative care services in non-hospital settings as a preventive service, the community palliative care services can now be offered to anyone who qualifies for services. Providing palliative care as a preventive service can help in preventing worse outcomes such as hospitalizations, increased emergency room use, or progression of mental health issues. This benefit will also greatly improve the quality of life and health outcomes for thousands of people who face serious medical conditions in our state. In consultation and collaboration with palliative care providers and others in the palliative care community, the Med-QUEST team is completing work with additional details on billing, reimbursement, and other implementation considerations.

B. Issues or Complaints Identified by Beneficiaries

No new issues or complaints were identified during this quarter.

C. Audits, Investigations, Lawsuits, and Legal Actions

Current Unified Program Integrity Contractor (UPIC) audits underway are for: several provider's billing practices for definitive and presumptive drug screens; and a repeat review for a hospice provider for extended periods of time in hospice.

Other cases of note under investigation:

- Medicaid Fraud Control Unit (MFCU) is coordinating with Health Plans and MQD on a Hawaii Island provider billing for telehealth psychotherapy when unlicensed mental health counselors are providing the services. The issue of if allowed with "supervision" of unlicensed providers is being researched.

- Research on the use of Current Procedural Terminology (CPT) 99072, which is a COVID Public Health Emergency (PHE) specific code. One Health Plan found providers billing for this after the conclusion of the PHE. Data run by MQD showed some providers have billed, but their claims were either denied or later voided. Thus, there did not appear to be an impact for Hawaii Medicaid.

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 Pre-Hearing Conference was held on April 10, 2024. Pre-Hearing briefs are due October 25, 2024, and the Administrative Hearing is scheduled for December 2-4, 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 was held on April 11, 2024. On June 25, 2024, the Hearing Officer issued an Administrative Hearing Decision assessing a Transfer of Asset penalty on the Claimants.

3. **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 was scheduled for May 1, 2024, continued to June 20, 2024, and then continued to June 28, 2024 by agreement of the Parties.

4. **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 was scheduled for June 20, 2024 and continued to June 28, 2024 by agreement of the Parties.

5. **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. Petitioner withdrew his request for an administrative hearing.

6. **In the Matter of Petitioner J.M.** (Appeal #18) – Petitioner requested authorization for a certain number of wet wipes. The total number of requested wet wipes was not approved. Petitioner requested an administrative hearing on the denial of the additional requested wet wipes. An administrative hearing is scheduled for August 29, 2024 by agreement of the Parties.

7. **In the Matter of Petitioner J.M.** (Appeal #19) – Petitioner requested authorization for a replacement stander due to the Petitioner's growth. Petitioner's health plan denied the request due to a lack of information about the Petitioner's growth. Petitioner requested an administrative hearing on the denial and submitted the requested information to DHS. The health plan reconsidered its decision based on the information and Petitioner withdrew his request.

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. The Circuit Court found in favor of Bekkum and DHS is considering its option to appeal.

2. **[Appellants], 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. The Appellant's opening brief was filed, and DHS' Answering Brief is due on July 15, 2024.

3. **[Appellants] 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 an out-of-state 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 was filed on May 3, 2024, the Answering Brief was filed on June 19, 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 reached a settlement with no payment or request for attorneys' fees and a stipulation to dismiss with prejudice was filed on April 15, 2024.

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 (ICA). The ICA issued its Summary Disposition Order on April 19, 2024, affirming the Circuit Court's Order and Judgment in favor of DHS. The Judgment on Appeal was filed on May 16, 2024. Aloha Nursing's request for a 30-day extension of time to submit its application for Writ of Certiorari to the Hawaii Supreme Court was granted.

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 (ICA). The ICA issued its Summary Disposition Order on April 29, 2024, affirming the Circuit Court's Order and Judgment in favor of DHS. The Judgment on Appeal was filed on May 30, 2024. Aloha Nursing requested a 30-day extension of time to submit its application for Writ of Certiorari to the Hawaii Supreme Court was granted.

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.

Foreclosure Actions

There are approximately 14 foreclosure actions that list DHS as a defendant. These actions are usually brought by banks or mortgage companies against Medicaid claimants and/or their estates. Through these actions, DHS requests any remaining surplus funds from the sale of the foreclosed property to be distributed to DHS.

D. Unusual or Unanticipated Trends

Hawaii continues its unwinding process. During this quarter, it processed the renewals for the final cohorts, including residents of Maui County, and west Maui who were impacted by the Maui wildfires in August of 2023. Residents of Maui County had their renewal dates pushed to the last three months of unwinding to allow as much time as possible for recovery efforts.

E. Legislative Updates

The 2024 Hawaii legislative session concluded the first week of May. Following up from last quarter's report, the legislature did make several significant investments in long-term supports and services, including funding rate increases for home and community based residential providers. Additional investments were made for a Long-term Care Strategic Plan, and Kupuna Care services.

Maui wildfire recovery efforts were the primary focus during the legislative session, as well as addressing the continued affordable housing shortage crises and related homelessness crises.

F. Descriptions of any Public Forums Held

Hawaii held one Public Forum during this time period. Medicaid Health Advisory Committee (MHAC) comments and questions were received from this meeting and are summarized below.

MHAC meeting, April 17, 2024

The Med-QUEST Division (MQD) presented information and updates on the 1) Stay Well Stay Covered campaign for the restart of renewals for all Medicaid members, 2) the Section 1115 Demonstration Renewal for 2024, 3) the Medicaid Membership Card, and 4) 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. HMSA was the second health plan to present their information on this issue to the MHAC.

There were no questions from the MHAC or the public on the Stay Well Stay Covered campaign. Questions/comments were asked by the MHAC on the four remaining items and are summarized below.

The Public had no questions on the Section 1115 Demonstration Renewal for 2024, the State Plan Amendments and updates and HMSA's presentation on their Health Plan Member Communications. The Public had questions/comments on the Medicaid Membership Card which is summarized below.

Section 1115 Demonstration Renewal 2024

MQD presented information on the Section 1115 Demonstration Renewal for 2024 regarding the timeline for approval from the Centers for Medicare and Medicaid Services (CMS). Hawaii's current 1115 Demonstration Waiver is scheduled to end July 31, 2024. However, MQD explained that CMS will not be able to approve the Section 1115 Demonstration Renewal for 2024 by August 1, 2024, due to current workload. CMS is anticipating the approval date to be sometime during the first quarter of 2025. One MHAC member commented that she acknowledges that the MQD team is being very proactive with the Section 1115 Demonstration Renewal and suggest MQD work with CMS to expedite the approval.

Medicaid Membership Card

MQD had a representative from the Hawaii Medical Service Association (HMSA) present on the Medicaid Membership Card on behalf of all the health plans that provide Medicaid services in the State of Hawaii. They explained that the Medicaid members are experiencing a difficult time proving they have Medicaid because the Medicaid Membership Card references QUEST Integration and not Medicaid. The health plans updated the front of the Medicaid Membership Card to define QUEST Integration as the State's Medicaid program. Four MHAC members provided comments and questions regarding this issue. All four MHAC members agree with the new card's format as it is more simple, clear, and identifies that QUEST Integration is the program that the health plans are providing the Medicaid services under.

Another MHAC member asked about the Medicaid Membership Card for the individuals in Fee For Service. MQD confirmed that these individuals receive a Medicaid Membership Card. She also asked about whether there is a Membership Card for dental and MQD said there is not one. This MHAC member also asked if the health plans will be offering a digital card that a member could download and will the update include the new language. HMSA said they will need to take this question back to the health plans to review.

A member from the public asked when will the Medicaid member be issued the updated card. HMSA explained that for their particular health plan, HMSA will only issue a new card if the member is a newly enrolled member into Medicaid, if the member lost eligibility in Medicaid and regained their eligibility, or if the member requests a new card. HMSA does not issue a new Medicaid member card annually.

State Plan Amendments (SPA)

MQD presented on the SPA's that were recently approved and pending with CMS. MQD also commented on two upcoming SPAs regarding adding hearing services under a health service initiative and am updated payment methodology related to a vision health service initiative. A member from MHAC wanted to know more about the hearing coverage for children in schools as hearing tests are not being performed in schools and parents have to do this on their own. She asked if MQD will be providing hearing tests in schools. MQD stated that they will address this issue and provide more information in the next MHAC meeting as this issue is new and MQD is still exploring the options for this service.

HMSA Presentation on their Health Plan Member Communications with their Medicaid population

HMSA presented their guiding principles for how they connect and communicate with their QUEST Integration Medicaid members. The MHAC had several comments and questions for HMSA. One MHAC member stated that he was surprised by HMSA's statistic that the average age for an HMSA member is 20 for females and 27 males. He asked how does HMSA know how to manage someone who is older? The HMSA representative acknowledged the concern, and that HMSA should not tailor their messaging for only the majority of its population but should also think about other age groups. This MHAC member, who is also a physician, asked if HMSA collects data on why a member would choose to change their PCP, and if they do collect this information, is this shared with the physician as the physicians should be made aware so they can make improvements. Per HMSA, they do not silo out the communications from the members and they do try to connect the dots as to why the member is changing PCPs. She said the PCP can see the members who have dropped off of their panel and the members who have joined. MQD asked HMSA specifically if the member calls to change the PCP does HMSA ask the reason why and is that information compiled, gathered, and shared from a quality perspective? HMSA said they will take this inquiry back to be discussed and shared at a later time.

Another MHAC member commented that she was struggling with HMSA's presentation as she did not see how QUEST Integration Medicaid members were uniquely identified as there was no specific strategy for this population with social drivers of health. She was also surprised by the average age of the HMSA QUEST Integration Medicaid member and wanted more information on what strategies HMSA will develop to make connections with this group. She could not identify what HMSA is doing differently for the QUEST Integration Medicaid members vs. how they treat their commercial population. HMSA explained that they have to align their communication strategies for all of their members but should also align the unique elements of the QUEST Integration Medicaid population. HMSA stated that they do have unique strategies for this population. For example, the language requirements and the focus groups for the Long-Term Services and Supports (LTSS) population. HMSA also has a dedicated community health and equity team, and they recognize they should have spent more time covering this area in their presentation as there is always opportunity to improve in this space.

Another MHAC member commented that HMSA should focus on how they engage their Medicaid members with the organization and that HMSA should invest more in the language services on their website. HMSA said they appreciate all the comments and will take them back to the HMSA communications team.

III. Enrollment and Disenrollment

A. Member Choice of Health Plan

April 2024 – June 2024	# of Members
Individuals who chose a health plan when they became eligible	3,468
Individuals who were auto-assigned when they became eligible	2,880
Individuals who changed health plan after being auto-assigned	902
Individuals in the ABD program that changed health plan within days 61 to 90 after confirmation notice was issued	15

IV. Performance Metrics

A. Impact of the Demonstration

1. Providing Insurance Coverage to Beneficiaries and the Uninsured Population

Total enrollment as of 6/24/24: 445,214

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	477	425 (96.5%)	244 (55.5%)
Appeals	323	232 (84.4%)	113 (40.1%)

*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).

V. Budget Neutrality and Financial Reporting Requirements

A. Financial Performance of the Demonstration

As shown in the most recent Budget Neutrality workbook from the quarter ending March 31, 2024, the Demonstration continues to accrue budget neutrality savings for this past quarter. In addition, the Budget Neutrality workbook also shows budget neutrality savings for the Expansion eligibility Hypothetical Group. Hawaii continues to project budget neutrality savings in future years.

B. Updated Budget Neutrality Workbook

The Budget Neutrality Workbook for the quarter ending 6/30/2024 will be submitted by the 8/31/2024 deadline. The Budget Neutrality Workbook for the quarter ending 3/31/2024 is attached (Attachment B).

C. Quarterly and Annual Expenditures

Expenditures for the quarter ending 6/30/2024 were reported on the CMS-64 and certified on 7/30/2024. A summary of expenditures is shown on the attached Schedule C for the quarter ending 6/30/2024.

D. Administrative Costs

There have been no significant increases in Hawaii's administrative costs for the quarter ending 6/30/2024. 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 team received feedback from CMS and is actively working on submitting a revised report.

- The UH Evaluation Team held a Rapid Cycle Assessment presentation for Health Plans, providers, and MQD on Q2 2023 on June 7th, 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.	Challenges to enrolling members is largely due to provider capacity,

	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	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: Health Plans identified racial/ethnic or geographical disparities on the utilization of several health service 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)	Shortage of Health Plans staff and community health workers to address SDOH and social needs

	healthcare access and quality. 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.	
Primary Care	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 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 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	Health Plans had challenges with reporting on primary care

VBP	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	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 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	CIS was implemented and demonstrates that Medicaid can develop innovative programs to address SDOH. 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.

HCBS/LTSS	Data is available in the interim evaluation report.
SHCN	Data is available in the interim evaluation report
SDOH	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	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

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