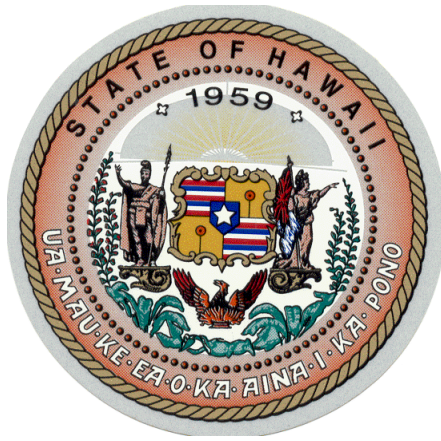




Hawai'i Managed Care Quality Strategy 2026

STATE OF HAWAII
Department of Human Services
Med-QUEST Division



Contents

I. Managed Care Quality Strategy Introduction and Background.....	4
Purpose for the Managed Care Quality Strategy.....	4
Background on Medicaid and Managed Care in Hawai'i	5
Community Care Services (CCS)	7
The HOPE Initiative	7
Achieving the HOPE Vision	10
Managed Care Quality Strategy Goals, Objectives, Aims and Guiding Principles	11
Next Steps	15
Managed Care Quality Strategy Development, Evaluation and Revision Process	15
Stakeholder Engagement	16
Timeline for Review and Updates	16
II. State Standards	18
Access to Care Standards.....	18
Network Adequacy	18
Availability of Services	22
Access to Care during Transitions of Coverage/Transitions of Care	22
Coordination and Continuity of Care.....	23
Authorization and Denial of Services	25
Long Term Services and Supports	27
Health Equity and Disparities	30
Provider Selection and Disenrollment.....	31
Practice Guidelines	32
Enrollee Information	34
Enrollment and Disenrollment of Members	35
Confidentiality	37
Member and Provider Grievance and Appeals	38
Sub-contractual Relationships and Delegation	39
Health Information Technology	40
Claims Payment	41
Encounter Data and Drug Rebate Submission	42
Non-emergency Medical Transportation (NEMT)	43
Provider Accreditation	44
Non-Duplication Strategy	45

III.	Improvements and Interventions	48
IV.	Managed Care Quality Strategy Implementation.....	76
	Managed Care Quality Strategy State Agency Collaboration	76
	Quality Program.....	76
	Quality Assurance(QA)	76
	Health Plan Quality Assessment and Performance Improvement Program (QAPI)	81
	Contract Compliance.....	82
	Quality Measurement	83
	Monitoring and Evaluation.....	83
	Performance Measures	84
	External Quality Review (EQR) activities and technical report.....	88
	Review of Compliance with Federal and State-specified Operational Standards.....	89
	Performance Improvement Project Reviews	90
	Validation of Performance Measures.....	90
	Validation of Network Adequacy	90
	Member and Provider Survey.....	90
	Annual Report	91

Table of Tables

Table 1 – HOPE Goals, Strategic Areas and Building Blocks.....	8
Table 2a – Comparison of 2023 and 2026 Managed Care Quality Strategy Objectives	11
Table 2b – HOPE Strategies, Managed Care Quality Strategy Goals and Managed Care Quality Strategy Objectives.....	12
Table 3 - QI Network of Providers – Primary and Acute Care	19
Table 4 - QI Network of Providers – LTSS and Behavioral Health.....	20
Table 5 - CCS Network of Providers	20
Table 6 - CCS Geographic Access to Providers	21
Table 7 – Appointment Wait Times	22
Table 10 - Practice Guidelines Requirements	34
Table 11- Hawai'i Medicaid Populations	34

Table 12 – Hawai'i Medicaid Member Disenrollment Criteria.....	36
Table 13 - EQRO Activities.....	89

I.Managed Care Quality Strategy Introduction and Background

The State of Hawai'i Department of Human Services (DHS) Med-QUEST Division (MQD) is the single state agency that manages Hawai'i's Medicaid program; inclusive of the Children's Health Insurance Program (CHIP) program. MQD seeks to improve the quality of health and health care services for Medicaid beneficiaries by the most cost effective and efficient means through the QUEST Integration (QI) and Community Care Services (CCS) programs, with an emphasis on prevention and quality health care.

To support this effort, and as required by the Code of Federal Regulations (CFR) 438.340, MQD has developed and will maintain a Managed Care Quality Strategy to serve two purposes. The first purpose is to serve as a technical document to conform to the CFR requirements. The second purpose is to serve as a blueprint to guide the development of innovations to meet the division's goals.

This document is meant to build a cohesive, agency-wide approach encompassing the division's goals, objectives, interventions, and ongoing evaluation. It is not intended to comprehensively describe all delivery and quality health care by all Health Plans.

Purpose for the Managed Care Quality Strategy

In accordance with 42 CFR 438.340, at a minimum, quality strategies must address:

- The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs).
- The State-defined network adequacy and availability of services standards for §438.68.
- Examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.
- A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each Health Plan and PIHP with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c).
- The performance improvement projects to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in a Health Plan or PIHP.

- Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each Health Plan, and PIHP contract.
- A description of the State’s transition of care policy required under §438.62(b)(3).
- The State’s plan to identify, evaluate, and reduce, to the extent practicable, health disparities.
- For Health Plans, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of §§438.700 – 438.730.
- The mechanisms implemented by the State to comply with §438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).
- Information related to non-duplication of External Quality Review (EQR) activities, as required under §438.360(c); and
- The State’s definition of a “significant change” for the purposes of paragraph (c)(3)(ii) of this section.

Additionally, MQD intends to use the Managed Care Quality Strategy to:

- Monitor that the services provided to beneficiaries conform to professionally recognized standards of practice and code of ethics;
- Identify and pursue opportunities for improvements in health outcomes, accessibility, efficiency, beneficiary and provider satisfaction with care and service, safety, and equitability;
- Provide a framework for the agency to guide and prioritize activities related to quality; and
- Assure that an information system is in place to support the efforts of the Managed Care Quality Strategy.

Background on Medicaid and Managed Care in Hawai‘i

The State of Hawai‘i implemented the QUEST program through a Section 1115 demonstration waiver on August 1, 1994. QUEST stands for:

- **Q**uality care;
- **U**niversal access;
- **E**fficient utilization;
- **S**tabilizing costs; and
- **T**ransforming the way healthcare is provided to QUEST members.

QUEST provided medical, dental, and behavioral health services statewide to enrolled members through a competitive managed care delivery system. The managed care delivery

system helped Hawai'i ensure access to high-quality, cost-effective care; establish contractual accountability among the Health Plans and health care providers; and assure a predictable and slower rate of expenditure growth.

The QUEST program has gone through many changes since 1994. In 2009, MQD implemented its QUEST Expanded Access (QExA) program that allowed its aged, blind, or disabled (ABD) population to also benefit from managed care. In 2014, the QUEST Integration (QI) program combined several programs into one-statewide program providing managed care services to all of Hawai'i's Medicaid population.

Since its implementation, CMS has renewed the QUEST demonstration six times. The current QUEST Integration demonstration titled "Hawai'i QUEST Integration" ("demonstration") (Project No. I I-W-00001/9) began on January 8, 2025 and runs through December 31, 2029. The current demonstration retains several authorities from prior demonstrations and adds additional authorities to the managed care program. The demonstration's historical objectives are now aligned with a more holistic MQD mission and framework created as part of the development of the Hawai'i 'Ohana Nui Project Expansion (HOPE) program, described later in this section.

The demonstration goals include:

1. Improve health outcomes for Medicaid beneficiaries covered under the demonstration;
2. Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth; and
3. Support strategies and interventions targeting the social determinants of health.

Along with maintaining access to care to the vast majority of mandatory and optional Medicaid eligibility groups set forth in the State's approved state plan, the key benefits and services that the demonstration authorizes include:

- Cognitive and habilitation services;
- Supportive employment and financial management services for individuals requiring specialized behavioral health care;
- Community Integration Services Plus (CIS +) for beneficiaries with an eligible health need who are either homeless or at risk for homelessness;
- Pre-release services for juveniles and adults;
- Health Related Social Needs;
- Contingency management;
- Non-medical transportation;

- Nutrition Supports benefits; and
- A limited set of Home and Community-Based Services (HCBS) for the population “at risk” of deteriorating to the Long-Term Services and Supports (LTSS) level of care.

Community Care Services (CCS)

In addition to the basic behavioral health services provided by QI Health Plans, in 2013, MQD implemented the Community Care Services (CCS) program which provides intensive behavioral health services to adults diagnosed with a qualifying serious mental illness (SMI) and/or a serious and persistent mental illness (SPMI) and determined to meet specific CCS eligibility criteria by MQD. Once the member is enrolled into the CCS program, all behavioral health services are covered and provided by CCS. The QI Health Plans continue to cover and provide all medical services in coordination with the CCS Health Plan, which covers and provides all behavioral health care, SUD and CIS services.

The HOPE Initiative

MQD carried on the tradition of innovation by implementing the Hawai‘i ‘Ohana Nui Project Expansion (HOPE) program initiative in 2017 to develop and implement a roadmap to achieve a vision of healthy families and healthy communities. MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being, measurably lower prevalence of illness, and attain a more sustainable growth rate in healthcare spending. The goal of the program is to achieve the Triple Aim of better health, better care, and sustainable costs for our community.

Six guiding principles govern the overarching framework that will be used to develop a transformative healthcare system that focuses on healthy families and healthy communities:

1. Assuring Continued Access to Health Insurance and Health Care
2. Emphasis on Whole Person and Whole Family Care over their Life Course. ‘Ohana Nui –Focus on Young Children and their Families
3. Addressing the Social Determinants of Health (SDOH)
4. Emphasis on Health Promotion, Prevention and Primary Care
5. Investment in System-Wide Changes
6. Leveraging and Supporting Community Initiatives

In order to accomplish the vision, HOPE activities are organized along two major axes: (1) four strategic focus areas, which include multiple targeted initiatives to promote integrated health systems and payment reform initiatives, and (2) three foundational building blocks, which directly support the four strategic areas and also enhance overall system

performance as presented in Table 1. The HOPE initiative guides the Medicaid Managed Care Quality Strategy.

Table 1 – HOPE Goals, Strategic Areas and Building Blocks

Goals	Healthy Families, Healthy Communities, Achieving the Triple Aim – Better Health, Better Care, Sustainable Costs			
Strategies	1. Invest in primary care, prevention, and health promotion	2. Improve outcomes for High-Need, High-Cost Individuals	3. Payment Reform and Alignment	4. Support community driven initiatives
Foundational Building Blocks	1. Use data and analytics to drive transformation and improve outcomes			
	2. Increase workforce capacity			
	3. Accountability, performance measurement and evaluation			

The first two strategies reflect the short- and long- term investments needed to accomplish the Triple Aim. The first strategy is focused on investing in primary care, health promotion, and prevention early in one’s life and over one’s life. The second strategy is focused on people with the highest, most complex health and social needs because they use a majority of health care resources, and there is potential for a strong return on investment. The health and well-being of individuals with complex needs must be addressed in order to begin to bend the cost curve, and the savings accrued will be used to support the sustainability of HOPE initiatives including investments in primary care, children, and health-related services.

The third strategy reflects the need to pay for care differently by moving away from rewarding volume, and toward accountability for overall cost and quality that is essential for supporting the integrated delivery system reforms identified in the first two strategies. The fourth strategy reflects MQD’s commitment to invest in community care, support community initiatives, and develop initiatives that link integrated health systems with community resources in order to improve population health.

The foundational building blocks of health information technology, workforce development and performance management and evaluation are critical to the success of the four strategies. Each of the four strategies is briefly described below.

Strategy 1: Invest in Primary Care, Prevention, and Health Promotion

Lifestyle factors such as regular physical activity, not smoking, adopting a healthy diet, and maintaining a healthy body mass index are strongly associated with increased lifespan and reduced onset of preventable chronic diseases. That is why there is a strong emphasis in

the HOPE vision on primary, secondary, and tertiary prevention, which emphasize preventing illnesses onset through adoption of healthy behaviors; increased detection of illnesses and disease in earlier, more treatable stages through greater screening; and increased disease management to avoid tertiary complications. Furthermore, in order to achieve HOPE goals, Hawai'i needs to close the gaps between prevention, primary care, and physical and behavioral health care. The goal is to improve health overall by building healthy communities and individuals through prevention, health promotion, and early mitigation of disease throughout the life course. MQD plans to achieve this with four priority initiatives: (1) Invest in Primary Care, (2) Promote Behavioral Health Integration, (3) Support Children's Behavioral Health, and (4) Promote Oral Health and Dental Care.

Strategy 2: Improve Outcomes for Individuals with Complex Health Conditions

The top one percent of patients account for more than 36 percent of health care expenditures, and the top five percent account for 65 percent of the nation's spending on health care. These trends are also evident in Hawai'i. Improving care management for the high needs high cost (HNHC) population while balancing quality and associated costs will require engagement from payers, providers, patients, community leaders, and other stakeholders. This is a priority because this is a vulnerable population with complex medical, behavioral, and social needs, and there is a potential for a return on investment that may help offset upfront costs of new interventions that improve outcomes. The goals are to improve outcomes and decrease costs of care for the population.

Strategy 3: Payment Reform and Alignment

There is emerging consensus among providers, payers, patients, purchasers, and other stakeholders that efforts to deliver affordable quality health care in the United States have been stymied to a large extent by a payment system that rewards providers for volume as opposed to quality.¹ New payment models require providers to make fundamental changes in the way care is provided, and the transition to new ways of providing care may be costly and administratively difficult even though new payment models are more efficient over time. In order to accelerate this transition, a critical mass of public and private payers must adopt aligned approaches and send a clear and consistent message that payers are committed to a person-centered health system that delivers the best health care possible. MQD's intends to develop a multi-payer Value-Based Purchasing (VBP) plan in collaboration with other State partners that will describe MQD's approach to fundamentally change how health care is provided by implementing new models of care that drive toward population-based care. The goal is to improve the health of Medicaid beneficiaries by providing access

¹ The Commonwealth Fund. "The Road Not Taken: The Cost of 30 Years of Unsustainable health Spending Growth in the United States." March 2013.

to integrated physical and behavioral health care services in coordinated systems, with value-based payment structures.

Strategy 4: Support Community Driven Initiatives to Improve Population Health

The fourth strategy reflects MQD's commitment to invest in communities by supporting community initiatives and develop initiatives that link integrated health systems with community resources in order to improve population health. MQD will work with various strategic partners across the spectrum to evolve the health care delivery system from the local level to the top. Improvements in population health at the local and regional levels require aligned state policies, alignment at the Health Plan level and a collaborative and supportive approach to local initiatives, actionable data, transformation support and investment funding. The goal is to support and/or develop partnerships that will design new models to increase integration, collaboration and alignment among Health Plans, local hospitals, community-based organizations, housing authorities, county government and public health agencies, affordable housing providers, corrections, behavioral health and substance use disorder providers.

Achieving the HOPE Vision

MQD intends to achieve the HOPE vision through managed care contracts for the provision of covered services to eligible Medicaid and Children's Health Insurance Program (CHIP) members for necessary medical, behavioral health, and long-term services and supports in a fully risk-based managed care environment. The Health Plans will assist MQD through the tasks, obligations and responsibilities described in the contracts.

Health Related Social Needs and Social Determinants of Health

Social determinants of health (SDOH), the conditions in which people are born, grow, live, work and age that shape health, and more recently, Health Related Social Needs (HRSN), the individual social and economic barriers that directly limit an individual's ability to maintain health and access to care, are ongoing priorities in the demonstration. MQD recognizes the impacts both SDOH and HRSN have on individuals and population groups, including Native Hawaiians and Pacific Islanders, and is committed to addressing the factors which could lead to improved health outcomes.

Further, Hawai'i state law supports MQD's prioritization of addressing SDOH and relatedly, HRSN. Hawai'i Revised Statute §226-20 (2014) recognizes that all state agency planning should prioritize addressing the social determinants of health to improve health and wellbeing for all, including Native Hawaiians. Therefore, it is essential that MQD build on and support culturally appropriate and effective initiatives which promote health and wellness for both individuals and communities.

Managed Care Quality Strategy Goals, Objectives, Aims and Guiding Principles

MQD's Managed Care Quality Strategy is founded on the four HOPE strategic focus areas. This year, an in-depth reassessment was conducted which revitalized commitment to MQD's vision and mission and resulted in an enhancement of objectives. The current fifteen objectives include three new objectives and from 2023, six unchanged, one renamed, two combined into one, two with added sub-objectives, and two modified. Table 2a compares 2023 and 2026 objectives. Table 2b identifies 2026 strategies, goals and objectives.

Table 2a – Comparison of 2023 and 2026 Managed Care Quality Strategy Objectives

MANAGED CARE QUALITY STRATEGY OBJECTIVES		
2023	2026	ACTION
1) Enhance timely and comprehensive pediatric care	1) Enhance timely and comprehensive pediatric care	UNCHANGED
2) Reduce unintended pregnancies, and improve pregnancy-related care	2) Reduce unintended pregnancies, and improve pregnancy-related care	UNCHANGED
3) Increase utilization of adult preventive screenings in the primary care setting 4) Expand adult primary care preventive services	3) Increase and Expand Adult Primary Care Screening and Preventative Services	COMBINED
5) Promote behavioral health integration and build behavioral health capacity	4) Build behavioral health capacity a) Build capacity for Substance Use Disorder Treatment services b) Build capacity for Mental Health Treatment services	CREATED SUB-OBJECTIVES
6) Support specialized behavioral health services for serious I/DD, MH, and SUD	5) Support specialized behavioral health services for members with I/DD, serious MH disorders, and SUD a) Support specialized behavioral health services for I/DD populations, and increased transitions to the community for institutionalized I/DD members b) Support specialized behavioral health services for serious MH disorders and SUD	CREATED SUB-OBJECTIVES
9) Advance care at the end of life	6) Advance care at the end of life	UNCHANGED

MANAGED CARE QUALITY STRATEGY OBJECTIVES		
2023	2026	ACTION
10) Provide supportive housing to homeless beneficiaries with complex health needs 11) Assess and address social determinants of health needs 16) Align payment structures to support work on social determinants of health	7) Assess and address Health-Related Social Needs a) Address food insecurity by augmenting nutrition supports b) Provide supportive housing to homeless beneficiaries with complex health needs c) Build and enhance data and infrastructural supports to address the Health-Related Social Needs	MODIFIED
12) Enhance community integration/reintegration of LTSS beneficiaries	8) Enhance community integration/reintegration of LTSS beneficiaries	UNCHANGED
13) Enhance nursing facility and HCBS; prevent or delay progression to nursing facility level of care	9) Enhance nursing facility care and HCBS; prevent or delay progression to nursing facility level of care	UNCHANGED
14) Maintain or enhance access to care	10) Expand access to care	RENAMED
15) Increase coordination of care and decrease inappropriate care	11) Improve healthcare delivery through administrative simplification and utilization management oversight	MODIFIED
17) Align payment structures to enhance quality and value of care	12) Align payment structures to enhance quality and value of care	UNCHANGED
	13) Improve Coordination of Health Benefits for Dually Covered Populations	NEW
	14) Enhance Member Transparency and Member Engagement	NEW
	15) Increase access to dental care and improve dental health outcomes	NEW
7) Provide appropriate care coordination for populations with special health care needs		DISCONTINUED
8) Provide team-based care for beneficiaries with high needs high cost conditions		DISCONTINUED

Table 2b – HOPE Strategies, Managed Care Quality Strategy Goals and Managed Care Quality Strategy Objectives

HOPE Strategies	Managed Care Quality Strategy Goals	Managed Care Quality Strategy Objectives	
Invest in Primary Care, Prevention and Health Promotion	Advance primary care, prevention,	OBJECTIVE 1	Enhance pediatric primary care through prevention and health promotion

HOPE Strategies	Managed Care Quality Strategy Goals	Managed Care Quality Strategy Objectives	
	and health promotion	OBJECTIVE 2	Reduce unintended pregnancies, and improve pregnancy-related care
		OBJECTIVE 3	Increase and Expand Adult Primary Care Screening and Preventative Services
		OBJECTIVE 15	Increase access to dental care and improve dental health outcomes
	Maintain access to appropriate care	OBJECTIVE 10	Expand access to care
		OBJECTIVE 13	Improve Coordination of Health Benefits for Dually Covered Populations
Improve outcomes for High-Need, High-Cost Individuals	Integrate behavioral health with physical health across the continuum of care	OBJECTIVE 4	Build behavioral health capacity a. Build capacity for Substance Use Disorder Treatment services b. Build capacity for Mental Health Treatment services
		OBJECTIVE 5	Support specialized behavioral health services for members with I/DD, serious MH disorders, and SUD a. Support specialized behavioral health services for I/DD populations, and increased transitions to the community for institutionalized I/DD members b. Support specialized behavioral health services for serious MH disorders and SUD
	Enhance care in LTSS settings	OBJECTIVE 6	Advance care at the end of life

HOPE Strategies	Managed Care Quality Strategy Goals	Managed Care Quality Strategy Objectives	
		OBJECTIVE 8	Enhance community integration/reintegration of LTSS beneficiaries
		OBJECTIVE 9	Enhance nursing facility care and HCBS; prevent or delay progression to nursing facility level of care
Payment Reform and Alignment	Align payment structures to improve health outcomes	OBJECTIVE 11	Improve healthcare delivery through administrative simplification and utilization management oversight
		OBJECTIVE 12	Align payment structures to enhance quality and value of care
Support community driven initiatives	Support community initiatives to improve population health	OBJECTIVE 7	Assess and address Health Related Social Needs a. Address food insecurity by augmenting nutrition supports b. Provide supportive housing to homeless beneficiaries with complex health needs c. Build and enhance data and infrastructural supports to address the Health-Related Social Needs
		OBJECTIVE 14	Enhance Member Transparency and Member Engagement

MQD intends to enhance overall investments by the Health Plan across all these areas, including necessary infrastructure supports. Section III – Improvements and Interventions describes the initiatives that may be undertaken to achieve these objectives.

Next Steps

Following the release of the Managed Care Managed Care Quality Strategy and in collaboration with MQD stakeholders, detailed action steps and timelines will be developed to support successful execution of the Managed Care Quality Strategy. Administrative simplification and standardization for providers, the Health Plans, and DHS will be considered as detailed action steps and timelines are developed. Contingency plans for timelines and next steps may be created as needed to enable the agency to adapt to unforeseeable, impactful events such as public health emergencies (PHEs) or budget crises. Additionally, MQD will work with stakeholders to ensure that the evaluation framework effectively assesses the chosen steps to meet these objectives of the Managed Care Quality Strategy.

Managed Care Quality Strategy Development, Evaluation and Revision Process

The development of the Managed Care Quality Strategy is initiated by the Quality Committee within MQD. This internal team is a multidisciplinary group with representation from MQD branches and offices. The Quality Committee minimally includes the Medicaid Medical Director; Health Care Services Branch (HCSB) administrator; Quality and Member Relations Improvement Section (QMRIS) administrator; HCSB/ Contract Monitoring and Compliance Section (CMCS) supervisor; HCSB/ Data Analysis and Provider Network Section supervisor; the Health Analytics Office (HAO) administrator; Clinical Standards Office administrator, and representatives from the Clinical Standards Office (CSO). The Quality Committee engages program leadership staff including the Medicaid Director, Policy and Program Development Officer, and Finance on key decisions as needed.

The Quality Committee, in collaboration with Subject Matter Specialists within MQD, develop the strategies, goals, objectives, and interventions included in the Managed Care Quality Strategy, assesses the effectiveness of initiatives, and revises the Managed Care Quality Strategy based on stakeholder feedback, performance reports, and health outcome data. Throughout the process, MQD maintains regular communication channels between leadership and operational staff to ensure programmatic alignment and support. The support and recommendations of subject matter specialists throughout MQD are requested to identify program gaps, formulate solutions, and prioritize quality initiatives that are addressed in this Managed Care Quality Strategy and the continuous quality improvement system that MQD maintains. This quality improvement system is described in Section IV – Managed Care Quality Strategy Implementation.

The Quality Committee conducts a substantial review of related program materials, such as reports authored by the External Quality Review Organization (EQRO), reports from Health Plans, and the latest evidence-based research. Specifically, the annual External Quality Review (EQR) Technical Report provides detailed information about QI and CCS Health Plan performance with respect to quality, access, and timeliness of care and services; it includes

information on Health Plan regulatory compliance, progress on CMS Adult and Child Core Set measures as well as selected Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and performance improvement projects (PIPs). The EQRO also administers and reports on provider satisfaction surveys, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys of adult, child and HCBS beneficiary satisfaction, and Health Plan comparison reports. MQD evaluates these survey results and operational performance reports when assessing state modifications to the Managed Care Quality Strategy annually.

Stakeholder Engagement

In addition to internal review processes, MQD seeks external feedback through a number of methods to assess the Managed Care Quality Strategy. MQD conducts public forums to hear from beneficiaries, providers, advisory committees, and other stakeholders about their experiences related to Medicaid program activities. MQD incorporates input from these and other essential stakeholders including the EQRO, government agency partners (e.g. Department of Health), Health Plans, and advocates. These stakeholders provide critical feedback and information useful in identifying metrics and quality activities important to the Medicaid population. Reports from, and regular meetings with, these partner agencies and stakeholders help MQD understand the gains and gaps to statewide progress that informs the strategy.

MQD will utilize feedback from the Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) to inform quality improvement priorities, identify member experience concerns, and support the development of member-centered initiatives. The BAC provides an important mechanism for ensuring member perspectives are incorporated into quality improvement activities, policy development, and program planning.

Timeline for Review and Updates

MQD reviews and updates the Managed Care Quality Strategy as needed or when a significant change in priorities occur, and no less than once every three years. The process for reviewing the Managed Care Quality Strategy includes an evaluation of its effectiveness. The results of the review are made publicly available on the MQD website. MQD obtains public input by submitting the Managed Care Quality Strategy for public comment during the initial release of the strategy, and subsequently every three years, or sooner, if significant changes are made.

As part of the public feedback process, MQD obtains input on the draft Managed Care Quality Strategy from key stakeholders through public meetings, distribution through various listservs, and posting on its public facing website. Any feedback or comments received during public meetings are recorded. The draft is posted on MQD's website, and an

email notification is sent to key stakeholders soliciting feedback and allowing for a 30-day period for public input. After the public comment period, MQD reviews the feedback received, and may make changes as appropriate. The strategy is then submitted to CMS for review and feedback. Revisions will be made to the Managed Care Quality Strategy based on CMS' feedback then the final Managed Care Quality Strategy will be made available on the MQD website.

For purposes of updating and reviewing the Managed Care Quality Strategy, "significant change" is defined as:

- A pervasive pattern of quality deficiencies identified through analysis of the quality performance data submitted that results in a change to the goals or objectives of the Managed Care Quality Strategy;
- Overarching changes to quality standards resulting from regulatory authorities or legislation at the State or federal level; or
- A change in membership demographics or the provider network of 50 percent or greater within one year.

Changes to formatting, dates, or other similar edits are defined as "insignificant," as well as legislative/regulatory changes that do not change the intent or content of the requirements contained within. Changes to the details included in the Appendices of the Managed Care Quality Strategy will also be considered insignificant, but appendices will be regularly updated as needed in the version of the Managed Care Quality Strategy posted online.

II. State Standards

This year, an in-depth reassessment of the Managed Care Quality Strategy was conducted which revitalized commitment to MQD's vision and mission and resulted in an enhancement of the state standards. The interdisciplinary and intra-divisional effort spanned over a period of six months and culminated in the following impact to the state standards from 2023:

twenty standards evolved into twenty-three. Fourteen standards are unchanged. Access to care was modified; three were subgrouped (Prior Authorizations, Member and Provider Grievances and Appeals, and Encounter Data and Drug Rebate Data Submission); and two are new (Reporting, Monitoring, and Evaluation; and Member Services and Communication).

All standards for access to care, structure and operations, and quality measurement and improvement are incorporated in the Health Plan contracts/requests for proposal (RFPs). The language in the Health Plan contracts for each standard is in alignment with the regulations, and in some cases, more stringent than the regulations. Monitoring for each of these standards is achieved by a variety of methods, including required reporting and EQRO compliance reviews.

Access to Care Standards

MQD ensures that Health Plan contracts align with 42 CFR Part 438, subpart D regulations. MQD divides state access to care standards into 9 specific program areas. Those areas are discussed in the subsections below.

Network Adequacy

Hawai'i is a predominantly rural state comprised of six major islands, with substantial physician and ancillary provider shortage challenges. The only way to travel between islands is via air transportation. Ensuring access to care is particularly challenging on the rural neighbor islands where shortages in specialty care are well documented. In 2025, there was a physician need for 3,688 FTEs with only 3,044 available; the largest deficit remains in primary care with a shortage of 178 FTEs across all islands.² When considering the shortage locally, shortages ranged from a low in Oahu of thirteen percent to a high on the Maui island of forty percent.

Therefore, a variety of unique and creative strategies are needed to ensure that network adequacy standards are met, and Medicaid beneficiaries have access to needed care. Strategies employed have ranged from increased access to telehealth resources, to provision of non-emergency medical air transportation and lodging, as needed, for patients

² https://ahec.hawaii.edu/_docs/2026-final-physician-workforce-report.pdf
Med-QUEST Division - Managed Care Quality Strategy 2026

living on the neighbor islands to travel to Oahu to access some services.³ Telehealth services are reimbursable at the same rates as in person visits, by law, to encourage widespread adoption.⁴

MQD ensures minimum network requirements are met via the Health Plan contracts. Accordingly, Health Plans are required to ensure that their network has sufficient number, mix, and geographic distribution of providers to offer an appropriate range of services and access to preventive, primary, acute, behavioral health, and long-term services and supports.

MQD will work with Health Plans to improve provider directory accuracy, timeliness, and usability to ensure members have access to reliable information regarding participating providers, provider availability, accessibility accommodations, languages spoken, telehealth availability, and acceptance of new patients.

Table 3 - QI Network of Providers – Primary and Acute Care

QI Providers (Primary and Acute Care)
• Hospitals (a minimum of 5 on Oahu; 1 on Maui; 1 on Kauai; 2 on Hawai'i (1 in East Hawai'i and 1 in West Hawai'i); 1 on Lanai and 1 on Molokai if bidding Statewide) • Emergency transportation providers (both ground and air) • Non-emergency transportation providers (both ground and air) • Primary Care Providers (PCPs) (at least 1 per 300 members) • Physician specialists, including but not limited to: cardiologists, endocrinologists, general surgeons, geriatricians, hematologists, infectious disease specialists, nephrologists, neurologists, obstetricians/ gynecologists, oncologists, ophthalmologists, orthopedists, otolaryngology, pediatric specialists, plastic and reconstructive surgeons, pulmonologists, radiologists and urologists • Laboratories which have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or a waiver of a certificate of registration • Optometrists • Pharmacies • Physical and occupational therapists, audiologists, and speech-language pathologists • Licensed dietitians • Physician Assistants • Home health agencies and hospices • Durable medical equipment • Case management agencies • Long-term services and supports (listed below) • Providers of lodging and meals associated with obtaining necessary medical care • Sign language interpreters and interpreters for languages other than English

³ <https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2019/QI-1921.PDF>
[Accessed 7/16/20]

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Table 4 - QI Network of Providers – LTSS and Behavioral Health

QI Providers (LTSS and Behavioral Health)
• Adult day care facilities • Adult day health facilities • Assisted living facilities • Community care foster family homes (CCFFH) • Community care management agencies (CCMA) • Expanded adult residential care homes (E-ARCHs) • Home delivered meal providers • Non-medical transportation providers • Nursing facilities • Personal care assistance providers • Personal emergency response systems providers • Private duty nursing providers • Respite care providers • Psychiatrists (1 per 150 members with a Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) diagnosis) • Other behavioral health providers to include psychologists, licensed mental health counselors, licensed clinical social workers, Advanced Practice Registered Nurse (APRN) – behavioral health (1 to 100 members with a SMI or SPMI diagnosis) • State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment • Certified substance abuse counselors

Table 5 - CCS Network of Providers

CCS Providers
• Behavioral healthcare specialist services as provided by psychiatrists, psychologists, social workers, certified substance abuse counselors, and advance practice registered nurses who specialize in psychiatric-mental health nursing. • Case management • Inpatient behavioral health hospital services • Outpatient behavioral health hospital services • Mental health rehabilitation services • SUD services • Day Treatment Programs • Psychosocial rehabilitation (PSR)/Clubhouse • Residential treatment programs • Pharmacies • Laboratory Services • Crisis services: mobile crisis response and crisis residential services • Interpretation services • Supportive housing • Representative payee • Supported employment

- Peer Specialist (a Peer Specialist is someone who has gone through the same or similar life experience as the member, and will collaborate with the Community Health Worker to address the member's needs in a holistic manner)

MQD requires each Health Plan to submit a quarterly Provider Network Adequacy Verification Report (PNA) that demonstrates that the Health Plan offers an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate to meet the needs of the anticipated number of members in the service area. MQD requires CCS to have their own provider network for provision of behavioral health services for their members and ensure in-person services are available twenty-four (24) hours a day, seven (7) days a week, throughout the State.

The PNA report measures key performance indicators (KPI's) such as:

- Overall ratio of PCPs to Adults / Children
- Percent of Adults / Children Members with access to their PCP within Driving Time Standards
- Percent of Adults / Children PCP Reached – Statewide
- Percent of Specialist Reached – Statewide
- Occupancy of LTSS settings nearing or exceeding capacity

Additionally, the Health Plans are required to maintain a minimum number of providers within a particular geographic area. These requirements may be modified to account for and to promote the availability of telehealth services to achieve minimum geographic access.

Table X – QI Geographic Access to Providers

QI	Urban	Rural
PCPs	30 minute driving time	60 minute driving time
Specialists	30 minute driving time	60 minute driving time
OB/GYN	30 minute driving time	60 minute driving time
Adult Day Care and Adult Day Health	30 minute driving time	60 minute driving time
Hospitals	30 minute driving time	60 minute driving time
Emergency Services Facilities	30 minute driving time	60 minute driving time
Mental Health Providers	30 minute driving time	60 minute driving time
Pharmacies	15 minute driving time	60 minute driving time
24-Hour Pharmacy	60 minute driving time	N/A

Table 6 - CCS Geographic Access to Providers

CCS	Urban	Rural
Hospitals	30 minute driving time	60 minute driving time
Emergency Services Facilities	30 minute driving time	60 minute driving time

Mental Health Providers	30 minute driving time	60 minute driving time
Pharmacies	15 minute driving time	60 minute driving time
24-Hour Pharmacy	60 minute driving time	NA

Availability of Services

In addition to the minimum required providers, the Health Plans (QI and CCS) are required to have a sufficient network to ensure members can obtain needed health services within acceptable wait times. Health Plans are required to establish and monitor policies and procedures to ensure that the network providers comply with acceptable wait times and take corrective action when they fail to comply. These standards are monitored through a secret shopper survey and reported quarterly in the Timely Access Report.

Table 7 – Appointment Wait Times

Health Service	Wait Time
Emergency Medical Situations	Immediate care 24/7 without prior authorization
Urgent Care and PCP Pediatric Sick Visits	Appointments within 24 hours
PCP Adult Sick Visits	Appointments within 72 hours
Behavioral Health (urgent visits)	Appointments within 72 hours
Behavioral Health (routine visits)	Appointments within 21 days
PCP visits (routine)	Appointments within 21 days
Visits with Specialist or Non-emergency Hospital Stays	Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity

To ensure the ongoing adequacy, accessibility, and quality of its provider network, MQD is required to participate in two annual validation activities. The first is the Network Adequacy Validation (NAV), performed by an external third-party auditor to evaluate compliance with network adequacy standards, including provider availability, geographic accessibility, and appointment access requirements. The second is the Network Adequacy and Access Assurances Report (NAAAR), submitted annually to the Centers for Medicare & Medicaid Services (CMS), which provides a detailed analysis of the health plan's provider network and demonstrates compliance with federal network adequacy and access requirements. Findings from both the NAV and NAAAR processes are reviewed by MQD and incorporated into quality improvement initiatives to improve provider network performance and ensure members have timely access to services.

Access to Care during Transitions of Coverage/Transitions of Care

To ensure continuity of care, all members in the QI program transferring to a new Health Plan due to contract changes or member selection and who are receiving medically necessary covered services the day before enrollment into their new Health Plan, continue

to receive services from their new Health Plan without any form of prior approval and without regard to whether such services are being provided by the new plan's contracted or non-contracted providers. During transitions of care, Health Plans are expected to ensure that, their new members receive all medically necessary emergency services; receive all prior authorized long-term services and supports (LTSS), including both Home and Community Based Services (HCBS) and institutional services; adhere to a member's prescribed prior authorization for medically necessary services, including prescription drugs, or other courses of treatment; and provide for the cost of care associated with a member transitioning to or from an institution.

QI Health Plans are required to identify and refer adult members with SMI or SPMI for CCS eligibility review. Once enrolled into the CCS program, transitions for newly enrolled CCS members are coordinated by the CCS Health Plan. The CCS Health plan coordinates transition of all behavioral health care, SUD and CIS services with the Department of Health's Child and Adolescent Mental Health Division (DOH-CAMHD), the Department of Health's Adult Mental Health Division (DOH-AMHD), the Department of Health's Developmental Disabilities Division (DOH-DDD), the State Hospital, prison, QI Health Plans, and other agencies and organizations involved who have an established relationship with CCS members.

To mitigate an abrupt change in treatment that may be detrimental to the member's health and to reduce the risk of hospitalization or institutionalization, the CCS program ensures that the member has access to services consistent with the access they previously had. This includes retaining their current provider for a period of time regardless of whether the provider is in-network while the member is referred to providers of service that are a part of the provider network. To support transitions between providers, the previous treating provider(s) are expected to respond fully and timely to requests for historical utilization providing the new treating provider(s) with copies of medical records in compliance with Federal and State law.

Coordination and Continuity of Care

A Care Delivery and Health Coordination program has the potential to improve the effectiveness, safety, and efficiency of the health care delivery system. A well-designed program includes a whole-person/whole-family approach, while synchronizing and integrating the delivery of health care from multiple entities throughout the continuum of care. An effective program is able to address the multifaceted needs of populations with complex medical and social conditions including behavioral health conditions.

Health Plans must have an MQD-approved Care Delivery and Health Coordination program that complies with the requirements in 42 CFR §438.208, RFP-MQD-2021-008 Sections 3 and 11, and MQD Health Plan Manual. The Health Plans must provide whole-person and person-centered Care Delivery and Health Coordination Services to members receiving LTSS and HCBS, and to members who meet the criteria for Special Health Care Needs (SHCN) and Expanded Health Care Needs (EHCN). The Health Plans are required to provide appropriate Care Delivery and Health Coordination support across multiple settings and across the continuum of care with the focus on improving health care outcomes and decreasing inappropriate service utilization.

MQD requires the Health Plans to identify target populations through advanced data analytics and other processes; complete assessments; develop and implement person-centered health action plans; and, complete reassessments and develop updated health action plans according to the timelines and terms specified by the contract. Contractual requirements and compliance with federal regulations are monitored by MQD via Health Plan reporting and other quality assurance activities.

Care Delivery and Health Coordination Services include the coordination of physical, behavioral health, and social services; managing transitions of care, including transitions to and from Health Plans; identifying and addressing gaps in care; providing health promotion and disease management education; facilitating timely communications across the care team; and assuring an institutional level of care assessment is completed and the eligibility determination for long-term care is submitted, as applicable.

MQD requires Health Plans to utilize a multi-disciplinary team approach to provide Health Coordination Services which includes clinical and non-clinical staff such as community health workers when appropriate. To encourage flexibility in approaches while ensuring staffing adequacy, MQD requires Health Plans to submit Staffing Plans that comply with all applicable laws, regulations, and contractual requirements, rather than specifying staffing ratios for Care Delivery and Health Coordination.

Covered Benefits

MQD requires the Health Plans provide all medically necessary covered services to all eligible members. These medically necessary covered services are expected to be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to individuals under Medicaid fee-for-service (FFS). The Health Plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The Health Plan must ensure that services are provided in a manner that facilitates maximum community placement for members that require LTSS.

Additionally, a member's access to behavioral health services cannot be more restrictive than accessing medical services. The Health Plan must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to enrollees (whether or not the benefits are furnished by the same Health Plan).

The delivery of Covered Benefits is influenced by multiple factors, such as network adequacy, access, and parity. These and other factors are routinely monitored by MQD for compliance with contractual requirements and federal regulations through a variety of Health Plan reports. A few examples include the Provider Network Adequacy Verification and Timely Access reports, the Prior Authorizations Medical and Pharmacy reports, and Mental Health and Substance Use Disorder Parity report.

Authorization and Denial of Services

The implementation of Prior Authorization (PA) protocols has demonstrated efficacy in reducing spending on certain types of services such as medical imaging, non-preferred drugs, drugs prone to misuse and overuse, power mobility devices, and non-emergency medical transportation, but is also known to increase provider burden, delay receipt of care, and can worsen health outcomes if not implemented optimally.⁵ MQD requires Health Plans to have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. The procedures must be developed to reduce administrative burden on the providers and Health Plans are required to utilize any MQD-required standardized format for authorization of services.

Health Plans must ensure that all prior authorization/ pre-certification decisions, including but not limited to any decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, are made by a health care professional who has appropriate clinical expertise in addressing the member's medical, behavioral health, or LTSS needs.

Medical necessity approvals must be made by licensed clinical staff or unlicensed staff under the supervision of licensed staff. Medical necessity denials must be made by licensed clinical staff. All denials of medical, behavioral health, and LTSS shall be reviewed and approved by the Health Plan medical director. In addition, all administrative denials for

⁵ Altarum's Center for Value in Health Care. "Impacts of Prior Authorization on Health Care Costs and Quality." A. Turner, G. Miller, and S. Clark. November 2019. <https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf>. [Accessed 07/15/20]

children under the age of twenty-one (21) years shall be reviewed and approved by the Health Plan medical director.

Health Plans may place appropriate limits on a service based on criteria such as medical necessity, or for utilization control provided that:

- the services furnished can reasonably be expected to achieve their purpose;
- the services supporting members with ongoing or chronic conditions or who require LTSS are authorized in a manner that reflects ongoing need for such services and supports; and
- family planning services are provided in a manner that protects and enables the member's freedom to choose their family planning provider and receive family planning services consistent with 42 CFR §441.20.

Prior authorization is not required of emergency services, but prior authorization may be required of post-stabilization services and urgent care services. Health Plans' prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR §438.910(d).

At a minimum, this prior authorization (PA) pharmacy standard focuses on enforceable and measurable goals, such as a 24 hour or less turn-around time to respond to a pharmacy PA request. However, the objective is to raise the bar above the minimum standards currently set by MQD. Future objectives may focus more on improvement in provider satisfaction with the health plan's prior authorization processes.

In addition to already established requirements, Health Plans will modernize prior authorization processes to be compliant with CMS-0057-F, the CMS Interoperability and Prior Authorization Final Rule. Compliance with this new requirement will improve prior authorization for medical services and supplies through:

1. Accelerated Prior Authorization decisions
2. Providing greater transparency in denial reasons
3. Enhancing member and provider access to prior authorization status and related data
4. Enabling seamless payer to payer data exchange
5. Streamlining, end to end, electronic prior authorization processes
6. Reducing administrative burden for both providers and health plans.

MQD monitors prior authorizations and denials, and prior authorization processes to ensure contract compliance through Health Plan reporting. MQD encourages Health Plans to implement evidence-based strategies to improve the PA process such as regular reviews of

services and medications that require PA, eliminating PA requirements for certain providers, protecting continuity of care for patients receiving ongoing treatments, providing timely responsiveness and communication to providers on PA requests, and reducing provider burden through standardized and automated approaches that require minimal effort.⁶

Long Term Services and Supports

The Hawai'i Medicaid Program offers Long Term Services and Supports (LTSS) to beneficiaries meeting eligibility criteria. Individuals enrolled in managed care meeting nursing facility level of care are offered a choice of institutional services or Home and Community Based Services (HCBS). Those not meeting criteria for nursing facility level of care, but considered to be "at risk" for deterioration to nursing facility level of care, are offered a limited set of HCBS services in the managed care setting.

NURSING FACILITY SERVICES

Institutionalized services generally refer to long-term care services provided in licensed residential facilities, such as nursing facilities and intermediate care facilities for individuals with intellectual disabilities, where individuals receive comprehensive health, personal care, and supportive services, including room and board, on a 24-hour basis. These settings are considered "institutional" because they assume responsibility for the member's ongoing care and supervision.

Quality monitoring is addressed in the section titled Objective 9: Enhance nursing facility care and HCBS; prevent or delay progression to the nursing facility level of care.

HOME AND COMMUNITY BASED SERVICES

HCBS waivers are designed to provide supports in community settings as an alternative to institutional care, allowing individuals to remain in their homes or community-based residential settings whenever appropriate.

In accordance with the HCBS Settings Final Rule (42 CFR §441.301(c)(4) and §441.710(a)(1)), MQD has established robust procedures to ensure every setting where HCBS is provided—or where HCBS members reside—meets the federal settings requirements. Compliance and

⁶ Altarum's Center for Value in Health Care. "Impacts of Prior Authorization on Health Care Costs and Quality." A. Turner, G. Miller, and S. Clark. November 2019. <https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf>. [Accessed 07/15/20]

quality monitoring are addressed in the section titled Objective 9: Enhance nursing facility care and HCBS, and prevent or delay progression to the nursing facility level of care.

Additional monitoring and oversight activities for HCBS are explained in the sections below under each applicable authority.

1115 QUEST Integration Demonstration

Beginning in 2026, MQD will utilize and participate in CMS's Access Rule 1115 Quality Measure Set Pilot. The goal of the HCBS Quality Measure Set is to establish a standardized approach for measuring and improving the quality of home and community-based services, ensuring that Medicaid beneficiaries have access to person-centered, high-quality supports that promote health, independence, community integration, and overall quality of life. The pilot will support MQD's efforts to strengthen oversight of access to care and the quality of HCBS delivered to Medicaid beneficiaries. The pilot encompasses three key reporting areas: 1) access rule compliance measures, 2) LTSS/MLTSS Quality Measures, 3) HCBS CAHPS Survey. These measures are discussed in greater detail in the section titled Objective 9: Enhance nursing facility care and HCBS, and prevent or delay progression to the nursing facility level of care.

1915(c) Home and Community Based Services (HCBS) for Individuals with Intellectual and Developmental Disabilities (I/DD) Waiver

Under §1915(c) of the Social Security Act and 42 CFR 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. As a state standard, to ensure equitable and consistent access to HCBS services to all beneficiaries receiving these services, MQD adopted a Quality Strategy framework in accordance with CMS requirements. As such, this HCBS framework provides a basis for standardized assurances that apply to the state's 1915(c) waiver population served by the Department of Health Developmental Disabilities Division (DOH-DDD).

In accordance with CMS requirements, MQD has developed a Quality Strategy for Home and Community Based Services that addresses six areas of performance:

1. Administrative Authority;
2. Level of Care;
3. Service Plan;
4. Qualified Providers;

5. Health and Welfare; and
6. Financial Accountability.

DOH will be required to collect and report on this set of standard and supplemental performance measures to track and appropriately evaluate the quality of care delivered across all settings and programs. MQD will support quality measurement across all domains and subdomains that builds upon existing quality measurement efforts through independent surveys. An appropriate balance of measure types and units of analysis will be used. A standardized approach to data collection, storage, analysis, and reporting will be developed and implemented. MQD will ensure that emerging technology standards, development, and implementation are structured to facilitate quality measurement and support continuous quality improvement.

Performance measures associated with assurances for the 1915(c) program have a threshold of eighty-six percent (86%). Any performance measure with less than an 86% success rate will trigger further analyses to determine the root cause for the failure to meet the threshold. Strategies that may be implemented to meet quality assurances may include quality improvement training, revisions of policies and procedures as appropriate, recruitment of additional staff if needed, or reallocation of staff if warranted; the strategy will be tailored to the deficiency noted. All deficiencies identified during routine monitoring, including the plan implemented to remediate the deficiency where needed, will be summarized for reporting to CMS.

MQD defines high-quality HCBS services as those that are delivered in a manner that:

- Provides for a person-driven system that optimizes individual choice and control in the pursuit of self-identified goals and life preferences;
- Promotes social connectedness and inclusion of people who use HCBS, in accordance with individual preferences;
- Includes a flexible range of services that are sufficient, accessible, appropriate, effective, dependable, and timely to respond to individuals' strengths, needs, and preferences and that are provided in a setting of the individual's choosing;
- Integrates healthcare and social services to promote well-being;
- Promotes privacy, dignity, respect, and independence; freedom from abuse, neglect, exploitation, coercion, and restraint; and other human and legal rights;
- Ensures each individual can achieve the balance of personal safety and dignity of risk that he or she desires;
- Supplies and supports an appropriately skilled workforce that is stable and adequate to meet demand;

- Supports family caregivers;
- Engages individuals who use HCBS in the design, implementation, and evaluation of the system and its performance;
- Reduces disparities by offering equitable access to, and delivery of, services that are developed, planned, and provided in a culturally sensitive and linguistically appropriate manner;
- Coordinates and integrates resources to best meet the needs of the individual and maximize affordability and long-term sustainability;
- Delivers—through adequate funding— accessible, affordable, and cost-effective services to those who need them;
- Supplies valid, meaningful, integrated, aligned, accessible, outcome-oriented data to all stakeholders; and
- Fosters accountability through measurement and reporting of quality of care and consumer outcomes.

Health Equity and Disparities

As mentioned, health and health care disparities refer to differences in health and health care between groups that are closely linked with social, economic, and/or environmental disadvantage. Disparities occur across many dimensions, including race/ethnicity, socio-economic status, age, location, gender, disability status, and sexual orientation. MQD is focused on reducing disparities that may impact Hawai'i residents, including the Native Hawaiian population, rural populations or those with other geographic barriers, or any disparity affecting health care delivery and outcomes.

MQD takes a multi-pronged approach to support health equity and reductions in health and health disparities. Contractually, Health Plans are required to provide their Medicaid members with services without regard to race, color, creed, ancestry, sex, including gender identity or expression, sexual orientation, religion, health status, income status, or physical or mental disability. MQD manages a grievance hotline that allows beneficiaries to call to file any type of grievance, including grievances related to actual or perceived discrimination.

To proactively promote the identification of health disparities, MQD collects substantial demographic information via its application; this information, including the beneficiary's age, race, ethnicity, sex, primary language, and disability status data, are shared with the beneficiary's assigned Health Plan per §438.340, via the Health Plan enrollment record file (834 report) sent both daily and monthly. Health Plans are encouraged to examine their data by these various dimensions provided, and when disparities are identified, develop targeted interventions to address them.

Additionally, MQD developed a Social Determinants of Health (SDOH) Transformation Plan in partnership with its Health Plans which, represents MQD’s plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex (gender when available), primary language, and disability status. MQD is requiring Health Plans to submit patient-level data files on quality data to support and augment efforts to conduct disparities-based analyses. The SDOH Transformation Plan represents a shared MQD and Health Plan Road Map to comprehensively and systematically address health disparities.

Early implementation stages of the plan will emphasize the use of analytics and analytic methods by MQD and the Health Plans to identify and monitor health disparities, and increased identification of unmet social needs through enhanced data collection methods. Later implementation stages will focus on identifying and fortifying community-based SDOH supports, addressing social needs through referrals and resources, and targeting efforts to address the needs of populations at high risk for adverse health outcomes through socially and culturally appropriate mechanisms. Simultaneously, the SDOH Transformation Plan will pave the way for the development of financial mechanisms to address and mitigate health disparities and unmet social needs. Health Plans will be expected to align to, and describe their “on the ground” community and beneficiary-level activities that will realize the overall goals and strategies of, the SDOH Transformation Plan.

Structure and Operations

MQD ensures that Health Plan contracts align with 42 CFR Part 438, subpart D regulations. MQD divides structure and operations standards into thirteen (13) specific program areas. Those areas are discussed in the subsections below.

Provider Selection and Disenrollment

MQD intends to maintain a fair, unbiased, and non-discriminatory provider selection process. Health Plans are required to have written policies and procedures for the selection and retention of providers. These policies and procedures must include a process for identifying and assuring that excluded providers are not part of their network.

For example, Health Plans must conduct monthly screening of participating providers, employees, contractors, and other applicable individuals against Hawai'i's excluded provider list, the U.S. Department of Health and Human Services Office of Inspector General’s List of Excluded Individuals and Entities (LEIE), and any other exclusion databases required by MQD to ensure excluded individuals and entities are not participating in the Medicaid program.

Health Plans are not allowed to discriminate with respect to participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable Hawai'i State law, solely based on that license or certification.

Health Plans shall verify, through HOKU or other MQD-approved mechanisms, that providers selected for participation maintain active Medicaid enrollment and meet applicable provider screening, licensure, certification, and credentialing requirements prior to participation in the provider network.

Similarly, Health Plans in Hawai'i are not allowed to discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments. A Health Plan is not required to contract with every willing provider.

Provider selection, retention, and disenrollment decisions must be implemented in a manner that maintains compliance with MQD network adequacy standards and ensures continued access to medically necessary services for Medicaid beneficiaries.

If the Health Plan does not or will not include individuals or groups of providers of a specialty grouping in its network, it must provide that information to MQD. Further, if the Health Plan decides during the contract period that it no longer will include individuals or groups of providers in its network, the Health Plan must give the affected providers written notice of the reason for its decision and notify MQD if the individuals or providers represent five percent (5%) or more of the total providers in that specialty, or if it is a hospital.

MQD may direct a Health Plan to suspend, restrict, terminate, or remove a provider from participation when necessary to protect beneficiary safety, maintain program integrity, ensure compliance with state or federal requirements, or address provider performance concerns identified through oversight, monitoring, audits, investigations, or other quality review activities.

These provider selection and oversight requirements support MQD's commitment to maintaining a qualified provider network, ensuring beneficiary access to care, preventing fraud, waste, and abuse, and improving the quality and safety of services provided to Medicaid beneficiaries.

Practice Guidelines

Clinical practice guidelines are recommendations to enhance and optimize care delivered to patients that are based on the best available scientific evidence, and are intended to maximize the benefit of therapeutic interventions while minimizing harm. When based in sound theory, and implemented effectively, practice guidelines are a key resource to support quality assurance and quality improvement activities by bringing attention to best

practices, reducing practice variability, enhancing translation of evidence-based methods into practice, and improving the quality, safety, and person-centeredness of healthcare delivered. Valid guidelines are powerful resources for positively influencing health outcomes, but must be effectively disseminated and implemented to have an influence on the practice of care; several tools (e.g. point of care mobile applications, self-management tools, etc.) have emerged to assist with the implementation of guideline recommendations.⁷

MQD uses clinical guidelines to support policy decisions which are adapted or adopted from national professional organizations. Some examples include, the United States Preventive Services Task Force (USPSTF) for screening recommendations, the Centers for Disease Control and Prevention for recommendations on best practices across a variety of infectious and chronic conditions, the American Committee on Immunization Practices for immunization recommendations, the Public Health Service Clinical Practice Guidelines for tobacco cessation guidelines, and the American Academy of Pediatrics/Bright Futures for Early Periodic Screening Diagnostic and Treatment (EPSDT) periodicity of screening and diagnostic testing. MQD issues guidance as needed and additionally develops practice guidelines based on emerging and evolving clinical practice.

Consistent with 42 CFR 438.236(b), MQD requires contracted Health Plans to adopt practice guidelines based on valid and reliable clinical evidence, adopted in consultation with network providers, reviewed and updated regularly, and disseminated to all affected providers and, upon request, to members or potential members. Health Plans are required to include, as part of their Quality Assurance Performance Improvement (QAPI) Program, practice guidelines that meet the requirements as stated in §438.236 and current NCQA standards.

MQD reserves the option to specify topics for practice guidelines that Health Plans must work collaboratively to develop. Health Plans may additionally issue their own practice guidelines. Health Plan compliance with regards to clinical practice guidelines is reviewed by the EQRO at least every 3 years. Health Plan practice guideline policies and all current practice guidelines are subject to review by MQD. Additionally, in compliance with 42 CFR 438.236, MQD requires that Health Plans ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

⁷ “Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies.” European Observatory on Health Systems and Policies. Edited by R. Buess, N. Klazinga, D. Panteli, and W. Quentin. [https://www.ncbi.nlm.nih.gov/books/NBK549283/#:~:text=Clinical%20guidelines%20\(or%20%E2%80%9Cclinical%20practice,harms%20of%20alternative%20care%20options%E2%80%9D](https://www.ncbi.nlm.nih.gov/books/NBK549283/#:~:text=Clinical%20guidelines%20(or%20%E2%80%9Cclinical%20practice,harms%20of%20alternative%20care%20options%E2%80%9D). Accessed on May 29, 2026.

Table 10 describes the requirements for the Practice Guidelines.

Table 10 - Practice Guidelines Requirements

Practice Guidelines Must Be:	
• Relevant to the needs of the Health Plan's membership; • Based on valid and reliable clinical evidence, national recommendations, or a consensus of healthcare professionals in a particular field; • Aligned with the goals of this contract, Hawai'i Medicaid Managed Care Quality Strategy, and the Health Plan's QAPI; • Designed as systematic strategies to enhance use and implementation of evidence-based practices in support of addressing disparities, improving quality, enhancing adoption of evidence-based models and practices, and increased adoption of HIT-based strategies; • Adopted in consultation with in-network healthcare professionals; • Reviewed and updated periodically as appropriate; • Disseminated broadly to all affected providers, and upon request, to members and potential members; • Evaluated for adoption and implementation through provider-based reporting; • Promoted by the Health Plan for adoption and implementation through provider-based education activities; practice transformation support including HIT-based strategies; and other incentives.	

Enrollee Information

MQD operates the Medicaid program through contracts with managed care programs that provide a package of medical, behavioral health, and LTSS benefits to individuals meeting the Medicaid financial and non-financial eligibility requirements for individuals and families. Description of the individuals eligible and benefits are found in Hawai'i Administrative Rules, Title 17, Med-QUEST Division (1700 series). Medicaid Populations are described in Table 11 below.

In addition to existing enrollee communication requirements, MQD requires Health Plans to provide members with clear, accurate, and understandable information regarding covered benefits, provider availability, member rights, grievance and appeal processes, and available support resources. Health Plans shall utilize plain language and culturally appropriate communication methods to promote informed decision-making and member engagement.

Table 11- Hawai'i Medicaid Populations

Medicaid Covered Managed Care	• Children under 19 years of age • Former foster care children under age 26 • Pregnant women
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Populations (Lawfully residing)	• Parent or caretaker relatives • Eligible noncitizens (Lawful permanent residents, Cuban/Haitian entrants, or COFA migrants) • U.S. Citizens or nationals who are Medicaid eligible • Individuals who are aged, blind, or with a disability (ABD) • Eligible individuals under ABD Medically Needy Spenddown • Individuals with breast and cervical cancer
Non-Medicaid Covered Managed Care Populations (i.e. state funded populations)	• Individuals who are ABD, ineligible for Medicaid due to citizenship status, and legally reside in Hawai'i • Individuals with breast and cervical cancer who are ineligible for Medicaid due to citizenship status • Non-qualified aliens (non-citizens) and refugees who are Medicaid eligible
Excluded from Managed Care (i.e. Fee-for-service populations)	• Medicare Savings Program Members and Qualified Disabled Working Individuals not eligible for full Medicaid benefits; • Enrolled in the State of Hawai'i Organ and Transplant Program (SHOTT); • Incarcerated individuals who are admitted as an inpatient in a medical institution not on the grounds of the incarceration facility; • Out-of-State Foster Care children; • Repatriates; • Emergency Services for Non-citizens; and • Eligible under non-ABD medically needy spenddown.

Enrollment and Disenrollment of Members

MQD makes eligibility determinations based on requirements described in 42 CFR Part 435 and in accordance with Hawai'i's State Plan. MQD is solely responsible for determining eligibility. Provided the individual applying for Medicaid meets all eligibility requirements, the individual shall become eligible for Medical Assistance, and be effectively enrolled in and covered by a Health Plan on the date a completed application is received by the program. If the individual applying for Medicaid has Medicaid eligible medical expenses which were incurred no earlier than two (2) months immediately prior to the date of application, coverage may begin sooner to the date of application and correspond with the first date that eligible medical expenses were incurred.

MQD provides informational notices to potential members upon their approval of eligibility to allow them to choose a participating Health Plan. Upon notification of application approval, eligible individuals who submitted their applications electronically are provided the opportunity to select a participating Health Plan. Individuals who make a Health Plan selection will be enrolled in that Health Plan retroactively to the date of eligibility, or prospectively, as applicable. Individuals who do not make a choice of Health Plans when notified of eligibility, and those who do not submit an application electronically, will be

auto-assigned to a Health Plan retroactively to date of eligibility, or prospectively, as applicable. MQD conducts a rolling plan change period during which members are allowed to change plans without cause, after twelve (12) months of continuous membership in a particular Health Plan. Eligible individuals are also allowed a one-time change of Health Plan during the ninety (90) days grace period following their enrollment in a Health Plan whether enrollment is a result of selection or auto-assignment. In addition, for a variety of valid reasons, members are also allowed to make changes to their Health Plan enrollments throughout the year.

Quality-based auto-assignment is a powerful financially-based strategy to promote and incentivize quality improvement, and is used by several state Medicaid programs. When implemented effectively, this strategy can complement and supplement other quality-based incentive programs such as pay for performance programs.⁸ MQD determines auto-assignment based on an algorithm that may take into consideration Health Plan enrollment volume, distribution of enrollee sub-groups, Health Plan performance, Health Plan scorecard and quality metrics, and additional criteria to be specified. Currently, Health Plans are notified in advance of the performance or quality measures that will be used in the auto-assignment algorithm; measures may be updated up to once per year and have historically focused on HEDIS[®] and CAHPS measures. Auto-assignment methodologies, including the relative weight of each component included in the formula, are modified as needed after adequate notifications to Health Plans. MQD reserves the right to incorporate enrollment caps and limits into the auto-assignment methodology.

MQD has sole authority to disenroll a member from a Health Plan and from the programs. Allowable and Prohibited Reasons for disenrollment are listed in the following Table 12 below.

Table 12 – Hawai‘i Medicaid Member Disenrollment Criteria

Allowable Reasons for Disenrollment	Prohibited Reasons for Disenrollment
• Member no longer qualifies based on the medical assistance eligibility criteria or voluntarily leaves the program • Death of a member • Incarceration of member • Member enters the state hospital • Member enters Hawai‘i Youth Correctional Facility • Member enters State of Hawai‘i Organ and Tissue Transplant (SHOTT) program	• Pre-existing Medical Conditions • Missed Appointments • Changes to Member’s Health Status • Utilization of Medical Services • Diminished Mental Capacity • Uncooperative or Disruptive Behavior resulting from the Member’s special needs

⁸ Centers for Health Care Strategies, Inc. “Performance Incentive Programs.” <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/StatePerformanceIncentiveChart040606.pdf>. 11/04/01 [Accessed 7/16/20]

Allowable Reasons for Disenrollment	Prohibited Reasons for Disenrollment
• Member is in foster care and has been moved out-of-state by DHS • Members becomes a Medicare Special Savings Program member beneficiary • Member provides false information with the intent of enrolling in the programs under false pretenses • Member is a medically needy individual who is two full months in arrears in the payment of the designated spend down or cost share	

Confidentiality

MQD is committed to protecting the confidentiality of member information. MQD requires that the Health Plan not disclose confidential information to any individual or entity except in compliance with the following:

- a) 42 CFR Part 431, Subpart F;
- b) The Administrative Simplification provisions of HIPAA and the regulations promulgated thereunder, including but not limited to the Security and Privacy requirements set forth in 45 CFR Parts 160 and 164; Section 346-10, HRS; and
- c) All other applicable federal and State statutes and administrative rules, including but not limited to:
 - a. Section 325-101, HRS, relating to persons with HIV/AIDS;
 - b. Section 334-5, HRS, relating to persons receiving mental health services;
 - c. Chapter 577A, HRS relating to emergency and family planning services for minor females;
 - d. 42 CFR Part 2 relating to persons receiving substance abuse services;
 - e. Chapter 487J, HRS, relating to social security numbers;
 - f. Chapter 487N, HRS, relating to personal information; and
 - g. Session Laws of Hawai'i, Act 139(16), relating to insurance.

MQD requires that access to member identifying information shall be limited by the Health Plan to persons or agencies that require the information in order to perform their duties in accordance with this contract, including the U.S. Department of Health and Human Services (HHS), the Secretary, MQD and other individuals or entities as may be required by MQD.

Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. The Health Plan is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. The Health Plan, if it reports services to its members, shall comply with all applicable confidentiality laws. The disclosure of information in summary, statistical or other form that does not identify particular individuals, is not prohibited provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

If a health plan becomes aware of a potential compromise of a member's protected information, it must notify MQD within two (2) business days. A written report must then be submitted within thirty (30) days. MQD will investigate the incident in coordination with the health plan and will close the case once a satisfactory resolution has been reached. MQD reports all breaches to leadership on a monthly basis and maintains an annual tracking log of all reported incidents.

Member and Provider Grievance and Appeals

The Med-QUEST Division (MQD) requires Health Plans to maintain a formal member grievance and appeals system that complies with all applicable State of Hawai'i requirements and the provisions set forth in 42 CFR Part 438, Subpart F. Under contractual obligations established by MQD, Health Plans must ensure that member grievances and appeals are administered in a timely, equitable, and effective manner.

MQD further requires Health Plans to provide members with meaningful access to additional avenues of review, including the ability to file grievances or appeals directly with the State when issues remain unresolved at the Health Plan level. Health Plans must also inform members of their right to access the State administrative hearing process and clearly communicate the requirement to exhaust the Health Plan's internal grievance and appeals procedures prior to requesting a State administrative hearing. MQD oversees the effectiveness and compliance of member grievance and appeals systems through ongoing monitoring activities, including review of Health Plan policies, procedures, protocols, and grievance and appeals data and reporting.

In addition, MQD requires Health Plans to establish and maintain formal provider grievance and appeals processes. These processes enable providers to raise and resolve concerns, disputes, or operational issues involving the Health Plan, including matters related to member care, covered services, claims administration, or provider participation. Providers may utilize these procedures to seek review and resolution of issues affecting their contractual or operational relationship with the Health Plan. MQD monitors provider grievance and appeals systems through Health Plan reporting and oversight activities, including evaluation of procedures,

protocols, and related statistical and operational data via the Member Grievance and Appeals and Provider Grievance and Claims reports.

To further support Medicaid beneficiaries and providers, MQD operates a grievance hotline and provides Ombudsman services across all islands of Hawai'i. The Ombudsman assists eligible Medicaid beneficiaries and providers in addressing concerns related to access to care, quality of care, and limitations or denials of health care services covered under Medicaid programs. In addition, the Ombudsman serves as an independent resource to help individuals understand their rights, available benefits and services, and the processes available for resolving disputes and concerns.

MQD will collaborate with Health Plans and the Ombudsman Program to increase member awareness of available assistance resources and ensure members understand how to access support for grievances, appeals, complaints, and questions regarding services and benefits. These efforts are intended to improve member engagement, strengthen transparency, and support timely resolution of member concerns.

Sub-contractual Relationships and Delegation

Contingent upon approval from DHS, Health Plans may be permitted to delegate certain Quality Assurance and Program Improvement (QAPI) Program activities and functions. However, the Health Plan remains responsible for the QAPI Program, even if portions are delegated to other entities. According to §438.230, any delegation of functions requires a contract or written agreement between the subcontractor and the Health Plan. The contract or written agreement must describe the activities and reporting responsibilities of the sub-contractor, and provide for revocation of the agreement, or specify other remedies in instances of unsatisfactory performance. MQD requires the Health Plan to maintain policies and procedures detailing the process for evaluating and monitoring the subcontractor's performance. At a minimum, prior to execution of the delegation contract or written agreement there must be provisions for a site visit and evaluation of the sub-contractor's ability to perform the delegated activities. Subsequently, an annual site visit and/or documentation and record review must occur to monitor and evaluate the quality of the sub-contractor's assigned processes. The annual on-site visit may be waived if the subcontractor is accredited by NCQA.

Health plans are responsible for ensuring that data received from subcontractors is accurate, complete, and compliant with all encounter data reporting requirements. This includes verifying the accuracy and timeliness of reported data and screening submissions for completeness. Health plans are also responsible for providing subcontractors with information regarding the Member Grievance and Appeal system. In addition, health plans must develop and implement a training program that describes their approach to monitoring subcontractors' progress in recruiting and training staff to meet contractual requirements.

Health Information Technology

In accordance with 42 CFR 438.242, each Health Plan is expected to maintain a health information system that collects, analyzes, integrates, and reports data. The system provides information in areas including, but not limited to, service utilization, grievances, appeals and disenrollment for reasons other than loss of Medicaid eligibility.

As specified in 42 CFR 438.204(f), the Hawai'i Prepaid Medical Management Information System (HPMMIS) supports MQD's administration of the QUEST Integration programs. HPMMIS interfaces with Hawai'i's eligibility system, Kauhale On-Line Eligibility Assistance (KOLEA). KOLEA collects and processes Medicaid applications, including a series of automated verifications, to make eligibility determinations. This information is passed to HPMMIS, which provides enrollment processing, encounter record processing, claims processing, premium collection, per capita payments, and related tracking and reporting. MQD uses information from HPMMIS to produce reports which identify and aid in the investigation of provider abuse or misuse.

In 2020, MQD launched a new web-based provider management system called Hawai'i's Online Kahu Utility (HOKU). HOKU ensures MQD's compliance with the 21st Century Cures Act that requires States to enroll all Medicaid providers, both those in Medicaid fee-for-service and managed care organizations. In addition, MQD completed the implementation of Electronic Visit Verification (EVV), another requirement of the 21st Century Cures Act that mandates EVV for all Medicaid personal care services (PCS) and home health services that require an in-home visit by a provider. Both systems enhance program integrity, reduce provider fraud, waste and abuse, and improve the quality of encounter data entering HPMMIS to support a variety of program planning and monitoring purposes.

The 2018 Legislature established the MQD Health Analytics Office (HAO) as part of the first phase of the investment in the MQD IT system to achieve the goals of increased transparency, better health, better healthcare, and lower costs for beneficiaries of State-funded health insurance plans, including the Medicaid Program. In 2021, MQD applied for and received enhanced Federal Financial Participation (FFP) to evolve and enhance the Hawai'i Prepaid Medicaid Management Information System (HPMMIS) by developing an integrated data and analytics module and maturing the data governance processes of Medicaid data sources, together referred to as the Health Analytics Program (HAP). The HAP went live on December 31, 2025 and is in a post-Go-Live system stabilization period. It is currently receiving 7 health plan reports with more in development and will become the primary decision support system (DSS)/analytics data warehouse/repository for data analysis and reporting in early 2027.

In 2020, CMS implemented the Healthcare Interoperability requirements which were designed to open up and standardize data sharing in healthcare, giving patients easier access to their records, and preventing organizations from blocking the exchange of health information. In 2024, CMS expanded these requirements by introducing standardized APIs and processes for electronic prior authorization, along with new Provider Access and Payer-to-Payer data-sharing requirements. In 2026, CMS proposed further expanding interoperability requirements to include electronic prior authorization and data exchange for prescription drugs and pharmacy-related objectives. MQD met internally and with the health plans to achieve these deadlines.

MQD participates in several additional statewide Health IT initiatives to support quality efforts and data exchange; for example, build of a case management system to support optimal care delivery to 1915(c) waiver beneficiaries; support for enhanced connectivity between Federally Qualified Health Centers and the Hawai'i Health Information Exchange; funds to support enhanced meaningful use initiatives and public health data reporting; and other projects as needed to support MQD quality initiatives and support the overall quality of healthcare in the state.

Through future managed care contract, MQD will ensure that Health Plans are in full compliance with new requirements of 42 CFR 438.242 and the 21st Century Cures Act, including but not limited to, the development and deployment of a patient access applications programming interface (API), provider directory, payer-to-payer data exchange and supporting MQD with reporting as needed to enable more frequent Federal-State data exchange on dually eligible enrollees.

Claims Payment

MQD requires that the Health Plans develop and maintain a claims payment system capable of processing, cost avoiding, and paying claims accurately in accordance with the reimbursement terms established with the provider. Providers must submit claims no later than 12 months from the date of service. Health plans are required to submit all encounter data to MQD within 15 months from the date of service. Health plans shall pay ninety percent of all clean claims within 30 days, ninety-nine percent of all cleans claims within 90 days and one hundred percent of all clean claims within fifteen months from the date of service. Health plans shall resolve disputes timely and no later than 120 days from the date of adjudication or as otherwise defined in the provider contract.

In addition, the payment system must produce a remittance advice related to the health plan's payments to providers and must contain, at a minimum:

- An adequate description of all denials and adjustments using HIPAA standard Claim Adjustment Reason Codes (CARCs). Any payor-specific or customized reason codes shall also be fully explained in the same manner;
- The amount billed;
- The amount paid;
- Application of coordination of benefits (COB) and subrogation of claims (SOC); and
- Provider rights for claim disputes.

Encounter Data and Drug Rebate Submission

MQD collects and uses encounter data for purposes such as audits, investigations, identifying improper payments, program integrity activities, federal reporting (42 CFR 438.242(b) (1)), rate setting and risk adjustment; analyzing denial patterns, verifying quality measure data prior to release of withhold or incentive payments, service verification, managed care quality improvement, policy analysis and decision making, assessing utilization and access to care, hospital rate setting, pharmacy rebates, and research.

MQD requires that the Health Plan submits encounter data for all services rendered to members under this contract, including encounters where no liability exists, whether the encounter was paid or denied, and any adjustments or voids to previously submitted records. To ensure accuracy and completeness, Health Plans must verify the timeliness and correctness of reported data, screen for completeness, logic, and consistency, and collect service information in a standardized format.

The Health Plan submits encounter data to MQD at least once per month in accordance with the requirements and specifications defined by the State and included in the Health Plan Manual. The Health Plan and its subcontractors are expected to retain all encounter data for at least ten (10) years in accordance with 42 CFR 438.3(u) with provisions to maintain permanent history by service date for those services identified as “once-in-a-lifetime” (eg. amputation).

To ensure the accuracy and completeness of encounter data in HPMMIS, MQD conducts monthly comparisons between the Health Plans’ recorded submitted encounter files and the encounter files actually received in HPMMIS. MQD also performs quarterly reconciliations against each Health Plan’s financial ledgers. This process helps ensure that the data used for capitation rate-setting is actuarially sound. Reconciliation is conducted in two ways: comparing the number of CRNs and comparing the total claims expenditures recorded by the Health Plans. Key performance indicators (KPIs) are used to evaluate Health Plan performance by measuring variances between Health Plan data and HPMMIS data across major service categories (including inpatient, outpatient, professional, pharmacy, nursing home, and HCBS). KPIs also

assess the accuracy, completeness, and timeliness of encounter submissions and adjudicated claims used in the reconciliation process.

In accordance with CMS External Quality Review Protocol 5: Analyze Electronic Encounter Data, an Encounter Data Validation (EDV) study is conducted every 3 years to assess record-level completeness and element-level completeness and discrepancies through a series of comparative analyses. The study evaluates how complete and accurate the Health Plans' encounter submissions are compared to data historically provided to MQD's actuary for rate setting. A 5% benchmark is applied to identify data element omissions, surpluses, missing values, and discrepancies that require further investigation. Following the analyses, technical assistance is provided to the Health Plans to help identify root causes of issues and support corrective actions to improve MQD's encounter data quality.

At a minimum standard, for all covered outpatient drugs, as described in 42 CFR 438.3 (s), the Health Plan is responsible to continue to collect data to

- 1) Report drug utilization data that is necessary for the State to bill manufacturers for rebates following the State's reporting calendar.
- 2) Report drug utilization information, using the State's Prescribers' Digital Reference (PDR) file format, that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by the Health Plan.
- 3) Continue to improve 340B exclusion by establishing procedures to exclude utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from drug utilization data reports when states do not require submission of managed care drug claims data from covered entities directly.
- 4) Provide a detailed description of its drug utilization review program activities to MQD on an annual basis.

Non-emergency Medical Transportation (NEMT)

As a state comprised of multiple islands with limited access to critical and specialty care on rural islands, NEMT provides a crucial safety net to assure adequate access to services for members living in rural areas of the state. MQD requires Health Plans to provide transportation to and from medically necessary Medicaid covered medical appointments for members who have no means of transportation and who reside in areas not served by public transportation or cannot access public transportation; and as needed for specialists to render care to members. Transportation services include both non-emergency ground and air services.

MQD requires Health Plans to provide transportation to members who are referred to a provider that is located on a different island or in a different service area. Health Plans may use whatever modes of transportation that are available and can be safely utilized by the member. In cases where the member is a minor or requires assistance, Health Plans are expected to provide for one attendant to accompany the member to and from medically necessary visits to providers; in these cases the Health Plans are responsible for the arrangement and payment of the travel costs (airfare, ground transportation, lodging, and meals) for both the member and the attendant.

Provider Accreditation

Currently, MQD requires Health Plans to demonstrate that network providers are credentialed as required under §438.214. In addition, all providers who provide services to members must be enrolled with MQD as Medicaid providers consistent with provider disclosure, screening, and enrollment requirements. Health Plans must follow the most current NCQA credentialing and re-credentialing standards including delegation and provider monitoring/oversight. Health Plans are contractually required to submit their credentialing and re-credentialing and other certification policies and procedures to MQD for review and approval.

Health Plans must ensure that participating providers maintain active enrollment with MQD and continue to meet all applicable licensure, certification, credentialing, and enrollment requirements. Health Plans shall monitor provider enrollment status and take appropriate action when providers become inactive, suspended, terminated, or fail to complete required provider revalidation activities.

Health Plans shall ensure providers meet applicable state and federal screening, licensure, certification, and credentialing requirements. Health Plans shall also comply with applicable Clinical Laboratory Improvement Amendments (CLIA) requirements and any additional provider qualification standards established by MQD.

In compliance with § 5005(b) of the 21st Century Cures Act, MQD implemented a provider enrollment, eligibility verification and credentialing system in August 2020 called Hawai'i's Online Kahu Utility (HOKU), the system allows MQD to maintain direct responsibility for provider enrollment, screening, credentialing verification, and revalidation activities. Health Plans are required to utilize HOKU and MQD enrollment information, as applicable, to ensure participating providers meet Medicaid enrollment and credentialing requirements prior to furnishing services to Medicaid beneficiaries.

These credentialing and provider oversight activities support MQD's goals of ensuring beneficiary access to qualified providers, maintaining accurate provider information, strengthening program integrity, and promoting the delivery of safe, high-quality healthcare

services.

Non-Duplication Strategy

The non-duplication regulation provides states the option to use information from a private accreditation review to avoid duplication with the review of select standards required under §438.360(a). The standards that may be considered for this deemed compliance as referenced in §438.360(a) are those listed in Subpart D of the regulations for access to care, structure and operations, and measurement and improvement. MQD acknowledges that the activities required under §438.330(c & d) (for calculating performance measures and conducting Performance Improvement Projects [PIPs] are an option for deeming only for plans that exclusively serve dual eligible beneficiaries and therefore does not apply to MQD-contracted Health Plans. MQD may use information from a Medicare and/or a private accreditation review to avoid duplication with the review of select standards required under an external quality review. This option may be used at the discretion of MQD. Currently, MQD does not exercise the option of non-duplication.

Hawai'i Revised Statute 432E-11 requires that managed care plans doing business in Hawai'i are accredited by a national accrediting organization. The requirement for QUEST Integration is that National Committee Quality Assurance (NCQA) accredits all Health Plans.

Reporting, Monitoring, and Evaluation

In 2021, MQD updated its Health Plan Reporting package to now encompass 39 reports and 300+ key performance indicators (KPIs) to monitor and evaluate Health Plan performance across quality assurance standards and evidence-based practices. Building on this enhanced reporting infrastructure, MQD is also strengthening its evaluation capacity through its partnership with the contracted University of Hawai'i evaluation team, which provides independent assessment of the State's 1115 demonstration waiver initiatives through robust analytic and evaluation methodologies. To further promote collaboration and continuous quality improvement, MQD instituted annual "360 Review Presentations" for each Health Plan, offering a comprehensive assessment of plan-level performance, operational effectiveness, and progress toward quality assurance and improvement goals. Together, these efforts reinforce MQD's commitment to a data-driven Managed Care Quality Strategy that emphasizes accountability, collaboration, and ongoing monitoring of outcomes to advance high-quality, person-centered care.

MQD aims to improve and refine the 39 reports within the Health Plan Reporting Packages over the next 3 years by reevaluating whether the existing Key Performance Indicators

(KPIs) are fulfilling their intended purposes and meeting MQD's data needs, health plan monitoring requirements, and project support needs. In collaboration with subject matter specialists, MQD will adjust the KPIs as needed to ensure they align with each report's goals and address current and future federal and state reporting requirements. As we review these KPIs and reporting packages, we are assessing performance trends and overall usefulness to better engage with the Health Plans by identifying areas where they excel in providing quality care and where opportunities for improvement and gaps in care delivery exist. This evaluation will be particularly important as we anticipate all 39 reports will transition to the Health Analytics Program (HAP), with the goal of enhancing data accessibility through an integrated analytic platform that consolidates multiple data sources into a centralized system. Centralizing these reports will support the development of dashboards within the HAP, allowing data from multiple reports to be viewed together in ways that strengthen oversight of state waiver authorities, enhance managed care quality monitoring, and help assess healthcare disparities.

In addition to the Health Plan Reporting package, MQD completes annual reports that are submitted to CMS including Network Adequacy and Access Assurances Report (NAAAR) in compliance with federal regulations 42 CFR 438.207(d); Quality Measure Reporting (QMR) as described in 42 CFR Parts 433, 437 and 457; and Managed Care Program Annual Report (MCPAR) in compliance with 42 CFR § 438.66(e) as part of its managed care program monitoring activities and identifies areas needing technical assistance from CMS. By completing these reports timely, MQD improves access monitoring for Medicaid beneficiaries within a managed care delivery system. MQD also completes Medicaid Section 1115 Demonstration Monitoring Reports, which track demonstration progress, metrics, trends, and plans. In completing this report, it ensures alignment with the state's special terms and conditions and CMS's expectations.

Through its EQRO, MQD conducts Provider Satisfaction survey on a biennial basis and annual Member Satisfaction (CAHPS) survey for Child Statewide Population that includes Child Health Insurance Program (CHIP) population and children with chronic care conditions (CCC). A separate Child and Adult CAHPS are also conducted on alternating years. With these surveys, MQD intends to strengthen collaboration with its EQRO to enhance the Provider Satisfaction survey instrument, select an appropriate statistically valid sample, and develop the survey methodology, including determining an acceptable response rate and identifying strategies to maximize members' and providers' survey participation. MQD will also strengthen collaboration with QI health plans to implement additional strategies aimed at improving member and provider engagement during CAHPS and Provider Satisfaction surveys. Evaluation of response rates will be monitored through each survey's final report.

Member Services and Communication

Health plans are responsible for developing member service policies and procedures that encompass all of MQD's populations. MQD monitors health plan performance through the review and analysis of member service statistics, performance measures, and other required reporting to ensure that accessible services are provided to all beneficiaries, including individuals for whom English is a second language. Health plans are required to continuously monitor their performance in providing customer service to its members and submit quarterly data to MQD. These performance metrics are designed to ensure that members have timely access to care and to assess the effectiveness and quality of services provided.

III. Improvements and Interventions

Section I described the in-depth reassessment which revitalized commitment to MQD's vision and mission and resulted in an enhancement of objectives. Each objective along with initiatives actively implemented or in planning is described below.

OBJECTIVE 1	ENHANCE PEDIATRIC PRIMARY CARE THROUGH PREVENTION AND HEALTH PROMOTION
	a. Ensure timely and appropriate EPSDT visits and services across all islands b. Improve access to high quality behavioral health services for children c. Improve children's oral health through better preventative services

Objective 1a. Ensure timely and appropriate EPSDT visits and services across all islands

Intervention: Improve EPSDT data quality and drive improvement in data metrics

Deploy short term and long term EPSDT data improvement project. For short term goal- MQD will complete data assessment that includes comparison of different data sources, review of historical data discrepancies, identify data quality and operational issues. Collaborate with Health Plans to conduct root cause analysis. Data then will be analyzed and used for intentional improvement data metrics. Long term goal is to have EPSDT data automated in the Health Analytics Portal, starting with the request of information from the Health plans about current ongoing efforts to improve data metrics, methods to monitor what is working versus not working, and setting a goal for the next reporting period.

Success will be measured by having a validation process for data accuracy and improve data metrics.

Objective 1b. Improve access to high quality behavioral health services for children

Intervention : Increase programs for behavioral health services such as developing infrastructure to address infant and early childhood mental health (IECMH) and adverse childhood experiences (ACE), including establishing Certified Community Behavioral Health Clinics (CCBHC)

For IECMH- Develop a bundle payment model, continue to partner with stakeholders in building workforce capacity and access to service. For ACEs- Develop a screening tool for Hawaii and screening reimbursement. For CCBHCs- Currently Hawaii has two pilot clinics in Maui with the plan for expansion.

In addition, Med-QUEST is working on implementing the new Hawai'i law (Act 93) to allow unlicensed Mental Health Providers to deliver service and bill under the supervising licensed provider to increase access to behavioral health services.

Objective 1c. Improve children's oral health through better preventative services

Intervention: Increase public awareness of dental check-up, ensure access to transportation, improve data quality to make targeted improvement efforts.

Partner with community based organizations, FQHCs, stakeholders, and health plans to increase public awareness of oral health. Partner with HDS and CCMC to ensure support in finding dentist and access to transportation for dental appointments.

Success is measured by the ability to utilize data to monitor data metrics improvement.

OBJECTIVE 2

REDUCE UNINTENDED PREGNANCIES; IMPROVE PREGNANCY-RELATED CARE

MQD supports members in having healthy and welcome births through access to high quality primary care, pregnancy care, and family planning services.

Intervention 1: Identify and address any barriers to access family planning services

The Hawai'i Medicaid benefit covers family planning services including family planning drugs, supplies and devices to include but not be limited to any Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all individuals with reproductive capacity. Health Plans are required to provide services to members wishing to prevent pregnancies, plan pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. In addition, services are explicitly expected to include emergency contraception, contraceptive supplies and follow-up care, counseling related to risk behaviors and preventive strategies, as well as the diagnosis and treatment of sexually transmitted infections (STI). MQD partners with the Hawai'i State Department of Health (DOH), Essential Access (the Hawai'i Title X grantee), and various community stakeholders to identify, define, and address challenges members and providers encounter in accessing covered family planning benefits. This initiative strives to increase conscious family planning and improved access to contraception of choice among members of reproductive age.

Success will be defined by improvements to the following measures:

- Contraceptive Care—All Women† Most or Moderately Effective Contraception—15–20 Years
- Contraceptive Care—All Women† Long-Acting Reversible Contraception—15–20 Years
- Contraceptive Care—All Women† Most or Moderately Effective Contraception—21–44 Years
- Contraceptive Care—All Women† Long-Acting Reversible Contraception—21–44 Years

Intervention 2: Implementing AIM bundles through Statewide Perinatal Quality Collaborative

The Hawai'i perinatal quality collaborative, designed to improve the quality of care for families with babies in hospitals is included in a Hospital P4P Program. This collaborative joined the American College of Obstetrics (ACOG) Alliance for Innovation on Maternal Health (AIM). "AIM is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improving maternal safety and outcomes. The program provides implementation and data support for the adoption of evidence-based patient safety bundles." (<https://www.acog.org/practice-management/patient-safety-andquality/partnerships/alliance-for-innovation-on-maternal-health-aim>). Within the past year, the perinatal quality collaborative introduced a new bundle: CARE FOR PREGNANT AND POSTPARTUM PEOPLE WITH SUBSTANCE USE DISORDER and is in the process of coordinating with various stakeholders across the continuum of care to address this complex AIM bundle.

Success will be defined by improvements to the following measures

1. MCO P4P
 - a. Utilize same PPC measure found in P4P
 - Prenatal and Postpartum Care Timeliness of Prenatal Care—Total
 - Prenatal and Postpartum Care Postpartum Care—Total
 - b. *Match benchmark to P4P
2. Hospital P4P
 - a. AIM bundle(s) HAH and the hospitals Process/outcome metrics
 - b. Measure may need to be TBD until AIM collaborative and measures are selected
 - c. Benchmark will match P4P benchmark/requirements

Intervention 3: Expanding access to culturally relevant pregnancy care

In response to community stakeholder requests, MQD is expanding access to pregnancy care by adding a new type of providers: Hawai'i licensed non-nurse midwives practicing as Certified Professional Midwives and Certified Midwives. Non-nurse midwifery practice standards support cultural safety, shared decision-making, and respect for member autonomy across diverse communities. By integrating non-nurse midwife practitioners, MQD intends to empower pregnant and birthing members and counteract documented health disparities identified in birthing populations in Hawai'i.

Success will be defined for this first-time intervention by increasing the number of these new providers enrolling as Medicaid providers and the number of members utilizing services of these new providers. Data will be tracked with an aim to reach the following KPI.

- Two measures on number "credentialed" in HOKU and utilization
 - Number of non-nurse midwives
 - Benchmarks:
 - Year 1: 10
 - Year 2: 20
 - Year 3: 30
 - Number of members utilizing non-nurse midwives
 - Benchmarks:
 - Year 1: 10
 - Year 2: 25
 - Year 3: 40

OBJECTIVE 3

Increase and Expand Adult Primary Care Screening and Preventative Services

MQD is committed to increasing adult primary care screening and preventive services to improve health outcomes, reduce disparities, and decrease avoidable emergency department and hospital utilization. Through its managed care contracts, MQD continues to strengthen requirements that promote prevention, early detection of chronic disease, lifestyle change interventions, and improved chronic condition self-management. MQD has also expanded capacity to support advancing primary care, primary care spend measurement, Value Based Payment (VBP), Pay-For-Performance (P4P), and preventive program development, including the Diabetes Prevention Program.

Intervention 1: Advancing Primary Care Initiative

As part of its Advancing Primary Care initiative, MQD requires health plans to report primary care spend across three definitions:

- Primary Care Visits – direct primary care encounters where screenings, preventive counseling, and chronic disease management typically occur.
- Beneficial Primary Care Services – clinically beneficial preventive services such as screenings, immunizations, and evidence- based assessments.
- Primary Care Supports – services like care coordination and care management that help beneficiaries engage in preventive care and chronic disease management.

MQD also tracks low value primary care services to redirect resources toward high value preventive care. MQD will establish primary care spend targets by January 1, 2028, and monitor progress as part of the AHEAD initiative, further strengthening the role of primary care in prevention and early detection.

Increasing and expanding Adult Primary Care Screening and Preventative Services remain as key priority for MQD. It is MQD’s goal to improve access to and utilization of high-quality, equitable preventive and primary care services for Medicaid beneficiaries to promote optimal health outcomes, prevent disease, reduce health disparities, and decrease avoidable emergency department visits and hospitalizations. MQD aims to enhance collaboration with health plans to improve performances related to Preventive Care measures and strengthen chronic disease prevention and management through Primary Care.

Through its current managed care contract, MQD will continue to implement requirements of primary care prevention strategies. For example, Health Plans may implement a prevention and health promotion program to prevent or delay the onset of chronic diseases for members who are at risk of developing chronic diseases and would benefit from lifestyle change interventions; and improve self-management of chronic or medical conditions for members who have chronic condition(s).

Intervention 2: Pay for Performance Program and Auto Assignment Algorithm

MQD collects, monitors, and incentivizes performance on a wide range of preventive and chronic disease related measures through the P4P Program and the Auto Assignment Algorithm. While health plans must report on a broad set of measures, MQD will identify a smaller set of high priority measures for the quality pool to focus improvement efforts on the most impactful areas.

OBJECTIVE 4	BUILD BEHAVIORAL HEALTH CAPACITY
	a. Build capacity for Substance Use Disorder Treatment services b. Build capacity for Mental Health Treatment services

Objective 4a. Build capacity for Substance Use Disorder Treatment services

MQD’s substance use disorder (SUD) capacity-building strategy focuses on expanding access to evidence-based treatment, strengthening coordinated systems of care, and improving service integration across the continuum of care. MQD collaborates with the Department of Health

(DOH), Health Plans, and community partners to support implementation of evidence-based practices, including Medication Assisted Treatment (MAT), and to enhance statewide referral coordination for SUD treatment services.

Through contractual requirements, MQD requires Health Plans to coordinate with DOH's Hawai'i CARES 988 program to support a statewide coordinated entry system for individuals seeking substance use treatment. MQD also supports expanded Screening, Brief Intervention, and Referral to Treatment (SBIRT) activities in hospital emergency departments and may use performance-based incentives and value-based purchasing strategies to strengthen early intervention, treatment access, and quality of care.

MQD monitors and evaluates SUD capacity-building efforts through reporting, performance measurement, and quality oversight activities. In addition, Hawai'i is seeking federal Medicaid matching funds to provide targeted pre-release Medicaid services for eligible incarcerated individuals, including case management, care coordination, clinical services, and a 30-day supply of medications, including MAT for SUD treatment, to support continuity of care upon community reentry.

Intervention 1: SUD coding improvement

This initiative focuses on improving Substance Use Disorder (SUD) services by strengthening billing code accuracy and consistency across programs and providers. Improved billing structures will support better data collection, reporting, and analysis to help identify service gaps, trends, and outcomes more effectively.

Success will be defined by the ability to consistently collect, analyze, and report accurate SUD service data across programs and providers. Improved data quality will support better decision-making, strengthen service coordination, identify unmet needs, and ultimately improve access to effective care and outcomes for individuals receiving SUD services.

Intervention 2: Medication-Assisted Treatment (MAT)

This initiative focuses on improving access to Medication-Assisted Treatment (MAT) services by increasing the number of available providers within the community. Expanding provider availability will help ensure individuals receiving MAT services have consistent access to care and alternative provider options when continuity of treatment is disrupted.

Success will be defined by increased provider availability and improved access to timely MAT services within the community. Expanding MAT provider options will help reduce treatment disruptions, improve continuity of care, strengthen recovery support, and increase overall access to evidence-based treatment for individuals struggling with SUDs.

Intervention 3: SUD program for those exiting the in carceral setting

This initiative focuses on supporting individuals exiting incarceration by connecting them to a full continuum of SUD services, including Residential Treatment, Intensive Outpatient (IOP), Outpatient care, Medication-Assisted Treatment (MAT), Contingency Management (CM), and peer support through AA/NA meetings. The goal is to strengthen reentry success by ensuring access to treatment, recovery supports, housing, and basic needs services immediately upon release.

Success will be defined by increased engagement across the full continuum of SUD treatment and recovery supports, including Residential, IOP, Outpatient, MAT, CM services, and AA/NA participation, along with successful linkage to housing and public assistance programs after release. This will improve stability during reentry, reduce relapse and recidivism risk, strengthen long-term recovery outcomes, and support overall health and well-being for individuals transitioning back into the community.

Intervention 4: Reduce Overdose

This initiative focuses on reducing overdose deaths by expanding access to evidence-based treatment, overdose reversal medications, and recovery support services. It aims to strengthen community-based prevention and recovery infrastructure to better support individuals at risk of substance use-related harm.

Success will be defined by increased access to overdose prevention tools, expanded engagement in MAT and CM services, and higher utilization of peer and community-based recovery supports. This will reduce overdose deaths, improve early intervention and treatment engagement, strengthen recovery networks, and improve overall health and safety outcomes for the population.

Objective 4b. Build capacity for Mental Health Treatment services

MQD is exploring establishing a primary care Alternative Payment Model (APM) starting January 1, 2028. The APM will reward PCPs that provide behavioral health integration services by providing an enhanced per member per month (PMPM) payment. The intent is to incentivize and increase the number of PCPs that implement behavioral health integration models in primary care.

OBJECTIVE 5	Support specialized behavioral health services for members with I/DD, serious MH disorders, and SUD
	a. Support specialized behavioral health services for I/DD populations, and increased transitions to the community for institutionalized I/DD members

	b. Support specialized behavioral health services for serious MH disorders and SUD
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Objective 5a. Support specialized behavioral health services for I/DD populations, and increased transitions to the community for institutionalized I/DD members

The 1915(c) Home and Community-Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities (I/DD) enables Hawaii to provide long-term services and supports in community settings rather than institutions for eligible individuals with intellectual and/or developmental disabilities. Strengthening community-based and provider capacity, particularly for individuals with complex behavioral support needs, is essential to maintaining stability in the least restrictive setting. Priorities include expanding adult foster home capacity on the neighbor islands, exploring additional residential options such as Community Care Foster Family Homes (CCFFHs), and increasing provider capacity to deliver critical behavioral support and crisis stabilization services such as Training and Consultation (Behavior), Crisis Mobile Outreach, and Out-of-Home Stabilization. Together, these strategies can reduce avoidable inpatient admissions, decrease reliance on institutional care, and improve the utilization of acute and long-term care resources.

Intervention 1: Expand Specialized Behavioral Health and Community Provider Capacity

MQD and DDD will work to strengthen provider capacity to support individuals with I/DD who have complex behavioral support needs. This includes increasing provider capacity for specialized behavioral and crisis services, such as Training and Consultation (Behavior), Crisis Mobile Outreach, and Out-of-Home Stabilization.

The initiative will also focus on expanding community residential capacity, including Adult Foster Homes, particularly on the neighbor islands, and exploring additional residential options such as Community Care Foster Family Homes (CCFFHs). These efforts are intended to provide individuals with appropriate community-based options and supports that can help prevent unnecessary hospitalization or institutional placement.

Success will be defined by:

- Increased provider capacity for specialized behavioral health and crisis stabilization services;
- Increased availability of community-based residential options;

- Increased access to services for individuals with complex behavioral support needs; and
- Reduced avoidable inpatient admissions and institutional placements.

Intervention 2: Increase Community Transitions for Institutionalized I/DD Members

MQD and DDD will strengthen coordination and transition planning for individuals with I/DD who are residing in institutional settings and are able to transition to the community. This will include identifying individuals who may be appropriate for community transition, coordinating needed HCBS and residential supports, and strengthening collaboration among MQD, DDD, institutional providers, community providers, and other partners involved in the transition.

Transition efforts will focus on ensuring that necessary services, providers, housing or residential settings, behavioral supports, and other community resources are in place to support a safe and successful transition.

Success will be defined by:

- Increased number of individuals with I/DD successfully transitioning from institutional settings to the community;
- Increased identification and referral of individuals who may be appropriate for community transition;
- Improved coordination of services and supports needed for transition; and

Reduced reliance on institutional care through increased availability and use of appropriate community-based services.

Objective 5b. Support specialized behavioral health services for serious MH disorders and SUD

The Community Care Services (CCS) program is the behavioral health carve-out program that provides intensive behavioral health services, in addition to basic behavioral health services, to Medicaid-eligible adults age 18 and older diagnosed with a qualifying Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) who meet CCS eligibility criteria established by MQD. CCS plays a critical role in coordinating care across behavioral health, primary care, and community-based providers to ensure members receive comprehensive, person-centered services across the continuum of care. As CCS transitions to a new contractor,

a key priority will be maintaining continuity of care while strengthening accountability and service delivery. During the first year of the contract, MQD will closely monitor Key Performance Indicator (KPI) compliance to establish a baseline for performance improvement efforts and strategic planning. This approach will support the implementation of targeted financial incentive programs for areas requiring significant improvement, including Pay-for-Performance (P4P) initiatives and Performance Improvement Plans (PIPs), ultimately enhancing care coordination, service quality, and member outcomes.

OBJECTIVE 6

Advance care at the end of life

MQD is strongly committed to advancing care at the end of life. MQD has several active or proposed activities in place to support this initiative.

First, Health Plans are required to cover hospice care for qualifying members. Hospice is a program that provides care to terminally ill patients who are not expected to live more than six (6) months. Children under the age of twenty-one (21) years can receive treatment to manage or cure their disease while concurrently receiving hospice services. The state uses the Medicare fee schedule to reimburse hospice facilities who have complied with CMS quality assurance requirements. In exchange, the state monitors quality of care in hospice facilities through quality measures reportable via Health Plans to the state.

Next, MQD strongly encourages the completion of advanced care directives, and increased provider understanding and compliance with patient wishes. MQD monitors advanced care planning among members age 40 and older by age group and ABD status and among members 18+ receiving LTSS.

In 2025, Hawai'i was the first state to implement a Medicaid Community Palliative Care (CPC) which strengthens Med-QUEST Division's commitment to helping members live with dignity, comfort, and support, especially those facing serious illness or nearing the end of life. MQD designed this service to address unmanaged symptoms, caregiver strain, and preventable crises that disproportionately affect our high needs, high cost population. CPC provides interdisciplinary, culturally responsive care in the home and community, focusing on symptom management, advance care planning, and alignment of care with member values. By addressing medical needs alongside social determinants of health such as caregiver capacity, transportation, and other health-related social needs, CPC reduces suffering, minimizes avoidable emergency department use and hospitalizations, and allows members to remain in familiar settings. As we continue to refine this innovative benefit, CPC remains a key strategy

for improving quality of life, promoting equity, and ensuring that members receive coordinated, person-centered care throughout the final stages of life.

Reporting requirements will be established or expanded upon as needed to track implementation of this initiative; in addition, MQD has implemented quality measure reporting requirements for various hospice related measures. As needed, measures may be included in P4P programs to provide incentives to improve quality of care.

OBJECTIVE 7	Assess and address Health Related Social Needs
	A. Address food insecurity by expanding access to nutrition supports B. Provide supportive housing to homeless beneficiaries with complex health needs C. Build and enhance data and infrastructural supports to address Health Related Social Needs

Objective 7a. Addressing food insecurity by augmenting nutrition supports

Hawai'i Medicaid recognizes that food insecurity is a significant social determinant of health that contributes to poorer health outcomes, increased health care utilization, and higher overall costs of care. Individuals experiencing food insecurity are more likely to have difficulty managing chronic conditions, adhering to treatment plans, and maintaining overall health and well-being. To address these challenges, Hawai'i Medicaid is committed to strengthening nutrition supports as part of a broader quality improvement strategy focused on whole-person care.

Over the next two years, Hawai'i Medicaid will work with its managed care organizations (MCOs), community-based organizations, health care providers, and other stakeholders to expand access to evidence-based nutrition interventions for members identified as having nutrition-related health needs. These efforts will focus on populations most at risk for adverse health outcomes, including individuals with diabetes, cardiovascular disease, hypertension, obesity, maternal health needs, and other chronic conditions where nutrition plays a critical role in disease management.

The strategy will emphasize the use of nutrition-related services authorized under Hawai'i's Section 1115 Demonstration, including food and produce prescriptions, nutrition education, medically tailored meals, and other nutrition supports designed to improve health outcomes and reduce barriers to healthy food access. Nutrition interventions will be integrated into care management programs and coordinated through established referral pathways to ensure members receive appropriate services based on their clinical needs and social risk factors.

To support quality improvement efforts, Hawai'i Medicaid will encourage MCOs to incorporate standardized screening for food insecurity and nutrition-related social needs into routine care management activities. Screening results will be used to identify members who may benefit from nutrition supports and to facilitate timely referrals to qualified providers and community partners.

Hawai'i Medicaid will monitor implementation through a combination of process, utilization, and outcome measures, including:

- Number of members screened for food insecurity and nutrition-related social needs.
- Number of members referred to and receiving nutrition support services.
- Member engagement and completion rates for nutrition interventions.
- Changes in chronic disease indicators, where available, including diabetes and hypertension management measures.
- Reductions in potentially avoidable emergency department visits and inpatient admissions among participating members.
- Member-reported improvements in food security, health status, and quality of life.

Hawai'i Medicaid will also work with MCOs to evaluate opportunities for data sharing and outcome measurement that support continuous quality improvement and inform future program enhancements. Findings will be used to identify best practices, improve service delivery, and ensure nutrition supports are effectively meeting member needs.

Through these efforts, Hawai'i Medicaid seeks to improve health outcomes, advance health equity, address food insecurity, and strengthen the integration of social care and health care services across the Medicaid program.

Objective 7b: Provide Supportive Housing to Homeless Beneficiaries with Complex Health Needs

Through Hawai'i's Section 1115 Demonstration, MQD is implementing a continuum of housing-related services and supports to help eligible Medicaid members who are homeless or at risk of homelessness obtain and maintain stable housing. These efforts support members with

complex physical health, behavioral health, long-term care, and disability-related needs by providing housing navigation, tenancy supports, medical respite, housing assistance, and coordination with community resources. The goal is to improve housing stability and health outcomes, strengthen community integration, and reduce avoidable hospitalizations and institutional stays.

Intervention 1: Community Integration Services Plus (CIS+)

Community Integration Services Plus (CIS+) is a Medicaid benefit designed to help eligible members experiencing homelessness or housing instability obtain and maintain safe, stable housing while addressing their health-related needs. CIS+ provides housing-related services and supports, including housing navigation, pre-tenancy and tenancy supports, and coordination with community resources.

MQD will continue to monitor CIS+ implementation through health plan reporting, performance measures, and quality improvement activities to identify opportunities to improve access to services and member outcomes.

Success will be defined by:

- Increased access to CIS+ housing supports;
- Increased completion of CIS+ Action Plans;
- Increased placement of members into permanent housing;
- Improved housing stability for participating members; and
- Improved monitoring of CIS+ performance and member outcomes.

Intervention 2: Medical Respite and Housing Expense Supports

MQD is expanding housing-related services through Medical Respite and Housing Expense Supports. Medical Respite includes Short-Term Pre-Procedure Housing, Short-Term Recuperative Care, and Short-Term Post-Hospitalization Housing for eligible Medicaid members who are homeless or at risk of homelessness and need a safe setting to prepare for or recover from medical care.

Housing Expense Supports provide eligible members with assistance to help obtain or maintain housing, including allowable housing-related expenses such as rental and utility assistance.

Together, these services are intended to support safe transitions from hospitals and other institutional settings, improve access to needed medical care and recovery supports, prevent homelessness, and help members obtain or maintain stable housing.

Success will be defined by:

- Successful implementation of Medical Respite and Housing Expense Supports;
- Increased utilization of available housing-related services and supports;
- Increased successful transitions from hospitals and institutional settings into appropriate community settings;
- Increased housing placements and improved housing stability; and
- Reductions in avoidable hospitalizations and institutional stays.

Objective 7c. Build and enhance data and infrastructural supports to address Health Related Social Needs

MQD developed a Social Determinants of Health (SDOH) Transformation Plan in partnership with its Health Plans which, represents MQD's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex (gender when available), primary language, and disability status. MQD is requiring Health Plans to submit patient-level data files on quality data to support and augment efforts to conduct disparities-based analyses. The SDOH Transformation Plan represents a shared MQD and Health Plan Road Map to comprehensively and systematically address health disparities.

Early implementation stages of the plan will emphasize the use of analytics and analytic methods by MQD and the Health Plans to identify and monitor health disparities, and increased identification of unmet social needs through enhanced data collection methods. Later implementation stages will focus on identifying and fortifying community-based SDOH supports, addressing social needs through referrals and resources, and targeting efforts to address the needs of populations at high risk for adverse health outcomes through socially and culturally appropriate mechanisms. Simultaneously, the SDOH Transformation Plan will pave the way for the development of financial mechanisms to address and mitigate health disparities and unmet social needs. Health Plans will be expected to align to, and describe their "on the ground" community and beneficiary-level activities that will realize the overall goals and strategies of, the SDOH Transformation Plan.

Lastly, MQD is exploring implementing a primary care APM effective January 1, 2028. This APM will financially reward providers that screen and refer for health-related social needs. This will be accomplished through additional FFS payments and a PMPM that support this work.

OBJECTIVE 8

Enhance community integration/reintegration of LTSS beneficiaries

Objective 8. Enhance community integration/reintegration of LTSS beneficiaries

MQD is committed to helping individuals who require long-term services and supports (LTSS) live, work, and participate in their communities whenever possible. MQD will strengthen community-based services and supports, increase opportunities for individuals to transition from institutional settings to the community, improve the quality of HCBS, and expand community provider capacity. These efforts are intended to promote independence and self-determination, strengthen connections to family and community, reduce reliance on institutional care, and support individuals in receiving services in the most integrated setting appropriate to their needs.

Intervention 1: Money Follows the Person (MFP)

Money Follows the Person (MFP) is a federally funded initiative that helps eligible Medicaid beneficiaries transition from institutional settings, including hospitals, nursing facilities, intermediate care facilities, and other long-term care settings, into community-based living arrangements.

Hawai'i's MFP program supports transitions through both the QUEST Integration (QI) program and the 1915(c) Home and Community-Based Services (HCBS) Waiver for Individuals with Intellectual and Developmental Disabilities (I/DD). MFP assists individuals who want to live in the community but need support coordinating housing, services, providers, and other resources necessary for a successful transition.

Success will be defined by:

- Maintaining or increasing successful community transitions;
- Increasing referrals to the MFP program;
- Expanding outreach and engagement with institutions, providers, potential MFP participants, families, and community stakeholders; and

- Continuing coordination with Health Plans through regular MFP workgroup meetings.

Intervention 2: Intellectual/Developmental Disabilities (I/DD) MFP Expansion

MQD and the Department of Health Developmental Disabilities Division (DDD) will work together to improve MFP processes and expand transition supports for individuals receiving services through the 1915(c) HCBS Waiver for Individuals with I/DD.

This effort will include developing shared workflows, reporting processes, staff training, and coordination between MQD and DDD to support individuals with I/DD who are living in institutional settings and want to transition to the community.

Success will be defined by:

- Increasing successful community transitions for individuals with I/DD;
- Increasing referrals of eligible individuals to MFP;
- Implementing standardized transition workflows and reporting processes between MQD and DDD; and
- Conducting regular joint meetings and training activities between MQD and DDD.

Intervention 3: HCBS MFP Quality Measure Set for the Developmental Disabilities Division

MQD and DDD will develop and implement a standardized quality measurement framework for services provided through the DDD 1915(c) HCBS Waiver. This work will include implementation of the CMS HCBS MFP Quality Measure Set, including LTSS Measure Sets 1 and 2 and the required core and supplemental measures.

The initiative will also focus on developing a comprehensive assessment process, evaluating DDD's current data collection and reporting systems, and identifying steps needed to support ongoing quality measurement and reporting.

Success will be defined by:

- Implementation of the HCBS MFP Quality Measure Set;
- Development and implementation of a comprehensive assessment process;
- Reliable and complete data collection and reporting; and

- Increased availability and use of data to evaluate member outcomes and support quality improvement.

Intervention 4: Community Provider Capacity Development

MQD will work to strengthen the community-based provider network, including Adult Foster Homes (AFHs), Community Care Foster Family Homes (CCFFHs), HCBS providers, and caregivers capable of supporting individuals with complex medical, behavioral health, and long-term care needs.

This initiative will focus on increasing the number and capacity of Medicaid providers delivering community-based services, particularly on the neighbor islands where workforce and provider shortages may limit community placement options. Strengthening the provider network will improve access to community-based services, support successful transitions, and reduce unnecessary institutional stays.

Success will be defined by:

- Increasing the number and capacity of community-based providers;
- Reducing the number of members waiting for community placement;
- Increasing successful community placements; and
- Increasing provider participation in training and capacity-building opportunities.

OBJECTIVE 9

Enhance nursing facility care and HCBS; prevent or delay progression to nursing facility level of care

Objective 9. Enhance nursing facility care and HCBS; prevent or delay progression to nursing facility level of care

Providing high-quality care to LTSS beneficiaries, including residents in nursing homes as well as those receiving home and community-based services (HCBS) in lieu of nursing facility care, is a key priority for MQD. MQD improves and monitors the quality of care provided to beneficiaries in each of these settings closely through various strategies.

NURSING FACILITY SERVICES

Quality of care in nursing facilities will be monitored and improved through a combination of regulatory review, Preadmission Screening and Resident Review (PASRR) compliance , performance measurement, and pay-for-performance initiatives. The use of operationalized processes will support efficient reporting, reduce administrative burden, and optimize the use of available data systems for performance monitoring and quality improvement.

The State of Hawai'i Department of Health's Office of Health Care Assurance (DOH-OHCA) conducts annual surveys and complaint investigations of nursing facilities. MQD will leverage survey findings, certification actions, and other regulatory oversight activities such as the evaluation of nursing facility's Quality Assurance and Performance Improvement program as defined under 42 §CFR483.75 as part of its broader nursing facility quality monitoring framework.

MQD's EQRO also conducts PASRR compliance reviews on a quarterly sample of admissions to Medicaid-certified nursing facilities in the state of Hawai'i for compliance with the PASRR process.

To ensure sustainability of Hawai'i's nursing homes, Hawai'i law establishes the mechanism by which nursing facilities are paid; Health Plans therefore reimburse nursing facilities in accordance with HRS § 346E and § 346D-1.5 utilizing a case-mix reimbursement system at rates comparable to the current Medicaid fee schedule.

HOME AND COMMUNITY BASED SERVICES

Intervention 1: CMS' HCBS Access Rule and Quality Measure Set Reporting Pilot

Beginning in 2026, MQD is participating, through its Section 1115 Demonstration Waiver, in CMS's pilot of select home-and community-based services (HCBS) quality reporting requirements under the Ensuring Access to Medicaid Services Final Rule (Access Rule). The pilot encompasses two complementary components of the Access Rule: (1) the HCBS Quality Measure Set, which establishes a standardized approach for measuring and reporting on HCBS quality across key domains including community integration, person-centered care, and member experience; and (2) Access Rule Compliance Measures, which assess whether Medicaid HCBS programs are meeting core federal requirements related to critical incident management and person-centered service planning and delivery. Together, these components support MQD's efforts to strengthen oversight of access to and quality of HCBS delivered to Medicaid beneficiaries, and support MQD's planning and assessment efforts to prepare for broader federal HCBS quality reporting requirements as they take effect under the Access Rule.

The pilot encompasses three key reporting areas, focused on MQD's Medicaid managed care population served under the state's Section 1115 demonstration:

1. Access Rule Compliance Measures – These measures assess whether Medicaid HCBS programs are meeting core federal requirements in key areas including critical incident management (identification, investigation, and resolution/correction action) and person-centered service planning (reassessment of functional need and revision of service plan as necessary).
2. LTSS/MLTSS Quality Measures – These measures assess the quality of long-term services and supports delivered through Hawai'i's Medicaid managed care program, including whether services are delivered in a timely, person-centered manner and whether members can remain in or successfully transition to community-based settings when appropriate.
3. HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey – This standardized survey captures the experiences and perspectives of members receiving HCBS. The survey evaluates key domains including access to services, choice and control, community inclusion, workforce reliability, and overall satisfaction with services and supports.

MQD's participation in the pilot will provide an opportunity to test data collection and reporting methodologies, establish baseline performance, identify areas for quality improvement, and build state capacity to meet evolving federal HCBS quality reporting requirements. Through this work, MQD is strengthening the data infrastructure and reporting capacity needed to support ongoing HCBS quality oversight, monitoring, and accountability. The pilot's findings will help inform future quality strategies and support

Success will be defined using the performance measures in the HCBS Quality Measure Set, which includes the LTSS/MLTSS Quality Measures and the experience-of-care survey, and will have a threshold of 86%. The Access Rule Compliance Measures will have a threshold of 90%. Any measure that falls below its respective threshold will trigger further analysis to identify the root cause. Potential strategies to address deficiencies may include quality improvement training, updates to policies and procedures, hiring additional staff if needed, or reallocating staff as appropriate. All deficiencies noted during routine monitoring—and the actions taken to resolve them—will be summarized and reported to CMS.

Intervention 2: HCBS ICF LOC Level 3 Criteria and Rate

Members residing in CCFFHs and E-ARCHs are currently classified as either Level 1 or Level 2 based on their care needs. Each level has a corresponding reimbursement rate, with the Level 1

rate being lower than the Level 2 rate. The health plans may also authorize rates higher than Level 2 through single-case agreements for members with significant physical limitations, complex care needs, obesity, behavioral symptoms, or other factors that make placement difficult. However, the criteria vary across health plans, and there is no standardized rate associated with these agreements. MQD developed standardized criteria and is collaborating with its actuaries to establish corresponding enhanced reimbursement rates for use by the health plans when classifying Nursing Facility Level of Care (NF LOC) members as Level 3. The objectives are to: (1) reduce, and ideally eliminate, hospital waitlists by supporting timely community placement; and (2) provide higher reimbursement rates to contracted residential providers that deliver enhanced interventions and supports. Success will be measured by reduced hospital lengths of stay and increased capacity among CCFFH and E-ARCH providers.

Success will be defined using the performance measures included in the HCBS Quality Measure Set that focuses on LTSS rebalancing will have a threshold of 86%. The specific measures that will be monitored to measure success will include the MLTSS #7 Minimizing Facility Length of Stay and MLTSS #8 Successful Transition After Long-Term Facility Stay. Any measure that falls below threshold will trigger further analysis to identify the root cause. Potential strategies to address deficiencies may include quality improvement training, updates to policies and procedures, hiring additional staff if needed, or reallocating staff as appropriate. All deficiencies noted during routine monitoring—and the actions taken to resolve them—will be summarized and reported to CMS.

Intervention 3: HCBS Setting Final Rule Implementation

The Home and Community-Based Services (HCBS) Settings Final Rule establishes federal requirements to ensure that Medicaid-funded HCBS are delivered in settings that promote individuals' rights, independence, choice, and full integration into the community. The rule applies to HCBS provided under Medicaid waivers and state plan authorities.

Key requirements include:

- **Community Integration:** Individuals must have opportunities to engage in community life, work, and activities alongside people who do not receive HCBS.
- **Person-Centered Planning:** Services must be based on the individual's strengths, preferences, goals, and assessed needs.
- **Individual Rights:** Individuals must have privacy, dignity, respect, freedom from coercion and restraint, and control over their daily lives.
- **Choice:** Individuals must have choices regarding services, providers, schedules, roommates (where applicable), and living arrangements.
- **Setting Requirements:** Residential settings must provide protections related to privacy, access to food, visitors, personal belongings, and freedom to furnish and decorate living spaces.

MQD will monitor implementation of the HCBS Settings Final Rule through provider validation and ongoing compliance reviews, while leveraging participant experience data from the HCBS CAHPS Survey to evaluate the extent to which individuals experience choice, autonomy, community integration, and person-centered services.

Success will be defined using the performance measures in the HCBS Quality Measure Set, specifically the experience-of-care survey, will have a threshold of 86%. Any measure that falls below threshold will trigger further analysis to identify the root cause. Potential strategies to address deficiencies may include quality improvement training, updates to policies and procedures, hiring additional staff if needed, or reallocating staff as appropriate. All deficiencies noted during routine monitoring—and the actions taken to resolve them—will be summarized and reported to CMS.

Intervention 4: HCBS Expand ALF service to the at-risk members

Through its 1115 waiver, MQD also provides a limited set of HCBS services to 1915(i)-like beneficiaries who are “at risk” of deteriorating to nursing facility level of care. “At risk” beneficiaries are offered a subset of HCBS services including adult day care, adult day health, home delivered meals, personal assistance, personal emergency response system (PERS), and private duty nursing. Furthermore, Assisted Living Facility (ALF) services are now accessible and included within the package of HCBS benefits available for individuals who are assessed to be at risk for deteriorating to institutional LOC (the at-risk population). This initiative is consistent with the State’s goal of ensuring full access to the benefits of community living so that individuals can maintain independence in the least restrictive setting of their choosing, as clinically appropriate. The State anticipates this will help avoid or delay nursing facility placement by promoting greater access to personal care and supportive care services (e.g., homemaker, chore, attendant services, and meal preparation) that enable individuals with activities of daily living (ADL) needs to reside in the community longer.

Success will be measured by a reduction in the number of at-risk members whose conditions deteriorate to Nursing Facility Level of Care (NF LOC). Helping members maintain a higher level of functioning can contribute to lower healthcare costs and improved quality of life, including greater independence, autonomy, and social and community engagement.

The performance measures in the HCBS Quality Measure Set that focuses on LTSS rebalancing will have a threshold of 86%. The specific measures that will be monitored to monitor success will include: 1) MLTSS #6 Admission to a Facility from the Community. Any measure that falls below threshold will trigger further analysis to identify the root cause. Potential strategies to address deficiencies may include quality improvement training, updates to policies and procedures, hiring additional staff if needed, or reallocating staff as appropriate. All deficiencies

noted during routine monitoring—and the actions taken to resolve them—will be summarized and reported to CMS.

OBJECTIVE 10

Expand access to care

Expand access to care for Medicaid members by increasing opportunities for qualified provider participation and supporting appropriate service delivery methods. This objective will explore opportunities to expand provider status and scope of services for qualified professionals, including pharmacists and non-nurse midwives, support the appropriate use of telehealth, and improve awareness and understanding of non-medical transportation benefits. These efforts aim to reduce barriers to care, improve continuity of care, and increase access to healthcare services, particularly for members in rural and underserved communities.

Intervention 1: Expand pharmacist provider participation and services to improve access to care for Medicaid members.

This effort targets qualified pharmacists and aims to increase access to convenient and timely healthcare services, particularly preventive and routine care. Expanding provider status and the scope of services qualified pharmacists can provide may improve access to services, reduce delays in care, and increase healthcare support within members' communities.

Success will be defined by reviewing current policies, identifying operational and program impacts, and developing recommendations that support expanded pharmacist participation within Medicaid services.

Intervention 2: Expand non-nurse midwife provider participation and services to improve access to maternal and women's healthcare services for Medicaid members.

This effort targets qualified non-nurse midwives and aims to increase access to timely, coordinated, and community-based care. Expanding provider status and the scope of services qualified non-nurse midwives can provide may improve maternal health support, increase provider availability, and improve continuity of care, particularly in underserved and rural communities.

Success will be defined by reviewing current provider requirements, identifying barriers to participation, and developing recommendations that support expanded access to non-nurse midwife services.

Intervention 3: Support telehealth access and utilization to improve healthcare access for Medicaid members.

This effort targets healthcare providers and aims to support access to healthcare services which can be appropriately provided through the telehealth mode. Delivering appropriate services through the telehealth mode expands access to care, and members may experience fewer barriers to services, improved continuity of care, and increased access to healthcare resources, particularly in rural and underserved communities.

Success will be defined by appropriate utilization of telehealth to provide access to care and collaborating with stakeholders to develop recommendations that support the appropriate use of telehealth.

Intervention 4: Improve awareness and understanding of non-medical transportation benefits available to Medicaid members.

This effort targets healthcare providers and program partners and aims to improve access to transportation resources that support healthcare services. By improving access to transportation-related information and resources, awareness and understanding of non-medical transportation benefits, members may experience fewer barriers to care, helping them attend appointments and increased access to medically necessary services in a timely manner.

Success will be defined by reviewing current guidance, identifying opportunities for clarification, and developing recommendations that improve communication and understanding of non-medical transportation benefits.

OBJECTIVE 11

Improve healthcare delivery through administrative simplification and utilization management oversight

Over 99% of the Medicaid benefit is delivered through multiple managed care plans, all with separate preferred pharmacy drug lists, differing lists of services, supplies, and medications requiring prior authorization (PA), differing criteria for approval, and different PA submission processes. Improvement in healthcare delivery focuses on administrative simplification and utilization management oversight strategies to decrease administrative burden and workload, decrease patient care delays, and improve trust between members, providers, and payers.

Intervention 1: Prior Authorization (PA) simplification for pharmacy and medical requests

This initiative is designed to make the prior authorization process faster, more transparent, and less burdensome for both providers and beneficiaries, while still ensuring care is medically necessary. Administrative simplification, including a more standardized preferred pharmacy drug list, a standardized list of services and supplies requiring prior authorization, use of standard evidence-based criteria with transparent accessibility, use of technology and automated processes for PA requests and decisions, and improved communication notices to explain why a request is denied and what next steps can be taken will help improve healthcare delivery for providers and beneficiaries. MQD may leverage carve-outs for medications or classes of medications from the managed care plans with historically high denial rates, to ensure these drugs are equally accessible by all beneficiaries in a standardized, transparent, and streamlined process.

Success will be defined by increased transparency and standardization of prior authorization requirements and processes and decreased administrative burden and frustration from the community of members and providers. This improvement will afford providers more quality time to spend with their patients, affording more timely access to medically necessary services, supplies, and medication for members, and affording both the provider and member a deeper sense of trust within Med-QUEST.

Intervention 2: Strengthen state of oversight and monitoring of utilization controls including Prior Authorization (PA)

This initiative focuses on stronger oversight and increased monitoring of barriers to care created through utilization controls. The overall goal is to improve efficient delivery of cost-effective and evidence-based healthcare. The use of robust reporting, transparency, and compliance mechanisms will be used to help maintain close oversight of the MCOs' prior authorization process to provide feedback and create opportunities for remediation as needed. Stronger state oversight on the appropriateness of the reasons for denials and appeals and scrutinization of evidence-based criteria justifying denials cited by MCOs will help ensure consistency and adequacy in care amongst the MCOs.

Success will be defined as providing equal and standardized access to medically necessary services, supplies, and medication across the MCOs, and affording both the provider and beneficiary a deeper sense of trust within Med-QUEST.

OBJECTIVE 12

Align payment structures to enhance quality and value of care

MQD is advancing a comprehensive payment transformation effort through its participation in the Achieving Healthcare Efficiency Through Accountable Design (AHEAD) Model, supported by a cooperative agreement with the Center for Medicare and Medicaid Innovation (CMMI). This work builds on MQD’s long-standing commitment to strengthening primary care, improving outcomes across populations, and creating a more sustainable delivery system. Under AHEAD, MQD is expanding its use of alternative payment models (APMs) for primary care and initiating Medicaid participation in the statewide hospital global budget model, creating aligned incentives across hospitals, primary care practices, and Medicaid health plans. Together, these strategies are designed to support better access to high-value care, stabilize essential providers, and reduce avoidable differences in health outcomes.

MQD’s primary care APM supports practices in delivering comprehensive, coordinated care by offering tiered PMPM payments that increase with the adoption of key capabilities such as behavioral health integration, screening for health-related social needs, and improved referral pathways to social supports. These investments are intended to help primary care teams address factors that strongly influence health, strengthen the relationship between patients and their medical home, and improve quality and continuity of care.

At the same time, MQD is working with hospitals to implement Medicaid’s role in Hawai’i’s all-payer global budget approach. This model encourages hospitals to shift resources toward high-impact, community-based care, reduce avoidable utilization, and foster closer collaboration with primary care providers. Together, the primary care APM and hospital global budgets are designed to create aligned incentives across the systems supporting better transitions of care, improving chronic disease management, and encouraging providers to work collectively toward AHEAD performance goals. These efforts represent a major step in MQD’s move toward a more coordinated, person-centered delivery system that promotes high-quality care and improved outcomes for Medicaid beneficiaries.

OBJECTIVE 13

Enhance Health Benefit Coordination for Hawai'i's Dual-Eligible Population.

- a. Develop the Duals Data Dashboard (DDDASH)**
- b. Implement a targeted outreach initiative to increase enrollment into Hawai'i's D-SNPs.**

Objective 13a. Develop the Duals Data Dashboard (DDDASH)

Intervention: MQD will develop a Duals Data Dashboard (DDDASH) to identify the dual eligible population in Hawai'i.

As part of the Rural Health Transformation Program, MQD is developing a duals data dashboard (DDDASH) and Support Hub with the primary objective of enhancing the quality of care for the dual-eligible rural health population in Hawai'i. DDDASH will serve to identify dual eligible members across the state of Hawai'i and facilitate enrollment into Hawai'i's Dual Special Needs Plans (D-SNPs).

MQD's overarching strategic goal with DDDASH is to provide data to improve care for its rural health dual eligible members and to develop a self-sustaining dashboard for ongoing program oversight, evaluation and continuous improvement.

Success for this intervention will be the implementation and operational use of DDDASH.

Objective 13b. Implement a targeted outreach initiative to increase enrollment into Hawai'i's D-SNPs.

Intervention: MQD will implement a coordinated outreach and education strategy to increase enrollment into Hawai'i's D-SNPs. DDDASH will be used to identify members eligible for outreach and monitor enrollment activities.

Beginning January 1, 2027, Hawai'i will transition to a fully integrated dual eligible special needs plan (FIDE) only D-SNP state. To ensure that dual eligible members in Hawai'i have access to the highest level of integrated care, MQD will leverage DDDASH to implement a targeted outreach and education strategy to increase and sustain enrollment in Hawai'i's D-SNPs. MQD will collaborate with managed care organizations, D-SNPs, rural hospitals, and other Federally Qualified Health Centers (FQHCs) to conduct outreach and assist dual eligible members in selecting a plan that is best suited to their needs. DDDASH will support this initiative by providing oversight capabilities, identifying opportunities for cost saving, maximizing the use of supplemental benefits, and improving overall quality.

Success for this intervention will be measured by increased enrollment in Hawai'i's D-SNPs among the dual eligible population in Hawai'i.

OBJECTIVE 14

Enhance Member Transparency and Member Engagement

MQD will improve member engagement, transparency, and informed decision-making by increasing access to meaningful information regarding health plan performance, provider availability, member rights, and available support resources. MQD will collaborate with Health Plans, members, and community stakeholders to strengthen member participation, improve access to understandable healthcare information, and support members in navigating the

healthcare system.

MQD will utilize existing member experience data, person-centered planning measures, Home and Community based quality measures, grievance and appeal data, Ombudsman feedback, Beneficiary Advisory Council recommendations, and other quality monitoring activities to monitor progress and identify opportunities for quality improvement.

Interventions

- Strengthen member engagement through the Beneficiary Advisory Council (BAC) and other member feedback mechanisms to ensure member perspectives are incorporated into quality improvement activities, policy development, and program planning.
- Develop and maintain a consumer-friendly Managed Care Plan Choice Scorecard that includes member experience measures, quality performance measures, access measures, and other indicators that support informed health plan selection.
- Improve provider directory accuracy, completeness, and usability to support member access to participating providers and services.
- Increase member awareness of available support resources, including the Ombudsman Program, grievance and appeal processes, and other resources available to assist members in navigating the healthcare system and resolving concerns.
- Monitor member experience, engagement, transparency, and access measures to identify opportunities for improvement and support ongoing quality improvement efforts.

OBJECTIVE 15

Increase access to dental care and improve dental health outcomes

The administration of the dental programs will include focused quality improvement in the following areas:

Measurement of health outcomes: In dentistry, the service industry tracks services delivered in the form of payment claims, but does not track health outcomes or status directly in the form of diagnostic coding. As a means of assessing the quality of dental services delivered through the Medicaid program, MQD will determine appropriate health measurement markers and proxies for health outcomes. These measurements can then be used in measuring health value, and assessing quality, occurring across different portions of the dental provider economy.

Improvement of health outcomes and delivery efficiency: The overall quality goals of the dental program include both improving health outcomes, and improving the long-term financial efficiency of obtaining those improved health outcomes. This is a focus on high-value healthcare delivery systems that prove to be both cost-effective and leading to meaningful improvements in oral health.

Growing the prevention-oriented provider network: Improved health outcomes, and effective use of financial resources result from shifting program focus upstream toward dental services of prevention and early disease intervention. This is true for adult care, but especially for children's dental care. This is in contrast to a dental program that incentivizes providers to focus more on treatment of advanced or end-stage disease. The reorientation of dental service culture toward prevention directly reduces future dental expenses, and also creates a wider indirect cost benefit for medical diseases, which have been shown to increase in complexity and cost when oral health is compromised. The mechanisms to shift program emphasis toward prevention include financial incentives for effective prevention services, and education to providers about how to succeed in a prevention-focused healthcare economy. These incentives can encourage existing network providers to focus on disease prevention, and attract new providers of preventive services into the Medicaid network.

Growing role of the Prospective Payment System and exploring payment structure to enhance quality and value of care: As the role of health centers in dental services expands, and the financial payments made to these health centers grows at rates that exceed healthcare expenses in other dental service outlets, MQD plans to engage in analysis of health outcomes and evaluation of the cost-benefits of services delivered by health centers. As always, MQD is interested in balancing quality health care with prudent use of public funds.

Rebuild systems surrounding waste, fraud, and abuse (WFA) surrounding dental claims: MQD is engaged in improving the identification of potential dental claims WFA, including an updated system for WFA monitoring to include redefined tasks and contractual responsibilities by the third-party administrator.

Improved dental access for individuals with intellectual and/or developmental disabilities (I/DD): Among the most in need, and the least self-empowered, individuals with (I/DD) often possess significant medical complexities, behavioral challenges, or other access to care barriers and MQD continues to work to reduce barriers to care through modifications to existing dental industry reimbursement rates or incentives. MQD continues to focus on quality improvement and network development surrounding this at-risk population.

IV. Managed Care Quality Strategy Implementation

Managed Care Quality Strategy State Agency Collaboration

MQD's Quality Committee initiates the development of, and updates to, the Managed Care Quality Strategy. The following sections describe the MQD quality system that supports monitoring for quality assurance, assessment of MQD initiatives, selection of performance improvement projects (PIPs), and selection and measurement of performance and clinical quality measures that support achievement of MQD goals. This is an iterative process that takes into consideration the feedback from representatives from MQD branches and offices, Health Plans, External Quality Review Organization (EQRO), and partner government agencies (e.g. Department of Health), external stakeholders and other impacted individuals for purposes of improving care for the Medicaid population.

Quality Program

The Quality Program for the state of Hawai'i continues to be a comprehensive program built on continuous quality improvement. MQD will lead, and Health Plans will partner with, developing policies and procedures that will be hereafter referred to as the Quality Program.

The Quality Program will employ principles of comprehensive quality management through the simultaneous application of quality assurance and performance improvement. Quality assurance is defined as assurance that minimum specified standards are met. Quality improvement is defined as implementing new processes to improve service delivery and health outcomes by resolving persistent and/or underlying barriers.

At the state level, MQD has developed roles and responsibilities for team members that focus on either quality assurance or quality improvement while developing robust communication methods across teams and content specialists. Together, these teams will systematically address, report on challenges with, and participate in a collaborative approach to advance the goals and objectives of the MQD Managed Care Quality Strategy.

Quality Assurance

MQD quality assurance (QA) processes include cycles of receipt, review and analysis of performance reports required to be submitted by Health Plans.

The 360° report analysis is an ongoing performance accountability review of each Medicaid health plan. The review includes analysis of results from some of the routine reports already submitted to MQD by health plans; information gathered from MQD subject matter specialists regarding health plan strengths and opportunities to improve; results of select audits or reviews

(e.g., external review by HSAG); and identification of issues related to a health plan's performance or a pattern across multiple health plans. The 360° review supports a structured discussion with each health plan regarding their performance. Discussion acknowledges health plan strengths and also informs the health plan of MQD's expectations for specific improvements. The following figure depicts the QA team review process.

Figure 1 – Quality Assurance Cycle



Each quarter, Health plans will submit reports to the Health Analytics Office which review the data quality, calculate metrics and prepare review tools for the assigned content specialists or QA team. The QA team will conduct a performance review cycle, analyze submitted reports, review trends, outliers and reports for timeliness, completeness, and accuracy. Content specialists are assigned to review relevant reports and submit inquiries to Health Plans. Content specialists develop a full understanding of the information presented and assess performance activities, progress and challenges.

The content specialists will evaluate whether a contract requirement has been successfully met or not. If the requirement has not been met, escalation processes are triggered to determine whether deficiencies are explained and resolved or persist and require remediation.

The following information is gathered when performance is found to be non-compliant:

- The nature, severity, and duration of the violation;
- The type of harm suffered due to the violation (e.g., impact on the quality of care, access to care, or program integrity);
- Root cause analysis; and
- Health plan remediation plan and timeframe.

A key aspect of the escalation process is to determine whether the Health Plan has provided reasonable, timely and robust mitigation to ensure resolution. Additionally, content specialists evaluate whether additional contract compliance actions are required to be pursued per the requisite contract and according to §§ 438.700 – 438.730.

If the issues remain unresolved after a preliminary non-performance notice, MQD may direct the Health Plan to submit corrective action plan. If the Health Plan fails to cure the deficiency, MQD may consider imposition of sanctions.

As a part of the Quality Program, the quality assurance team is responsible for oversight of the Operational Effectiveness Program (OEP). The OEP is an incentive program focused on ensuring that Health Plans manage operations and performance effectively based on identified areas in need of improvement which will result in system-, regional-, provider-, or member-level benefit. Improvements in encounter data submissions will be included in the OEP.

MQD will define process measurement, performance measurement, and targets that will be maintained until sustained improvements are reached. The operational and performance metrics included in the OEP, the specific targets for each, and the time period of assessment for each metric, will be set annually by MQD, and may vary across plans.

Quality Improvement

MQD quality improvement processes include cycles of receipt, review and analysis of quality reports required to be submitted by Health Plans.

MQD's EQRO will work with the health plans to collect CMS Child and Adult Core Set quality measures and conduct CAHPS surveys for adults, children, HCBS members and providers. The metrics will be submitted to CMS Quality Measure Report (QMR) and the AHRQ's CAHPS

database for inclusion in the Medicaid and CHIP (MAC) Scorecard and other national reporting. Additionally, selected Core Set and CAHPs measures will be included the Managed Care Plan Choice Scorecard.

The results will be reviewed by their assigned content specialists who will present findings and trends to the Quality Committee. The Quality Committee will develop strategies to identify areas or topics for Performance Improvement Projects (PIPs), and establish metrics for the Pay-for-Performance (P4P) Program and the Auto Assignment Algorithm.

As a part of the Quality Program, the Quality Committee is responsible for oversight of the Quality Payment Program (QPP). The Quality Payment Program allows Health Plans to be eligible for financial performance incentives or Pay for Performance (P4P) as long as the Health Plan is fully compliant with all terms of the contract, particularly those overseen by the quality assurance team. The QA team will meet with the Quality Committee annually to share their key findings and make recommendations for adjustments to either assurance or improvement activities that may be executed in the next performance year.

The following figure depicts the relationship among different processes to successfully implement the Managed Care Quality Strategy.

Figure 2 – Managed Care Quality Strategy Oversight



Health Plan Quality Assessment and Performance Improvement Program (QAPI)

As part of the Quality Program, and to align and achieve the objectives of the MQD Managed Care Quality Strategy, MQD is collaborating with and expecting from Health Plans, that they also develop and implement a data-driven, outcomes based, continuous QAPI plan. The QAPI plan is expected to be focused on rigorous outcome measurement against relevant targets and benchmarks, and that appropriately support providers and beneficiaries for advancing quality goals and health outcomes. This process will include considerations for tracking outcomes and addressing deficiencies when improvement is not occurring. The QAPI will be expected to meaningfully demonstrate alignment with MQD-developed plans. It will cover all demographic groups, care settings, and types of services. Health Plans are expected to address the delivery and outcomes of clinical medical care, behavioral health care, member safety, and non-clinical aspects of service, including the availability, accessibility, coordination, and continuity of care.

The Health Plan's QAPI is a critical resource used by MQD to ensure population health management, including the capability to identify sub-populations (for example, by race, ethnicity, primary language or special populations) experiencing disparities. The Health Plan's QAPI is required to clearly describe such capabilities as:

- The established practice guidelines policies and procedures that support utilization management.
- The established mechanisms for the use of predictive analytics to identify populations at risk for poor health outcomes and high cost, stratify and report metrics at the state and regional or service area level, by sub-population and at the patient or provider level.
- The established mechanisms for detecting and addressing both under-utilization and over-utilization of services.
- The established mechanisms for assessing and addressing care furnished to populations with special health care needs, members enrolled in D-SNPs, and members using long-term service supports.
- The evidence-based approaches to Performance Improvement Projects (PIPs), including alignment and collaboration across Health Plans.

Health Plans are expected to conduct a minimum of three (3) PIPs each year in accordance with § 438.330(d). PIPs are designed to achieve demonstrably significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. MQD, or CMS, may select the PIP topics or review and approve topics recommended by the Health Plans. PIPs are required to follow standard quality improvement methods with:

- A clearly defined study question and objective;
- A description of the evidence-based intervention plan;
- Measurable indicators of output, process and outcomes;
- Valid sampling techniques;
- Data collection and evaluation strategy.

Contract Compliance

In combination with the Quality Program, through quality assurance and quality improvement, MQD enables an effective contract management process that ensures the Health Plans are operating in accordance with the contract. When contract requirements fail to be met, MQD may impose sanctions for non-performance or violations of contract requirements.

Examples of such non-performance or violations include when a health plan:

- Fails substantially to provide medically necessary services that the plan is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the State.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider.
- Fails to comply with the requirements for physician incentive plans, as set forth in §§422.208 and 422.210.
- Has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
- Has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

Imposition of a sanction occurs when the Health Plan is notified of the basis and the nature of non-performance or violation and the pending sanction. MQD may provide a reasonable

deadline for the Health Plan to cure the non-performance or violation prior to imposing the sanction. If imposition occurs, the Health Plan may appeal the sanction.

Examples of types of sanctions that may be imposed by the State include:

- Imposing civil monetary penalties (as described below);
- Suspending enrollment of new members with the Health Plan;
- Suspending payment;
- Notifying and allowing members to change plans without cause;
- Appointment of temporary management; or
- Terminating the Contract.

The civil or administrative monetary penalties imposed by MQD will not exceed the maximum amount established by federal statutes and regulations.

Quality Measurement

MQD has overall responsibility for the quality oversight process that governs all Medicaid programs, including the Health Plans, the DD/ID waiver, and related contracts.

As described above, the Health Analytics Office (HAO) at MQD receives and reviews all monitoring and quality reports contractually required to be submitted from the Health Plans. The HAO uses standardized reporting and review tools for all Health Plans and programs to allow for effective oversight, plan-to-plan comparisons, and trending over time. Findings from the reports are presented to Quality Committee. The meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The committee recommends feedback to the Health Plans and programs, and corrective action is requested when contract requirement deficiencies warrant such action. Findings and recommendations are also documented and shared in a systematic fashion.

Monitoring and Evaluation

Through the mutual responsibility of the Health Care Services Branch (HCSB) and the Health Analytics Office (HAO) teams, MQD will maintain an effective monitoring and oversight program over all managed care program operations described in § 438.66(a), including:

- Administration and management;
- Appeal and grievance systems;
- Claims management;
- Enrollee materials and customer services, including the activities of the beneficiary support system;

- Finance, including medical loss reporting;
- Information systems, including encounter data reporting;
- Marketing;
- Medical management, including utilization management and care management;
- Program integrity;
- Provider network management, including provider directory standards;
- Availability and accessibility of services, including network adequacy standards;
- Quality improvement;
- Areas related to LTSS not otherwise mentioned above;
- All other provisions of the contract, as appropriate.

MQD will monitor data submitted that includes, but is not limited to:

- Enrollment and disenrollment trends
- Member grievance and appeal logs;
- Provider complaint and appeal logs;
- Findings from the EQR process;
- Results from enrollee and provider satisfaction surveys’
- Performance on quality measures;
- Medical management committee reports and minutes;
- Annual Health Plan quality improvement plans;
- Audited financial and encounter data submitted by each Health Plan;
- Medical loss ratio summary reports;
- Customer service performance data;
- Data related to the provision of LTSS not otherwise mentioned above.

Performance Measures

MQD identifies standard performance measures that are linked to each objective. Selected performance measures may include:

- a. Clinical and Utilization Quality measures - a set of clinical and utilization measures are required from the Health Plan each year. MQD provides a list of the performance measures each calendar year for the next year’s required measures. The measures will include all Child and Adult Core Set measures and may include HEDIS measures.
- b. HEDIS-Like measures – a set of measures (both clinical and utilization measures) that are based on HEDIS measure definitions, but modified as needed to achieve such goals as

alignment with the CMS Medicaid Core Set, or alignment with MQD priorities. MQD provides a list of the HEDIS-like performance measures each calendar year for the next year's required measures.

- c. Other nationally developed quality measures - a set of measures (both clinical and utilization measures) with various measure stewards nationally that may or may not be endorsed by NCQA.
- d. Other "Homegrown" Quality measures – a set of measures (including clinical, utilization, or cost-based measures) that are defined by MQD to track priorities for which a HEDIS, HEDIS-like, or other nationally defined measure is unavailable, inadequate, or inappropriate. MQD will design these measures as needed and provide Health Plans with a format and frequency for reporting.
- e. Utilization dashboard - the Health Plan will supply information that may include a variety of output measures and performance metrics designed to track volumes of patients or services, including hospital admissions and readmissions, call center statistics, provider network, member demographics, etc. MQD will provide a list of the measures and a format and frequency for submission.
- f. EPSDT data - the Health Plan will report EPSDT information utilizing the CMS 416 format. This report includes information on EPSDT participation, percentage of children identified for referral, percentage of children receiving follow-up services in a timely manner, etc.
- g. Process and Contract Compliance Measures – for newly implemented initiatives, or for quality assurance initiatives, MQD may also develop process metrics or other types of metrics to track and measure contract compliance, or compliance with contract-associated benchmarks.
- h. Member Engagement and Transparency Measures – MQD may develop and monitor measures designed to evaluate member engagement, informed decision-making, transparency, member experience, provider access, and awareness of available support resources. These measures may include beneficiary feedback, Beneficiary Advisory Council (BAC) participation, provider directory accuracy, member awareness of Ombudsman services, grievance and appeal trends, and other indicators that support member-centered quality improvement activities.
- i. Survey Measures – MQD uses a series of surveys including the provider satisfaction survey, and CAHPS surveys to assess quality of care delivered to beneficiaries. MQD implements the CAHPS HCBS survey to collect data on beneficiaries receiving HCBS services. Measures from these surveys are critical to assessing performance through anonymous feedback from providers and beneficiaries alike; MQD continues to focus on measures derived from these surveys to evaluate Health Plan performance.

MQD may also utilize grievance and appeal data, Ombudsman reporting, and Beneficiary and Medicaid Advisory Committees feedback to evaluate member engagement, transparency, informed choice, and access to services. Existing HCBS quality measures related to member choice, person-centered planning, and service delivery may be incorporated into quality monitoring activities where appropriate.

MQD may require reporting of performance at any level of granularity including beneficiary-, provider-, practice-, health system- or plan-level. A subset of measures may be flagged for various incentives, including the quality payment program and auto-assignment algorithm; quality measures may also be used to design and implement other value-based program arrangements. For select programs, such as the Hospital P4P program, MQD may collect a set of measures directly from the hospitals. If selected for an incentive program, the relative impact of each measure on the overall incentive will also be determined by MQD. Target setting for incentives has typically focused on national benchmarks for HEDIS measures and achievement of a specific deliverable for process measures. In addition, MQD has generally rewarded plans for improvements over baseline. As the number and types of measures are expanded, MQD intends to explore more evidence-based target setting methods to support the design of performance rewards that are both ambitious and achievable.

The process of selecting performance measures for reporting and inclusion in one or more incentive-based programs is nuanced and requires multiple considerations.

- First, recommendations from subject matter specialists are critical to decision making because they are critically engaged with Health Plans in ongoing reporting and quality monitoring processes. The subject matter specialists are expected to be able to describe areas requiring performance improvement, and areas where incentives could accelerate, or where the absence of financial incentives hinders, progress.
- A second consideration is external input which includes CMS reporting requirements, and feedback and input from stakeholders. Measures that are tied to reporting requirements; and measures with strong stakeholder support will be prioritized. Some incentive programs require collaborative design with external agencies; in these instances, stakeholder input and collaboration will be weighed heavily in decision making.
- Third, MQD will consider feedback received through the Beneficiary Advisory Council (BAC), member surveys, Ombudsman activities, grievance and appeal processes, and other member engagement mechanisms when evaluating and prioritizing performance measures.
- A fourth factor is the extent of the proposed measure's relationship to MQD goals and objectives. It is anticipated that program implementation and measurement will, by

design, be in alignment with the Managed Care Quality Strategy, and therefore the program's goals and objectives.

- A fifth and key factor is the need to prioritize continuous quality improvement. Measures selected, to the extent feasible, will be retained for several years to ensure the ability to measure improvement over time. Stakeholder input will be sought in identifying measures that should be prioritized for long-term maintenance and monitoring. Similarly, decisions to replace measures included in incentive-based programs will balance the need for the change with the challenges and resource constraints associated with changing programmatic priorities and/or measurement methodology.
- Sixth, incentive-based programs require the selection of measures that are achievable yet ambitious over the measurement period. For programs in implementation, measures may be chosen that progressively incentivize planning and implementation, followed by utilization and outcomes.
- A final factor is considering the impact of administrative burden on providers, the Health Plans, and MQD.

These factors will be considered by the Quality Committee in issuing final guidance on reportable measures, and the subset of measures that will be incorporated into one or more incentive based structures.

Performance measures are submitted to MQD's EQRO as noted in the section below. A subset of measures are subject to audit by the EQRO. MQD has transitioned to beneficiary-level reporting of quality measures to support advanced analytics, including analyses of health disparities by sub-population. MQD encourages Health Plans to use beneficiary-level data to identify, document, and report on disparities; and implement strategies to address and mitigate disparities where identified.

The performance measures for each objective are detailed in Appendix A. MQD may supplement these measures with additional quality, transparency, member engagement, and access-related measures as necessary to support emerging priorities, federal requirements, and quality improvement initiatives.

Managed Care Plan Choice Scorecard

MQD will develop and maintain a consumer-facing Managed Care Plan Choice Scorecard designed to support informed member decision-making. The scorecard will incorporate member experience measures, including Consumer Assessment of Healthcare Providers and Systems (CAHPS) results, quality performance measures, access indicators, provider directory

performance, and other information that assists members in comparing available Health Plan options.

The scorecard will be publicly available and updated regularly to promote transparency, accountability, and informed health plan selection. MQD will work with Health Plans and stakeholders to identify meaningful measures that are understandable and useful to Medicaid beneficiaries.

External Quality Review (EQR) activities and technical report

An external quality review is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that Health Plans, or their contractors, furnish to Medicaid beneficiaries. This review is required to be conducted by an external quality review organization (EQRO) that meets competence and independence requirements. The review of health care services includes services provided in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

42 Part 438.350, subpart E, of federal regulations requires that states who contract with Health Plans utilize an EQRO to:

- a) Conduct reviews of performance improvement projects;
- b) Validate performance measures;
- c) Determine compliance with subpart D standards and quality assessment and performance improvement requirements within the previous 3-year period; and
- d) Validate network adequacy during the preceding 12 months.

Further, according to regulation, optional activities may be performed by the EQRO and include such activities as:

- a) Validation of encounter data;
- b) Administration or validation of consumer or provider surveys of quality of care;
- c) Calculation of additional performance measures that are mandatory;
- d) Conduct quality studies that focus on a clinical or nonclinical service at a point in time;
- e) Assist with quality rating;
- f) Provide technical assistance.

To comply with §438.350, subpart E, MQD contracts EQRO services through a standard, competitive bid process. MQD requires the EQRO vendor to perform both mandatory and optional services to ensure that medically necessary, cost-effective quality services are being provided to QI and CCS members through a range of independent assessment activities.

The EQRO is responsible for performing mandatory and optional activities as described in §438.358. Mandatory activities for each Health Plan include those described in the federal statute while optional activities are those that are required by the State of Hawai'i. Mandatory and State required activities are described in Table 13 below.

Table 13 - EQRO Activities

CMS Mandatory Activities	State Required
• Validation of performance improvement projects; • Validation of performance measures reported as required by the State of Hawai'i; and • A review, conducted within the previous 3-year period, to determine compliance with standards established by the State with regards to access to care, structure and operations, and quality measurement and improvement. • Validation of Network Adequacy to ensure that Medicaid and Children's Health Insurance Program (CHIP) managed care plans (MCPs) maintain provider networks that are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. • An annual detailed Technical Report that provides the state with EQR results for the prior contract year.	• Administration of the CAHPS Consumer Survey; • Administration of a provider satisfaction survey; and • Provision of technical assistance to the Health Plans to assist in conducting activities related to the EQR activities.

Review of Compliance with Federal and State-specified Operational Standards

The EQRO evaluates Health Plan compliance with State and federal requirements for organizational and structural performance. One-half of the full set of standards in Year 1 and Year 2 is reviewed to complete the cycle within a three-year period. A pre-on-site desk review, on-site review with interview sessions, system and process demonstrations, and record reviews are part of the review cycle.

Further, in instances where the Health Plan deficiencies are identified as a part of the EQRO review process, follow-up monitoring activities and corrective actions are put into place.

Performance Improvement Project Reviews

PIPs are designed as an organized way to assist Health Plans in assessing their healthcare processes and design interventions to improve member health, functional status, and/or satisfaction. The goal of the PIP validation is to ensure that the Health Plan and key stakeholders have confidence that reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP.

Consistent with the CMS protocol for validating performance improvement plans, the EQRO seeks to ensure that the Health Plans design, conduct, and report projects in a methodologically sound manner. The PIPs are based on a rapid-cycle framework, which includes five modules staged to allow for frequent and regular updates. This framework is intended to improve processes and outcomes of healthcare by way of focusing on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement.

The EQRO assesses each PIP for real improvements in care and services. In addition, the EQRO assesses outcomes and impacts on improving care and services provided to members. This information is reported to MQD for monitoring and follow-up. An important part of the PIP is to consider how information was gathered and lessons learned during the life of the PIP can be used going forward. The PIP process should be a learning experience that provides new knowledge and skills that can be applied to ongoing and future quality improvement efforts.

Validation of Performance Measures

The EQRO validates the accuracy of the results of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and non-HEDIS state-defined measure rates.

Validation of Network Adequacy

In accordance with 42 CFR §438.68, states that contract with MCOs, PIHPs, or PAHPs must develop and enforce network adequacy standards. Validating network adequacy is one of the mandatory external quality review activities described at 42 CFR §438.358(b)(1). The EQR technical report includes information on the validation of MCO, PIHP, and PAHP network adequacy during the preceding 12 months.

Member and Provider Survey

MQD conducts surveys of the QI child and Children's Health Insurance Program (CHIP) populations to learn more about member satisfaction and experiences with care using a standardized survey instrument. The EQRO then aggregates and reports on survey results.

Also, the EQRO, conducts provider surveys at the request of the MQD. The objective of this activity is to provide meaningful information to MQD and the QI Health Plans about providers' perceptions of the QI Health Plans.

Annual Report

MQD requires the EQRO to prepare a Technical Report with each Health Plans' plan-specific activities, services and operations adherent to the CMS protocols found in § 438.364 for external review quality reports. Specifically, the EQRO Technical Report addresses the objective of the EQRO oversight function, the technical methods of data collection and analysis, a description of the data obtained, including population-based aggregate measurement and analysis and the conclusions drawn from the data. The report includes areas of Health Plan strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries. The report includes recommendations for improving the quality of health care services furnished by each Health Plan, comparative information about all of the State's Health Plans, and an assessment of the degree to which each Health Plan has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This information is used to identify the need for benefit changes, Health Plan Contract amendments, additional Health Plan quality improvement activities, sanctions or other program changes. Additionally, the EQRO report is used to inform MQD of needed oversight or regulatory support to improve managed care health care delivery.

Copies of EQR information, upon request, is available through print or electronic media, to interested parties such as participating health care providers, enrollees and potential enrollees, recipient advocacy groups and members of the general public. Reports produced by the EQR are placed on the MQD website at the following web address:
<https://medquest.hawaii.gov/en/resources/consumer-guides.html>