Hawai‘i Quality Strategy 2020

STATE OF HAWAII

Department of Human Services

Med-QUEST Division

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I.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 Hawaii'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) 438.202, MQD has developed and will maintain a Medicaid 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 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 an 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 Medicaid 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 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 Hawaii's Medicaid population.

Since its implementation, CMS has renewed the QUEST demonstration five times. The current QUEST Integration demonstration titled "Hawai'i QUEST Integration" ("demonstration") (Project No. I l-W-00001/9) began on August 1, 2019 and runs through July 31, 2024. 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 (CIS) for beneficiaries with an eligible health need who are either homeless or at risk for homelessness; 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. All medical benefits and services continue to be provided by the QI Health Plan.

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 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 20 percent of health care expenditures, and the top five percent account for nearly half of the nation's spending on health care.[1] 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.[2] 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 Value-Based Purchasing (VBP) Road Map lays out the way MQD will 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 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

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[1] The National Academy of Medicine. "Effective Care for High-Need Patients: Opportunities for improving Outcome, Value, and Health." 2017. https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients-Executive-Summary.pdf [Accessed 07/15/20]

[2] The CommonWealth Fund. "The Road Not Taken: The Cost of 30 Years of Unsustainable health Spending Growth in the United States." March 2013.

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 Equity and Social Determinants of Health

As MQD works towards the HOPE vision, it will do so through a lens of health equity. Social determinants of health (SDOH) are the conditions in which people are born, grow, live, work and age that shape health. Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food security and access to healthy food choice, access to transportation, social support networks and connection to culture, as well as access to healthcare are all determinants of health. The health of population groups, including that of Native Hawaiians and Pacific Islanders, are affected differently by these factors, leading to disparities in health outcomes. Further, the island geography of Hawai'i has given rise to great diversity at the local community level.

Hawai'i state law recognizes that all state agency planning should prioritize addressing the social determinants of health to improve health and wellbeing for all, including Native Hawaiians (ACT 155 (2014) HRS §226-20). It is therefore essential that MQD build on and support culturally appropriate and effective initiatives, support interventions that promote and improve health equity, and reduce health and geographic disparities. Further, MQD recognizes that achieving the Triple Aim, healthy communities, and healthy families will not be successful if health disparities persist, and critical social needs are left unaddressed. As such, MQD is committed to systematically evaluating health disparities and identifying and addressing unmet social needs to achieve the objectives across all goal areas of the Medicaid Quality Strategy.

Quality Strategy Goals, Objectives, Aims and Guiding Principles

MQD's quality strategy is founded on the four HOPE strategic areas, and then organized into a total of seven overarching goals. Each goal is parsed into several objectives for a total of 17 objectives, and most objectives are cross-cutting in that they achieve more than one of MQD's goals. Table 2 identifies the strategies, goals, and objectives, and lists each objective under the

corresponding primary Quality Strategy Goal area. Cross-cutting objectives allow for a non-siloed and more effective and efficient approach to achieving the HOPE vision. Each objective is generally tied to more than one HOPE strategy, and works to advance Hawaii's progress across several goal areas simultaneously. This is foundational and essential, as the HOPE strategies are intended to be mutually reinforcing of one another in achieving the HOPE vision.

Table 2 – HOPE Strategies, Quality Strategy Goals and Quality Strategy Objectives

HOPE Strategies	Quality Strategy Goals	Quality Strategy Objectives	
Invest in Primary Care, Prevention and Health Promotion	Advance primary care, prevention, and health promotion	OBJECTIVE 1	Enhance timely and comprehensive pediatric care
		OBJECTIVE 2	Reduce unintended pregnancies, and improve pregnancy-related care
		OBJECTIVE 3	Increase utilization of adult preventive screenings in the primary care setting
		OBJECTIVE 4	Expand adult primary care preventive services
Invest in primary care, prevention and health promotion; and Improve outcomes for high-needs, high-cost individual	Integrate behavioral health with physical health across the continuum of care	OBJECTIVE 5	Promote behavioral health integration and build behavioral health capacity
		OBJECTIVE 6	Support specialized behavioral health services for serious intellectual/developmental disorders, mental illness, and Substance Use Disorders (SUD)
Improve outcomes for high-needs, high-cost individuals	Improve outcomes for high-need, high-cost individuals	OBJECTIVE 7	Provide appropriate care coordination for populations with special health care needs
		OBJECTIVE 8	Provide team-based care for beneficiaries with high needs high cost conditions
		OBJECTIVE 9	Advance care at the end of life
		OBJECTIVE 10	Provide supportive housing to homeless beneficiaries with complex health needs
Support community driven initiatives	Support community initiatives to improve population health	OBJECTIVE 11	Assess and address social determinants of health needs
Improve outcomes for high-need, high-cost individuals	Enhance care in LTSS settings	OBJECTIVE 12	Enhance community integration/re-integration of LTSS beneficiaries
		OBJECTIVE 13	Enhance nursing facility and Home and Community Based Services

HOPE Strategies	Quality Strategy Goals	Quality Strategy Objectives	
			(HCBS); prevent or delay progression to nursing facility level of care
Invest in primary care, prevention, and health promotion; Improve outcomes for highs-need, high-cost individuals; and Payment reform and alignment	Maintain access to appropriate care	OBJECTIVE 14	Maintain or enhance access to care
		OBJECTIVE 15	Increase coordination of care and decrease inappropriate care
Payment reform and alignment	Align payment structures to improve health outcomes	OBJECTIVE 16	Align payment structures to support work on social determinants of health
		OBJECTIVE 17	Align payment structures to enhance quality and value of care

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 Quality Strategy and in collaboration with MQD stakeholders, detailed action steps and timelines will be developed to support successful execution of the Quality Strategy, including the SDOH Transformation Plan. 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 Quality Strategy.

Quality Strategy Development, Evaluation and Revision Process

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

The QSLT develops the strategies, goals, objectives and interventions included in the Quality Strategy, assesses the effectiveness of initiatives, and revises the 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 experts throughout MQD are requested to identify program gaps, formulate solutions, and prioritize quality initiatives that are addressed in this Quality Strategy and the continuous quality improvement system that MQD maintains. This quality improvement system is described in Section IV – Quality Strategy Implementation.

The QSLT 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 validated 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®) survey of beneficiary satisfaction, and Health Plan comparison reports. MQD evaluates these survey results and operational performance reports when assessing state modifications to the Quality Strategy annually.

Stakeholder Engagement

In addition to internal review processes, MQD seeks external feedback through a number of methods to assess the 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.

Timeline for Review and Updates

MQD reviews and updates the 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 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 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 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 for final CMS approval. Once approved by CMS, the State's Quality Strategy is made available on the MQD website.

For purposes of updating and reviewing the 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 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 Quality Strategy will also be considered insignificant, but appendices will be regularly updated as needed in the version of the Quality Strategy posted online.

II. State Standards

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 nine (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 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 2019, there was a physician need for 3,483 FTEs with only 2,974 available; the largest deficit was in primary care with a shortage of 300 FTEs across all islands. When considering the shortage locally, shortages ranged from a low in Oahu of sixteen percent to a high on the Big Island of forty-four percent.[3]

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 living on the neighbor islands to travel to Oahu to access some services.[4] Telehealth services are reimbursable at the same rates as in person visits, by law, to encourage widespread adoption.[5]

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.

[3] University of Hawaii. "Annual Report on Findings from the Hawai'i Physician Workforce Assessment Project." Kelly Withy, MD, PhD. https://www.hawaii.edu/govrel/docs/reports/2020/act18-sslh2009_2020_physician-workforce_annual-report.pdf. [Accessed 07/15/20]
[4] https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2019/QI-1921.PDF [Accessed 7/16/20]
[5] https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2017/QI-1702A-FFS-17-01A.pdf [Accessed 7/16/20]

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

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 nurses trained in psychology • 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 the submission of a Provider Network Adequacy and Capacity Report 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.

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 5 – QI Geographic Access of 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 of 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 may also be reviewed and updated by MQD based on availability of telehealth services.

Table 7 - 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

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 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 institutional.

For the CCS program, transitions for newly enrolled CCS members are coordinated by the CCS Health Plan. The CCS Health plan coordinates transition of behavioral health care services with the Department of Health's Child and Adolescent Mental Health Division (DOH-CAMHD), the Department of Health's Adult Mental Health Division, 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 eligible members. Health Plans are required to identify, refer and coordinate the medical and behavioral services for adults with SMI or SPMI with the CCS program.

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 and service 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.

MQD requires the Health Plans have a care and service coordination program that complies with the requirements in §438.208, and is subject to MQD approval. The Health Plans must provide whole-person and person-centered care and service coordination services to members receiving LTSS and HCBS, and to members who meet the criteria for Special Health Care Needs. The Health Plans are required to provide appropriate care and service coordination support across multiple settings and across the continuum of care with the focus on improving health care outcomes and decreasing inappropriate utilization.

MQD requires the Health Plans to identify the target populations through advanced data analytics and other processes; complete assessments, and develop and implement a patient-centered care or service plans; and complete reassessments and develop an updated care or service 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.

Some of the care and service coordination services that may be provided include the coordination of physical, behavioral health, and social services; managing transitions of care, including transitions to and from Health Plans according the MQD contract requirements; 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, if applicable.

MQD encourages the Health Plans to utilize an interdisciplinary team to provide the services which includes clinical and non-clinical staff such as community health workers when appropriate. To encourage flexibility in approaches to care delivery while ensuring staffing adequacy, MQD may require the Health Plans to submit Staffing Plans that comply with all applicable laws, regulations, and contractual requirements, rather than specifying staffing ratios for care and service coordination in future contracts.

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).

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.[6] 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 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 the method of family planning to be used consistent with §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 §438.910(d).

MQD monitors prior authorizations and denials, and ensures 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

[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]

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[7].

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.

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 intends to adopt a quality strategy framework in accordance with CMS requirements that applies to all three HCBS receiving populations in the state. As such, this program-wide HCBS framework will provide 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), as well as the 1915(c)-like, and 1915(i)-like waiver populations covered within the state's 1115 waiver served by the state's Health Plans.

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. Person Centered Service Plan;
4. Qualified Providers;
5. Health and Welfare; and
6. Financial Accountability.

[7] 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]

Utilizing the framework developed by the National Quality Forum[8] for achieving high quality HCBS Services, 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.

Additionally, MQD is adopting the domain framework proposed by the National Quality Forum. The domains are listed below in Table 8 Domain Descriptions.

[8] National Quality Forum, "Quality in Home and Community Based Services to Support Community Living" https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/HCBS_Final_Report.pdf

Table 8 - Domain Descriptions

Domain Name	Description
Service Delivery and Effectiveness	The level to which services and supports are provided in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.
Person Centered Planning and Coordination	An approach to assessment, planning, and coordination of services and supports that is focused on the individual's goals, needs, preferences, and values. The person directs the development of the plan, which describes the life they want to live in the community. Services and supports are coordinated across providers and systems to carry out the plan and ensure fidelity with the person's expressed goals, needs, preferences, and values.
Choice and Control	The level to which individuals who use HCBS, on their own or with support, make life choices, choose their services and supports, and control how those services and supports are delivered.
Community Inclusion	The level to which people who use HCBS are integrated into their communities and are socially connected, in accordance with personal preferences.
Caregiver Support	The level of support (e.g., financial, emotional, technical) available to and received by family caregivers or natural supports of individuals who use HCBS.
Workforce	The adequacy, availability, and appropriateness of the paid HCBS workforce.
Human and Legal Rights	The level to which the human and legal rights of individuals who use HCBS are promoted and protected.
Equity	The level to which HCBS are equitably available to all individuals who need long-term services and supports.
Holistic Health and Functioning	The extent to which all dimensions of holistic health are assessed and supported.
System Performance and Accountability	The extent to which the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.
Consumer Leadership in System Development	The level to which individuals who use HCBS are well supported to actively participate in the design, implementation, and evaluation of the system at all levels.

MQD will utilize the recommended process for measuring quality standards in HCBS programs. Specifically, MQD will convene a standing panel of HCBS experts to develop, evaluate and recommend a core set of standard measures for use across the HCBS system, along with a menu of supplemental measures that are tailorable to the population, setting, and program. Health Plans and 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.

MQD has established priority goals for the domains which are tied to specific HCBS requirements. Those initial goals are included below in Table 9. Draft performance measures linked to domains and subdomains will be included in Appendix A. These measures will be revised as needed based on input from the HCBS panel, and revisited regularly to ensure currency and relevance to the priority goals of the program. Performance measures to satisfy assurances will be included in the Health Plan reporting requirements and monitored on a quarterly basis.

Table 9 - Priority Goals

Domain	Goal	HCBS Requirement
Service Delivery and Effectiveness	Establish overall health care standards and monitor those standards based on the responsibility level of the service provider.	Health and Welfare
System Performance and Accountability	Ensure that the State Medicaid Agency provides monitoring and oversight over the contracted entity.	Administrative Authority
Person Centered Planning and Coordination	Service plans are person center and address all members assessed needs (including health and safety risk factors) and personal goals 42CFR301(c)(1)-(3).	Person Centered Plan
Person Centered Planning and Coordination	Service plans are updated/revised at least annually or when warranted by changes in the member's needs.	Person Centered Plan
Choice and Control	Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.	Person Centered Plan
Choice and Control	Members are afforded choice between/among waiver services and providers.	Person Centered Plan
Community Inclusion	All settings are in full compliance with the HCBS Final Rule 42CFR301(c)(4).	Administrative Authority
Workforce	Establish adequate provider networks in accordance with the State contract requirements.	Administrative Authority
Workforce	Ensure that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing services.	Qualified Providers
Workforce	Ensure monitoring and oversight non-licensed/non-certified providers to assure adherence to contract requirements.	Qualified Providers

Domain	Goal	HCBS Requirement
Workforce	Ensure implementation of policies and procedures for verifying that training provided in accordance with the State contract requirements.	Qualified Providers
Human and Legal Rights	Demonstrate that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.	Health and Welfare
Human and Legal Rights	Policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed accordance with the State and contract requirements.	Health and Welfare
Equity	Level of care evaluations are provided to all members for whom there is a reasonable indication that HCBS services may be needed.	Level of Care
Equity	Ensure processes and instruments for determination of level of care are applied appropriately to determine initial level of care.	Level of Care
Holistic Health and Functioning	Demonstrate on an ongoing basis that the system identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.	Health and Welfare
System Performance and Accountability	Verify that claims are coded and paid for in accordance with the reimbursement methodology and only for services rendered.	Financial Accountability
System Performance and Accountability	Validate that rates remain consistent with the approved rate methodology throughout the contract cycle.	Financial Accountability

Performance measures associated with assurances for the 1915(c) program have a threshold of eighty-six percent (86%); the same standard will be ported and applied to the 1915(c)-like and 1916(i)-like programs. 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. Similar to quality improvement requirements in the 1915(c) waiver, quality improvement activities for the 1915(c)-like and 1915(i)-like populations will be required of Health Plans that fall below the minimum assurance standards across any of the domains and performance measures. 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.

As with other state assurances, and as described in Section IV – Quality Strategy Implementation, MQD will implement appropriate escalation processes to ensure robust mitigation when assurances are not met, including the imposition of sanctions if non-performance or violations are not resolved in a timely manner. MQD will require prompt notification and monitor swift action by Health Plans to urgently and adequately address any substantiated instances of abuse, neglect, exploitation and/or death identified.

Select HCBS assurances may be included in the Operational Effectiveness Program (OEP) to further financially incentivize Health Plans to meet standards in areas of compliance that require investments to improve. HCBS measures will be included and considered alongside other contractually required performance measures in the Joint Performance and Measure (J-PAM) review meetings. The LTSS Quality Program Committee will oversee quality improvement activities associated with meeting HCBS assurances, and the Quality Improvement (QI) team review process will be used to strategically monitor and guide improvement for all domains. Ongoing reporting and routine oversight of Health Plan activities by the LTSS Quality Program Committee will ensure a continuous quality improvement approach, and enable the diffusion and adoption of evidence-based practices to support QI.

Health Equity and Health 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 Hawaii 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; and plans are underway to collect data on gender identity. Sexual orientation is not collected. Health Plans are encouraged to segment their data by these

various dimensions provided, and when disparities are identified, develop targeted interventions to address them.

Additionally, MQD intends to develop a Social Determinants of Health (SDOH) Transformation Plan in partnership with its Health Plans which, when complete, will represent 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 will also require 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 is expected to develop 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. 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.

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. 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 require that a provider be removed immediately from a Health Plan network, if the provider fails to meet or violates any State or Federal laws, rules, or regulations; or the provider's performance is deemed inadequate by the State based upon accepted community or professional standards.

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.[9]

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 438.6(h) and 422.208, 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

[9] "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. Accessed on July 13, 2020.

and upon request to members or potential members. Health Plans are required to include, as part of its 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.

Practice guidelines previously issued by MQD and Health Plans have varied in scope and topic. Some medical practice guidelines previously issued have included comprehensive monitoring for persons with diabetes, and appropriate pharmacotherapy practices for persons with asthma; public health practice guidelines have addressed topics such as immunizations for children and adolescents, and cervical cancer screening; behavioral health guidelines have provided evidence based recommendations for the pharmacologic treatment of major depression and childhood Attention Deficit Hyperactivity Disorder.

Table 10 describes the requirements for the Practice Guidelines.

Table 10 - Practice Guidelines

Requirements for Practice Guidelines
• 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 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 mandatory 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.

Table 11- Medicaid Populations

Medicaid Covered Managed Care Populations	• Children under 19 years of age • Former foster care children under age 26 • Pregnant women • Parent or caretaker relatives • Individuals receiving transitional medical assistance • Adults 19 to 64 years of age • Individuals who are aged, blind, or with a disability • Non-citizens and refugees who are Medicaid eligible • Eligible 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 aged, blind, or with a disability, 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
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); • Out-of-State Foster Care children • Repatriates; • Retroactively eligible only; • Emergency Services for Non-citizens; and • Eligible under non-ABD medically needy spenddown.

Enrollment and Disenrollment of Members and Providers

MQD makes eligibility determinations based on requirements described in 42 CFR Part 435 and in accordance with Hawaii'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 three (3) 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 an annual open enrollment period during which members are allowed to change plans. 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.[10] 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 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 included in the following Table 12 below.

Table 12 - Disenrollment Reasons

Allowable Reasons for Disenrollment	Prohibited Reasons for Disenrollment
• Member no longer qualifies • Death of a member • Incarceration of member	• Pre-existing Medical Conditions • Missed Appointments • Changes to Member's Health Status

[10] 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 enters state hospital • Member enters Hawai‘i Youth Correctional Facility • Member enters State of Hawai‘i Organ and Tissue Transplant (SHOTT) program • 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	• Utilization of Medical Services • Diminished Mental Capacity • Uncooperative or Disruptive Behavior resulting from the Member’s special needs

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.

Member and Provider Grievance and Appeals

MQD requires Health Plans have a formal member grievance and appeals system that is consistent with the requirements of the State of Hawai'i and 42 CFR Part 438, Subpart F. MQD contractually requires expeditious and satisfactory resolution of grievances, and provides opportunities for members to file grievances or appeals directly with the State should the member's grievance not be resolved at the Health Plan level. The Health Plan's grievance system must provide information to members on accessing the State's administrative hearing system, including the requirement that members exhaust the Health Plan grievance system prior to accessing the State's administrative hearing system. Monitoring of the member grievance and appeals process, protocols and statistics is conducted via Health Plan reporting to MQD.

MQD requires Health Plans also have policies and procedures for a provider grievance system that includes provider grievances and provider appeals. Providers may utilize the provider grievance system to resolve issues and problems with the Health Plan (this includes a problem regarding a member). Monitoring of the provider grievance and appeals process, protocols and statistics is conducted via Health Plan reporting to MQD.

To support members and providers, MQD maintains a grievance hotline, as well as provides Ombudsman services to Hawaii Medicaid beneficiaries and providers on all islands. The Ombudsman assists in the resolution of issues and concerns about access to, quality of, or limitations to, health care for eligible Medicaid beneficiaries receiving services in Medicaid programs.

Sub-contractual Relationships and Delegation

Contingent upon approval from DHS, Health Plans may be permitted to delegate certain 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 written delegation agreement between the delegated organization and the Health Plan. The 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 maintain policies and procedures detailing the process for evaluating and monitoring the delegated organization's performance. At a minimum, prior to execution of the delegation 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 delegate is accredited by NCQA.

Health Information Technology

In accordance with 42 CFR 438.42, 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 Hawaii'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 Hawaii'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 has almost 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 are expected to 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.

Hawai‘i successfully applied and received HITECH funds in 2019 to support a rebuild of Hawaii's immunization registry. The Hawai‘i Immunization Registry (HIR) is maintained and operated by the Hawai‘i Department of Health. A rebuild with funding from MQD will pave the way for data exchange to support better monitoring of health and health outcomes, identification of disparities in vaccination status, and program integrity functions.

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. The Health Analytics Initiative (HAI) strives to improve and expand health informatics and analytics capabilities within MQD that are critical to perform essential functions, such as analyzing standardized comparative quality indicators, cost trends, and cost drivers, with a focus on care management and population health outcomes for Hawaii's citizens. The HAI would support HAO's business need for robust data analytics tools that provide the ability for researchers to submit queries directly through a Decision Support System (DSS)/analytics data warehouse/repository front-end application or to create data extracts for analysis and reporting.

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 438.42 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 reimbursement terms with the provider. The 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 many reasons such as audits, investigations, identifications of improper payments, and other program integrity activities; federal reporting (42 CFR 438.242(b) (1)); rate setting and risk adjustment; analysis of denial patterns; verification of reported quality measure data prior to release of withhold or incentive payments; service verification; managed care quality improvement; policy analysis; executive and legislative decision making; assessment of utilization patterns and access to care; hospital rate setting; pharmacy rebates; and research studies.

MQD requires that the Health Plan submit encounter data for all services rendered to members under this contract, including encounters where the Health Plan determined no liability exists, and whether the encounter was processed as paid or denied, along with any adjustments, or voids of encounter records previously submitted. MQD requires the Health Plan ensure that data received from providers and other subcontractors is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized format. The Health Plan is required to make all collected data available to MQD, and upon request, to CMS.

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 HPMMIS Health Plan Manual ("Health Plan Manual"), published by MQD. The Health Plan and its subcontractors are expected to retain all encounter data for a period of no less than ten (10) years in accordance with 42 CFR 438.3(u). Provisions shall be made by the Health Plan to maintain permanent history by service date for those services identified as "once-in-a-lifetime" (e.g., hysterectomy).

Health Plans' encounter data submissions must meet specified criteria for timeliness, accuracy and completeness. MQD may impose financial penalties or sanctions on the Health Plan for inaccurate, incomplete and late submissions of required data, information and reports.

For all covered outpatient drugs, as described in 42 CFR 438.3 (s), the Health Plan is responsible to:

1) Report drug utilization data that is necessary for the State to bill manufacturers for rebates no later than 45 calendar days after the end of each quarterly rebate period.
2) Report drug utilization information 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) Establish 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 are required to ensure that all criminal history record check requirements are conducted for all high-risk providers determined by the state and that all providers including, but not limited to, therapists, meet State licensure requirements. Health Plans are also required to comply with the provisions of Clinical Laboratory Improvement Amendments (CLIA) 1988.

In compliance with § 5005(b)(2) of the 21st Century Cures Act, MQD implemented a provider enrollment, eligibility verification and credentialing system in August 2020. Called Hawaii's Online Kahu Utility (HOKU), the system allows MQD to maintain direct responsibility for provider accreditation. Health Plans are required to work through the system to ensure that their providers have met accreditation requirement prior to providing services to Medicaid beneficiaries.

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). Although, the State currently does not utilize any non-duplication options as it relates to EQR activities, MQD acknowledges that the activities required under §438.358(b)i-iii (for conducting Performance Improvement Projects (PIPs), calculating performance measures and compliance monitoring review) are options for deeming only for plans that exclusively serve dual eligible beneficiaries.

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.

III. Improvements and Interventions

Section I described seven major goals of the MQD Quality Strategy and a total of 17 cross-cutting objectives that fell within these. Each objective, the primary and additional cross-cutting goals it serves, as well as the initiatives actively implemented or in planning under each objective are described below.

OBJECTIVE 1	ENHANCE TIMELY AND COMPREHENSIVE PEDIATRIC CARE
PRIMARY GOAL:	INVEST IN PRIMARY CARE, PREVENTION AND HEALTH PROMOTION
CROSS-CUTTING GOAL(S):	ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

MQD provides coverage for early and periodic screening, diagnosis, and treatment (EPSDT) services, to identify physical or mental defects in individuals, and, to provide health care, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered in accordance with section 1905(r) of the Social Security Act. EPSDT includes services to:

a) Seek out individuals and their families and inform them of the benefits of prevention and the health services available;

b) Help the individual or family use health resources, including their own talents, effectively and efficiently; and

c) Assure the problems identified are diagnosed and treated early, before they become more complex, and their treatment, more costly.

EPSDT services for children include oral health prevention and treatment services. Routine EPSDT services are captured via a standardized form that providers use to report EPSDT screenings and any findings and referrals arising from the visits. Annual reports submitted by Health Plans to MQD provide multiple indicators that are normally included in the CMS Annual EPSDT Participation Report. As part of ongoing quality improvement in this area, MQD intends to implement a more robust periodicity schedule in alignment with Bright Futures guidelines, and expand monitoring requirements to collect beneficiary-level data from the Health Plans on types of screenings conducted, findings, and additional referrals as appropriate. This data will be aggregated and disseminated by MQD for purposes of targeted provider and client oversight, education, and outreach.

Select EPSDT measures may be included in the Health Plan P4P program, or included in the state's auto-assignment algorithm as needed to incentivize improvements.

OBJECTIVE 2	**REDUCE UNINTENDED PREGNANCIES; IMPROVE PREGNANCY-RELATED CARE**
PRIMARY GOAL:	INVEST IN PRIMARY CARE, PREVENTION AND HEALTH PROMOTION
CROSS-CUTTING GOAL(S):	INTEGRATE BEHAVIORAL HEALTH WITH PHYSICAL HEALTH ACROSS THE CONTINUUM OF CARE ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

To support its core focus on 'Ohana Nui, a key focus of MQD is to support non-pregnant women in planning efforts to mitigate unintentional pregnancies, and pregnant women in receiving optimal pregnancy and post-partum care. MQD partners with the Hawai'i State Department of Health (DOH) on various public health initiatives to reduce unintended pregnancy through encouraging the adoption of "One Key Question" (OKQ), a standardized pregnancy intendedness question that when included as part of a routine screening, can help providers appropriately counsel women on either contraception or pregnancy preparedness. Another initiative strives to increase the use of Long-Acting Reversible Contraceptives (LARC) among women of reproductive age.

MQD provides access to 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. Through the exclusive use of state funds, MQD provides additional access to services related to the intentional termination of pregnancies (ITOPs).

Pregnancy care related measures are included as part of the Health Plan pay for performance pool and therefore incentivized with payments for achieving performance improvements as well as for meeting or exceeding quality benchmarks. Next, a maternal and child health quality improvement collaborative designed to improve the quality of care for mothers and babies in hospitals is included in a Hospital P4P Program, described further in Objective 3.

MQD additionally supports Screening for risky misuse of substances, provision of Brief Intervention and Referral to Treatment (SBIRT) as needed at prenatal care appointments. Pre-natal providers have received SBIRT training through a collaborative effort of MQD and DOH, and are able to receive an enhanced payout for conducting SBIRT screenings in their practices. Future SBIRT training for all primary care providers and ongoing refreshers are expected to be conducted by Health Plan, and incentivized through MQD's pay for performance pool.

OBJECTIVE 3	INCREASE UTILIZATION OF ADULT PREVENTIVE SCREENINGS IN THE PRIMARY CARE SETTING
PRIMARY GOAL:	INVEST IN PRIMARY CARE, PREVENTION AND HEALTH PROMOTION
CROSS-CUTTING GOAL(S):	INTEGRATE BEHAVIORAL HEALTH WITH PHYSICAL HEALTH ACROSS THE CONTINUUM OF CARE ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

MQD has implemented several strategies to enhance screening for both physical and behavioral health conditions in the primary care setting.

Health Plans are required to cover U.S. Preventive Services Task Force (USPSTF) screenings with a grade B recommendation or higher; through contracting, MQD will expand coverage to other screenings identified in recognized clinical practice guidelines such as those published by the Centers for Disease Control and Prevention (CDC), HRSA's women's preventive services guidelines, and the Department of Health's guidelines on screening for tuberculosis. Screenings

are expected to cover physical conditions including infectious diseases, common chronic conditions, and cancers, as well as behavioral health conditions and substance use disorders.

MQD collects quality measures to track screening rates for several preventive services and strategically incentivizes measures via the Health Plan P4P program as needed. In addition, MQD hopes to incentivize Health Plans to train all primary care providers on the SBIRT method, with the intent of transitioning incentives to measures that track the reach of SBIRT screening performed and referrals made. The Hospital P4P program previously focused on building capacity, but has now transitioned its measure to focus on percentage of the population receiving SBIRT screening.

Future contracting efforts are expected to reinforce behavioral health integration into the primary care setting for children and adults. The efforts include the development of capacity among primary care providers for identification, early intervention, treatment of mild to moderate behavioral health conditions, and referral to treatment as appropriate. Monitoring methods will be developed according to the interventions chosen to track implementation and expansion of screening for behavioral disorders in the primary care setting, and may be incentivized as needed to promote and increase participation.

Beyond P4P, additional financial levers that support primary care described elsewhere are expected to support this initiative. In particular, one of the primary care spend measures within the Advancing Primary Care initiative, when implemented, Objective 3 is anticipated to focus on tracking overall spend on primary preventive care services; therefore, efforts to increase primary care spend may inadvertently contribute to increased delivery of screenings in the primary care setting.

OBJECTIVE 4	EXPAND ADULT PRIMARY CARE PREVENTIVE SERVICES
PRIMARY GOAL:	INVEST IN PRIMARY CARE, PREVENTION AND HEALTH PROMOTION
CROSS-CUTTING GOAL(S):	ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

In addition to enhancing screenings (Objectives 1 and 3) for pediatric and adult populations, MQD has initiated several strategies to enhance the use of primary care preventive services for both physical and behavioral health conditions in the primary care setting.

Increasing the immunization rates of the population is a key priority for MQD. Health Plans are responsible for ensuring that their members receive all necessary immunizations, including all Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) approved vaccines. The State of Hawai'i participates in the Vaccines for Children (VFC) program, a federally funded program that provides public and private vaccines for children under the age of eighteen years. The Hawai'i Immunization Registry (HIR), the

state's key repository of immunization data, became non-operational in 2017 and efforts are currently underway to repair and restore the registry. In addition, MQD has partnered with DOH to build a new HIR and enable data exchange with MQD and has obtained federal match to support the project. Completion of the rebuild is expected to improve data linkages to enable a more accurate measure of population immunization status and enhance identification of populations that are inadequately immunized.

Through future managed care contracting, MQD hopes to implement enhanced 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).

Additional preventive services that may be required through managed care contracting include nutrition counseling, American Diabetes Association (ADA) recognized or American Association of Diabetes Educators (AADE) accredited Diabetes Self-Management Education (DSME) for beneficiaries with diabetes or gestational diabetes, smoking cessation services consistent with the Treating Tobacco Use and Dependence practice guidelines by the Agency for Healthcare Research and Quality including the provisions of tobacco cessation medications as appropriate, EPSDT referrals and treatments for children screening positive for one or more conditions, and comprehensive pediatric dental coverage including fluoride varnish services.

Finally, MQD supports the restoration of a dental benefit to support preventive health for its adult population and continues to engage in numerous planning and legislative activities to evaluate the feasibility and cost of implementing different versions of the benefit (ranging from basic to comprehensive) to various population groups (ranging from just pregnant women to the entire adult population).

Quality measure reporting to MQD heavily tracks the implementation of primary care preventive services; a subset of measures are prioritized for inclusion in the state's Health Plan P4P program. Moreover, as noted in Objective 3, target setting within the Advancing Primary Care initiative measure is expected to enhance investment in the provision of primary care preventive services.

OBJECTIVE 5	**PROMOTE BEHAVIORAL HEALTH INTEGRATION AND BUILD BEHAVIORAL HEALTH CAPACITY**
PRIMARY GOAL:	INTEGRATE BEHAVIORAL HEALTH WITH PHYSICAL HEALTH ACROSS THE CONTINUUM OF CARE
CROSS-CUTTING GOAL(S):	MAINTAIN ACCESS TO APPROPRIATE CARE

	ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

Promoting behavioral health integration is a foundational strategy tied to the goal of building a system of care for individuals with behavioral health conditions across the continuum of care. MQD's approach to behavioral health integration includes building capacity to integrate primary care with behavioral health, supporting utilization of a Coordinated Addiction Resources Entry System (CARES) and health homes, enhancing SBIRT screening in emergency departments, and implementing a comprehensive process for ongoing assessment.

Primary care and behavioral health providers need support in implementing behavioral health integration. MQD hopes to collaborate with DOH, the Health Plans, and other resources to develop a plan to support practices in implementing fully integrated care using evidence-based models such as the Collaborative Care Model (CoCM) and Medication Assisted Treatment (MAT) for substance use. The plan may also include strategies to support screening for behavioral health conditions in adult and pediatric practices, enhance bi-directional referral processes, and other activities that will result in increased behavioral health integration across the care continuum.

Through contracting, MQD will collaborate directly with, and require Health Plans to work with DOH's Hawai'i CARES to build a coordinated entry system for persons being referred for substance use treatment across the state. Beyond increasing integration and coordination of behavioral health resources in the community, MQD may enhance behavioral health capacity through the health homes, as described in Objectives 5 and 8.

MQD also supports expanded capacity for behavioral health screening, diagnosis and referral to treatment in hospital emergency department settings through its support of SBIRT screening in its Hospital P4P program, as described in Objective 3. Future P4P dollars may be used to incentivize provision of brief interventions as needed, along with referrals to treatment. Eventually, MQD hopes to enhance quality of care for behavioral health through a combination of P4P incentives and value-based purchasing.

Finally, through reporting, performance measurement and quality measurement, MQD expects to develop a comprehensive method for assessing the implementation and advancement of behavioral health capacity, and integration with behavioral health practice, in the primary care setting. As needed, measures may be chosen for the Health Plan P4P program to provide financial incentives to support advancements.

OBJECTIVE 6	**SUPPORT SPECIALIZED BEHAVIORAL HEALTH SERVICES FOR SERIOUS INTELLECTUAL/DEVELOPMENTAL DISORDERS, MENTAL ILLNESS AND SUBSTANCE USE DISORDERS**

PRIMARY GOAL:	IMPROVE OUTCOMES OF BENEFICIARIES WITH COMPLEX NEEDS
CROSS-CUTTING GOAL(S):	MAINTAIN ACCESS TO APPROPRIATE CARE ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

MQD supports the treatment of individuals with intellectual and developmental disorders, serious and persistent mental illness and severe substance use disorders through multiple strategies.

Medicaid managed care plans in Hawai'i are responsible for behavioral health services for all individuals with mental and behavioral conditions. However, for those youth and adults who have serious illnesses requiring specialized services, several additional options are made available:

a) Children and youth that are unstable and with moderate to high risk behavioral disorders may be referred to the DOH Child and Adolescent Mental Health Division (CAMHD)'s Support for Emotional and Behavioral Development (SEBD) program.

b) Both children and adults with intellectual or developmental disabilities are referred to DOH's Developmental Disabilities Division (DDD) for provision of 1915(c) waiver services

c) Adults with severe and persistent mental illness are served through either the DOH Adult Mental Health Division (AMHD), or the Community Care Services (CCS) program, or both.

To improve care coordination for individuals who receive behavioral health services through DOH, MQD will contractually require Health Plans to develop joint policies and procedures and coordinate closely on the provision of care to their beneficiaries with the DOH. Additionally the quality of services provided via the 1915(c) waiver is closely monitored; please review Section II for further details.

CCS provides a full range of specialized behavioral health services including inpatient, outpatient therapy, tests to monitor the member's response to therapy, and intensive case management. CCS services also include alcohol and/or drug abuse treatment where required. A series of reporting requirements monitor quality assurance and quality improvement goals of the CCS program. MQD may pursue shared/aligned incentive payment arrangements across its QI and CCS plans to support coordination of physical and behavioral health care for CCS clients.

OBJECTIVE 7	**PROVIDE APPROPRIATE CARE COORDINATION FOR POPULATIONS WITH SPECIAL HEALTH CARE NEEDS**
PRIMARY GOAL:	IMPROVE OUTCOMES OF BENEFICIARIES WITH HIGH NEED HIGH COST

CROSS-CUTTING GOAL(S):	ENHANCE CARE IN LTSS SETTINGS

Presently, MQD supports the delivery of care and service coordination to beneficiaries requiring Long Term Supports and Services (LTSS) and beneficiaries with Special Health Care Needs (SHCN). Through future contracting, MQD hopes to expand upon the quantity, quality, and scope of care and service coordination services available to beneficiaries with SHCN with or without an additional need for LTSS.

Through future managed care contracting, MQD may employ various strategies to effectuate an approach that further addresses the needs of individuals across the continuum of care for these populations. For example, beneficiaries who meet criteria may be parsed into multiple tiers by complexity. Beneficiaries may also receive different levels of care coordination (e.g. intensive care coordination) in alignment with their needs. To the extent feasible, MQD intends to support alignment and coordination of services for individuals with SHCN who independently also qualify for LTSS. MQD intends to work collaboratively with the Health Plans and other stakeholders to further describe roles and responsibilities of members of care teams to promote shared accountability for whole person care. To the greatest extent possible, MQD intends to encourage the Health Plans to provide care teams with utilization and pharmacy data to support the care teams, improve outreach and member engagement activities in culturally appropriate ways, utilize all forms of communication when appropriate (e.g. face-to-face, email, text, etc.) and utilize care coordination capacity that exists in communities.

Reporting and quality measurement will be used to closely track efforts by Health Plans to reach, engage, and provide appropriate services to beneficiaries.

OBJECTIVE 8	PROVIDE TEAM-BASED CARE FOR BENEFICIARIES WITH HIGH NEEDS HIGH COST CONDITIONS
PRIMARY GOAL:	IMPROVE OUTCOMES OF BENEFICIARIES WITH HIGH NEEDS HIGH COST
CROSS-CUTTING GOAL(S):	MAINTAIN ACCESS TO APPROPRIATE CARE ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

Team-based care is a key care delivery strategy with broad applicability. Through contracting, MQD strives to support the provision of team-based care approaches in the community setting to the extent feasible for members who require additional care coordination and case management.

To support various models of team-based care, MQD encourages community-based solutions to evolve naturally across the healthcare landscape through a variety of strategies intended to augment existing capacity, supplemented with additional team-based care resources and/or telehealth capacity within communities to the extent to which such infrastructure is lacking.

Two key resources that MQD may seek additional authorities to provide to support team-based care are health homes, and Project ECHO. MQD may seek authorities to set up specialized health homes to provide intensive care coordination that integrates services provided across all primary, acute, behavioral and LTSS needs to treat the whole person. Health homes may be designed to employ a team-based approach to support members through increasing levels of coordination and engaging a team of professionals and paraprofessionals such as Community Health Workers, Peer Support Specialists, Community Paramedicine, and other local community-based service providers to meet the needs of beneficiaries with severe and complex healthcare needs.

MQD will use reporting and quality measurement to track implementation and care rendered to beneficiaries enrolled in specialized health homes. MQD may also design a payment methodology for enrolled beneficiaries that will ensure appropriate care and incentivize ongoing engagement; VBP arrangements may be used to incentivize providers to achieve quality goals.

Project ECHO is an innovative medical education and mentoring model that builds provider capacity with multidisciplinary teams while improving access to specialty care. Project ECHO increases access to specialty treatment by providing front-line clinicians and non-clinicians with the knowledge and help needed to manage members with complex conditions. MQD may encourage support for Project ECHO in future managed care contracts.

OBJECTIVE 9	ADVANCE CARE AT THE END OF LIFE
PRIMARY GOAL:	IMPROVE OUTCOMES OF BENEFICIARIES WITH HIGH NEEDS HIGH COST
CROSS-CUTTING GOAL(S):	ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

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 advance care directives, and increased provider understanding and compliance with patient wishes. MQD intends to monitor rates of completion of advance directives through reporting and performance measurement.

Finally, MQD hopes to create and expand a specialty palliative care benefit, sometimes referred to as comfort, or supportive care, that is community based for individuals with serious illness. Planning efforts are underway on designing and seeking authority to create this benefit.

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 10	PROVIDE SUPPORTIVE HOUSING TO HOMELESS BENEFICIARIES WITH HIGH NEEDS HIGH COST
PRIMARY GOAL:	SUPPORT COMMUNITY INITIATIVES TO IMPROVE POPULATION HEALTH
CROSS-CUTTING GOAL(S):	IMPROVE OUTCOMES OF BENEFICIARIES WITH HIGH NEEDS HIGH COST MAINTAIN ACCESS TO APPROPRIATE CARE

Through the 1115 waiver demonstration, MQD has the authority to implement two benefits, namely community integration services (CIS) and community transition services (CTS), a set of

benefits available to individuals who meet a health needs-based criteria, and additionally are homeless or at risk for homelessness. The health needs-based criteria are met for individuals with a behavioral health or a physical health need that is likely to be ameliorated by the provision of CIS benefits. Behavioral health needs may either be mental health needs arising from serious mental illness, or substance use needs that are serious enough to require at least outpatient day treatment for Substance Use Disorder (SUD). A physical need may be any complex condition of indefinite length requiring improvement, stabilization, or prevention of deterioration of functioning. Beneficiaries who qualify must consent to enroll in CIS, and be re-assessed at least quarterly to determine if they continue to meet eligibility criteria. As such, as beneficiaries with complex health needs, the population served by CIS may overlap substantially with SHCN, CCS, and LTSS populations.

CIS benefits include services described below that are furnished as reasonably necessary, as clearly identified through the beneficiary's individualized care plan and only in cases where the beneficiary is unable to meet such expense or when the services cannot be obtained from other sources. The benefits provided include pre-tenancy supports, tenancy sustaining services, transitional case management, housing quality and safety improvement services, legal assistance, and house payments, including a one-time payment for security deposit and/or first month's rent.

MQD intends to evaluate the CIS program using a rapid cycle assessment approach, with frequent and ongoing assessments of implementation progress. A series of performance measures designed to measure progressive implementation and achievement of short, intermediate, and long-term outcomes will be included in Health Plan reporting requirements to track project progress and performance improvement. Select measures may be incentivized through P4P programs or other value-based strategies. The long-term goal is for MQD to implement a VBP strategy for CIS.

OBJECTIVE 11	ASSESS AND ADDRESS SOCIAL DETERMINANTS OF HEALTH NEEDS
PRIMARY GOAL:	SUPPORT COMMUNITY INITIATIVES TO IMPROVE POPULATION HEALTH
CROSS-CUTTING GOAL(S):	IMPROVE OUTCOMES OF BENEFICIARIES WITH HIGH NEEDS HIGH COST MAINTAIN ACCESS TO APPROPRIATE CARE

MQD has a multi-pronged strategy to assess and address social determinants of health (SDOH) need across the population.

MQD intends to work with its Health Plans to develop a statewide SDOH Transformation Plan and develop aligned work plans at the Health Plan level to operationalize the goals of the transformation plan. The broad goals of the SDOH Transformation Plan are described in detail

elsewhere (Section II) but include collection of SDOH data and addressing SDOH needs. Health Plans are expected to use the SDOH Transformation Plans to develop their individual SDOH Work Plans. Health Plans may also, in adherence with Medicare requirements, provide supplemental services that support statewide efforts to address SDOH.

Next, it is expected that the team-based care approach strongly supported by MQD will also be well-suited to enable the identification of social risk factors. Through contracting, MQD intends to make explicit allowances for Health Plans to screen for social risk factors and refer and link to needed social and support services for beneficiaries who are eligible for SHCN and LTSS. The presence of one or more unmet social needs may elevate a SHCN beneficiary into a higher tier of complexity, and as such, avail the beneficiary to more intensive services that include addressing the identified and unmet social needs. In the long-term, MQD hopes to expand screening for social risk factors to multiple settings, and include all Medicaid beneficiaries.

MQD will encourage Health Plans to offer supplemental benefits to Medicare-Medicaid dually eligible beneficiaries enrolled in Dual Special Needs Plans (D-SNPs) that further support state efforts to address SDOH. SDOH-related supplemental benefits provided as part of D-SNP plans may be included in the Health Plan's SDOH Work Plan.

Finally, addressing SDOH needs also broadly fits within the most expansive definition of primary care spend in the Advancing Primary Care initiative (Objective 3). Therefore, through monitoring and setting targets to increase spending via Advancing Primary Care, MQD may also indirectly impact the provision of supports to address the population's social needs.

A series of reporting requirements and performance measurement may be established to closely monitor the implementation of various SDOH efforts. SDOH efforts may also be incentivized through one or current or future MQD VBP efforts (see Objective 17).

OBJECTIVE 12	ENHANCE COMMUNITY INTEGRATION/RE-INTEGRATION OF LTSS BENEFICIARIES
PRIMARY GOAL:	ENHANCE CARE IN LTSS SETTINGS
CROSS-CUTTING GOAL(S):	ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE

Beneficiaries qualifying for LTSS interact frequently with the health care system, have physical or cognitive limitations that require ongoing supports, and often have chronic conditions that require continuous monitoring. Service coordination is therefore essential for assessing, planning, coordinating, and monitoring the provision of LTSS and HCBS services.

As part of planning, beneficiaries meeting the institutional level of care are offered a choice between Nursing Home (NH) and Home and Community Based Services (HCBS) wherever feasible, and form the 1915(c)-like HCBS population. For the 1915(c)-like population, Health

Plans are required to offer and document in the member's record the choice of institutional services or HCBS to members, when HCBS are available and are cost-neutral. Health Plans are strongly encouraged to promote community integration via HCBS services to the extent feasible, as evidence supports greater quality of life and lower costs when individuals receive HCBS services, as compared to institutional services.

To enhance community integration, MQD has employed several strategies: first, quality measures that assess rebalancing efforts by Health Plans may be selected for pay for performance based incentives. Next, MQD is planning to increase training of community HCBS providers to enhance their preparedness to manage challenging beneficiaries, and therefore increasing their capacity to accept HCBS beneficiaries. MQD also receives funding through the Going Home Plus program to provide beneficiaries with the enhanced supports (e.g. home modifications, etc.) they need to successfully complete their transition into a community-based setting.

A series of reporting requirements and quality measures are used to track community reintegration efforts by Health Plans; as needed, measures are included in P4P programs to provide incentives.

OBJECTIVE 13	**ENHANCE NURSING FACILITY AND HOME AND COMMUNITY BASED SERVICES; PREVENT OR DELAY PROGRESSION TO NURSING FACILITY LEVEL OF CARE**
PRIMARY GOAL:	ENHANCE CARE IN LTSS SETTINGS
CROSS-CUTTING GOAL(S):	ALIGN PAYMENT STRUCTURES TO IMPROVE HEALTH OUTCOMES

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. In addition, 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 LTSS level of care. Therefore, MQD monitors the quality of care provided to beneficiaries in each of these settings closely through various strategies.

First, numerous strategies ensure quality of care in nursing home settings. MQD's EQRO conducts Pre-Admission Screening and Resident Review (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.

Next, to ensure sustainability of Hawaii'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 an acuity-based system at rates

comparable to the current Medicaid fee schedule. Higher payments are expected to be closely tied to quality outcomes.

In partnership with the Healthcare Association of Hawai'i, MQD will launch a Nursing Facility Pay for Performance (P4P) program in 2021. Metrics for the program were carefully chosen to reflect the primary goals of care for the institutionalized population. Monitoring nursing facility performance in the program, and adjustment of metrics as needed, will become a key mechanism for monitoring the quality of care rendered to beneficiaries in nursing homes.

As noted previously, HCBS services are provided to qualifying Medicaid beneficiaries based on various authorities: first, the 1915(c) waiver provides fee-for-service HCBS to individuals with a qualifying intellectual or developmental disability. Next, the 1115 demonstration waiver provides HCBS in the managed care environment to 1915(c)-like individuals who meet institutional level of care, can access and receive HCBS services in a cost-neutral manner, and have chosen to receive HCBS services in lieu of institutional care.

Also via its 1115 demonstration waiver authority, MQD is able to offer HCBS services to 1915(i)-like individuals at risk of deterioration 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. Monitoring and evaluating the provision of At Risk services, and determining its effectiveness in preventing or delaying deterioration of beneficiaries, is a key priority of MQD.

A standard set of assurances apply to HCBS services offered to Hawaii's qualifying Medicaid beneficiaries, regardless of the authority under which they became eligible for HCBS services; these are described in detail in Section II; these assurances are designed to be both comprehensive and rigorous. As such, meeting these assurances ensures that beneficiaries are receiving a high quality of care. At this time, MQD's priority is to ensure that all HCBS-receiving populations are assured the care specified in the state standards; quality improvement activities will be designed focus on meeting assurances.

A series of reporting requirements and quality measures are used in combination to monitor quality of HCBS services provided. As needed, measures are included in P4P programs to provide incentives.

OBJECTIVE 14	MAINTAIN OR ENHANCE ACCESS TO CARE
PRIMARY GOAL:	MAINTAIN ACCESS TO APPROPRIATE CARE
CROSS-CUTTING GOAL(S):	ALIGN PAYMENT STRUCTURES TO IMPROVE HEALTH OUTCOMES

Given that Hawai'i has rural counties with limited access to minimally necessary care, MQD strongly supports efforts to maintain existing access to care, and enhancing access to care with

non-traditional strategies wherever feasible. Multiple strategies are supported to enable adequate access to care.

The state's Critical Access Hospitals are paid using an alternative fee schedule based on a per service rate that is calculated using historical costs for each hospital determined by the Medicaid cost report. Government-owned safety net hospitals are provided a uniform dollar increase to the base managed care payments made to Hawai'i government-owned safety net hospitals for actual inpatient and outpatient services provided to managed care enrollees, except for dual-eligible enrollees where Medicaid is not the primary payer. These direct uniform payment increases are based on the average loss per service unit for Medicaid and uninsured patient services.

For primary care providers, Health Plans are required to pay the providers an enhanced fee equivalent to the 2019 Medicare levels for specific services rendered. While at this time, PCP providers, obstetricians and gynecologists are eligible for the enhanced rates, future efforts by MQD may extend the alternative fee schedule to other types of providers and services, with a concomitant expectation of increased quality across services rendered.

Directed payments maintain and sustain access to critical access, safety net, and primary care resources throughout the communities, including in rural areas that would be seriously impacted if such facilities were to become financially unsustainable. These efforts in turn support health outcomes of impacted beneficiaries and contribute to overall quality of care.

Beyond financial support, MQD strongly supports additional strategies that enhance outreach to beneficiaries. For example, MQD implemented telehealth in 2017 and continues to collaborate with DOH to encourage enhanced access and use of telehealth resources. MQD promotes the use of telehealth to support the provision of integrated care. In 2020, MQD incentivized the development of a statewide plan to increase access and utilization of telehealth services through its pay for performance program. The State and MQD's past efforts to promote telehealth have strongly benefited efforts to assure access to care during the 2020 PHE.

To support team-based care and outreach to patients with complex conditions, MQD is interested in being able to cover services provided by community health workers, community navigators and other outreach workers, and community paramedics. Additionally, through the provision of Non-Medical Transportation, MQD ensures access of beneficiaries receiving HCBS to community services, activities, and resources specified by the beneficiary's service plan. Health Plans pay to transport residents from neighbor islands to Oahu, specialists and other providers from Oahu to the neighbor islands, as well as Hawaii residents to facilities on the mainland to ensure access to medically necessary care. Additional efforts to assess and address

SDOH needs, including transportation needs, as specified in Objective 11, will expand MQD's ability to enhance access to care for a greater number of beneficiaries.

OBJECTIVE 15	INCREASE COORDINATION OF CARE AND DECREASE INAPPROPRIATE CARE
PRIMARY GOAL:	MAINTAIN ACCESS TO APPROPRIATE CARE
CROSS-CUTTING GOAL(S):	ALIGN PAYMENT STRUCTURES TO IMPROVE HEALTH OUTCOMES

An overarching objective of the HOPE initiative is to decrease healthcare costs in a number of ways, such as: (a) improving coordination of care for beneficiaries with complex needs or complex coverage; (b) decreasing avoidable emergency department visits and hospitalizations; and (c) detecting both under-utilization of needed services and drugs, as well as over-utilization, to restore appropriate usage.

Multiple initiatives address this overarching objective through various strategies. For example, enhancing VBP models and global payment structures provide financial incentives to streamline care and increase efficiency. Enhanced community-based care coordination supports and addressing social needs of SHCN, and CIS beneficiaries reduces their inappropriate utilization of emergency and hospital services. Providing greater community support via telehealth, community health workers, and community paramedicine increases supports for beneficiaries outside the healthcare settings.

Three additional activities are worth noting. First, some of the key measures included in MQD's Hospital P4P program are focused on incentivizing hospitals to minimize readmissions and reduce avoidable admissions to their emergency departments. Therefore, the program strongly supports MQD goals to decrease inappropriate care.

Next, MQD has a substantial interest in increasing coordination of care for its dually eligible beneficiaries. Through contracting, MQD will require its Health Plans to have a dual-eligible special needs plan (D-SNP) for Medicare and Medicaid dually eligible members, and to obtain CMS approval for default enrollment authority to Medicare. Health Plans may also be encouraged to become Fully Integrated Dual Eligible SNPs (FIDESNP); also, if the D-SNP qualifies as a high performing plan, MQD may review any supplemental benefits proposed and work with the Health Plans to leverage those flexibilities to further support state efforts to address SDOH.

Finally, MQD supports efforts to monitor and address both the under and over utilization of services and drugs; some initiatives to further this work may include the establishment of a Prescription Monitoring Program (PMP) to improve patient care and stop controlled substance misuse, and continued collaboration with the State's Drug Enforcement Division to determine if it may be able to support the state's Prescription Drug Monitoring Program (PDMP).

OBJECTIVE 16	ALIGN PAYMENT STRUCTURES TO SUPPORT WORK ON SOCIAL DETERMINANTS OF HEALTH
PRIMARY GOAL:	ALIGN PAYMENT STRUCTURES TO IMPROVE HEALTH OUTCOMES
CROSS-CUTTING GOAL(S):	SUPPORT COMMUNITY INITIATIVES TO IMPROVE POPULATION HEALTH

MQD has four key financial strategies to encourage Health Plans to work on SDOH, including exploring capitation methodology reform to incorporate SDOH, allowances for the creation of alternative payment models to support community-clinical partnerships, the Advancing Primary Care initiative, and pay for performance incentives. Each of these approaches are described briefly below.

The incorporation of beneficiary-level SDOH variables, where present, or community and neighborhood-level SDOH into capitation methodology creates a financial mechanism by which MQD can signal the reallocation of financial resources to communities and sub-populations that are disproportionately impacted by SDOH, and therefore also have a greater burden of complex health needs. MQD may employ this strategy to support multiple avenues through which Health Plans are encouraged to assess and address the needs of beneficiaries with unmet social needs.

Next, MQD may further community-clinical partnerships where groups of providers, care coordinating entities, and community based organizations partner to support member patient care and/or population health through functions such as population health planning, improved care coordination, provider education, data analytics, and provision of resources to overcome SDOH-related barriers. These types of partnerships may facilitate community and strengthen community-level solutions to address SDOH needs. Such non-traditional partnerships may be supported by uniquely structured alternative payment models.

The Advancing Primary Care initiative, mentioned earlier, is a strong area of interest for MQD, as it is expected to support increased investment in primary care. In the broadest sense, primary care spend may include the wrap-around support services including team-based care and SDOH supports that augment and enhance the provider's capacity to manage the patient's care in the outpatient setting. As a result, the initiative may also incentivize investment in SDOH at it is implemented.

Finally, as appropriate, P4P measures may be utilized to support SDOH; for example, measures that track increased data collection, referrals to social services as needed, and work done on SDOH may be utilized. VBP reform to incentivize the implementation and expansion of CIS/CTS benefits to support qualifying homeless beneficiaries will, if implemented, augment SDOH-related financial incentives. The Hospital P4P program incentivizes the establishment of a hospital-based SDOH collaborative intended to design and implement a program to screen,

collect, and document social determinants of health of patients in a standardized manner across Hawai'i hospitals.

OBJECTIVE 17	ALIGN PAYMENT STRUCTURES TO ENHANCE QUALITY AND VALUE OF CARE
PRIMARY GOAL:	ALIGN PAYMENT STRUCTURES TO IMPROVE HEALTH OUTCOMES
CROSS-CUTTING GOAL(S):	INVEST IN PRIMARY CARE, PREVENTION, AND HEALTH PROMOTION MAINTAIN ACCESS TO APPROPRIATE CARE

MQD has launched, or expects to launch, several P4P, VBP, and other financial initiatives to enhance the quality and value of care rendered across various settings. These programs collectively intend to promote wellness and improve health outcomes for all populations served by MQD. Measures and areas chosen for payment arrangements are diverse, including but not limited to those supporting prevention and health promotion, member satisfaction, chronic disease management, behavioral health screening, coordination for those with complex behavioral and physical health conditions, and access to care and appropriate utilization. Measures are thoughtfully chosen to avoid inadvertently rewarding providers for exclusively catering to the healthiest populations, or for avoiding populations with more complex health needs.

Our Health Plan P4P program, described throughout the Quality Strategy, is currently implemented as a withhold-based program. Through future contracting, the P4P program may be diversified through the implementation of payment withhold or bonus pools to incentivize quality and progress in various areas ranging from contract compliance and quality assurance, to implementation of new initiatives. In addition to the Health Plan P4P Program, MQD has also utilized quality metrics in its auto-assignment algorithm to further reward Health Plan performance. MQD's Hospital P4P program is administered separately from the Health Plan P4P program, in close partnership with the Healthcare Association of Hawai'i (HAH). Measures are selected in partnership with hospitals to accelerate progress across various MQD quality objectives. Using a similar model, MQD plans to launch a Nursing Home P4P program with HAH in 2021.

To support the provision of high quality and adequate care in multiple settings, MQD has also directed payments to specific facilities (See Objective 16). As additionally noted in Objectives 3, 4, and 11, the Advancing Primary Care initiative, when implemented, may require Health Plans to increase investment in, support of, and incentive primary care. Primary care may be defined variously, ranging from narrower to broader definitions. For example, in the narrowest sense, primary care is the provision of care in the outpatient setting by primary care providers. A broader definition includes the provision of preventive services, including behavioral health integration, in the primary care setting. In the broadest definition, primary care additionally

includes the wrap-around support services including team-based care and SDOH supports that augment and enhance the provider's capacity to manage the patient's care in the outpatient setting. Health Plans may be accountable for demonstrating increased investment and spending across these various levels of primary care.

In addition, via contracting, Health Plans may be encouraged to work on aligning payment structures to enhance quality and value of care in multiple ways. For example, MQD may require Health Plans increase VBP strategies to encompass a broader range of provider types such as PCPs; hospitals; LTSS, behavioral health, and substance use disorder providers; rural health providers; and other specialty providers. Health Plans may be encouraged to advance providers along the VBP continuum toward VBP strategies that may encompass multi-payer efforts. MQD intends to adopt a framework, such as the Healthcare Payment Learning & Action Network (HCP LAN, or LAN) Alternative Payment Model (APM) framework to assess VBP engagement and levels of provider readiness, and determine the timeline and targets by type of provider. MQD also hopes to promote its priorities by encouraging Health Plans to tie Health Plan P4P program measures to provider-based VBP models and initiatives. As noted in Objective 6, MQD is considering the use of shared/aligned incentive payment arrangements across QI and CCS plans to support a whole person approach to care for CCS beneficiaries.

Finally, MQD will also strive to enhance rate setting methodologies to support payment for social risk factors, implement pay for performance programs, enhance adoption of VBP including multi-payer models and global budgets. VBP reporting and data collection by Health Plans may be expanded to track diffusion and adoption of VBP, along with the advancement along the chosen VBP framework.

IV.Quality Strategy Implementation

Quality Strategy State Agency Collaboration

As mentioned, the Quality Strategy Leadership Team (QSLT) within MQD initiates the development of, and updates to, the Medicaid 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 is evolving to become 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.

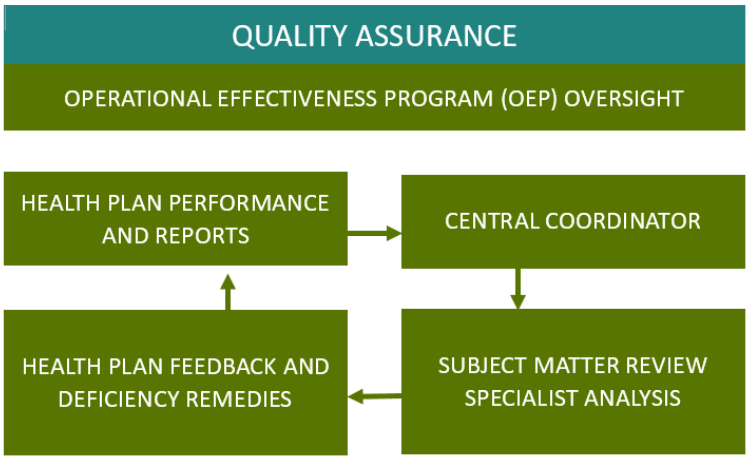
At the state level, MQD has developed roles and responsibilities for team members that focus on either quality assurance or quality improvement while developing robust communication methods across teams and content experts. Together, these teams will systematically address, report on challenges with,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

Quality Assurance (QA)

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

The following figure depicts the QA team review process.

Figure 1 - Quality Assurance



Each quarter, 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.

Health plans will submit reports to a Central Coordinator who will then share reports to the assigned content specialists. 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, MQD may direct the Health Plan to submit a corrective action. If the Health Plan fails to cure the deficiency, MQD may consider imposition of sanctions.

MQD will develop risk levels and based on collected information assign identified deficiencies a risk level. The risk level assignment and the imposition of specific sanctions will be commensurate with the non-compliance or deficiency, taking into consideration the information collected along with the following factors:

- Whether the violation (or one that is substantially similar) has previously occurred;
- The timeliness in which the Health Plan self-reports a violation;
- The Health Plan's history of compliance;
- The good faith exercised by the Health Plan in attempting to stay in compliance (including self-reporting); or
- Any other factor that MQD deems relevant based on the nature of the violation.

Identified deficiencies and contract compliance actions will be coordinated with cross-functional teams.

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.

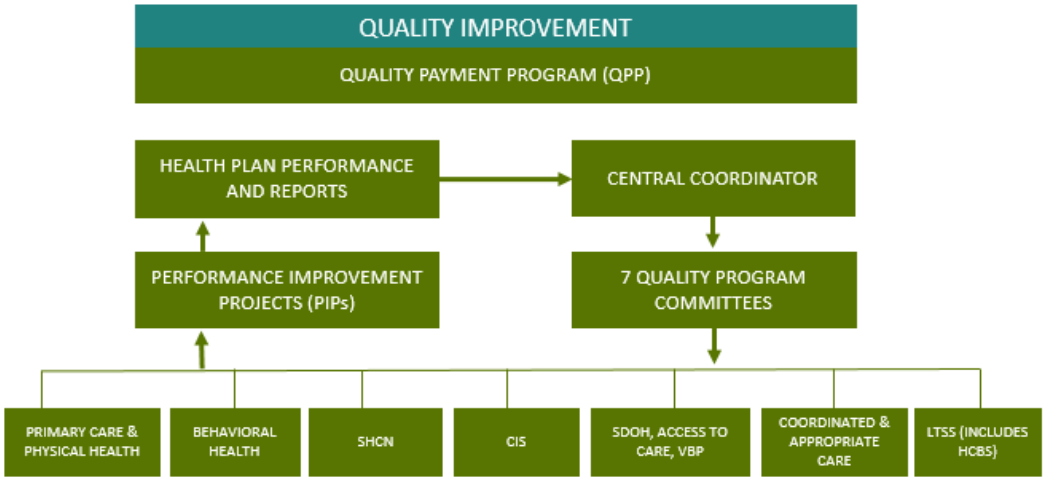
MQD will define process measurement, performance measurement, and targets that will be maintained until sustained improvements are reached. The operational and performance metrics included in the OEP, the specific targets for each, and the time period of assessment for each metric, will be set annually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

The following figure depicts the QI team review process.

Figure 2 - Quality Improvement



Health Plans will submit reports to a Central Coordinator who will share reports to assigned content specialists that will evaluate quality performance. The QI team anticipates managing seven quality program committees. Each content specialist will be responsible for facilitation and support of an assigned committee. The seven committees include:

1. Primary care and physical health
2. Behavioral health
3. Special health care needs (SHCN)
4. Community Integration Services (CIS)
5. Social Determinants of Health (SDOH), Access to Care, Value-based Purchasing (VBP)
6. Coordinated & Appropriate Care
7. Long Term Support Services (LTSS) including Home and Community-based Services

Each committee will meet quarterly and actively assess delivery system and Health Plan affiliated actions, trends and outcomes. These strategies will align with PIPs and the insights gathered from committees and PIPs will act as reinforcing levers to inform future activities.

As a part of the Quality Program, the QI team 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 Quality Payment Program will be comprised of multiple performance measures that align with the HOPE initiative and Quality Strategy. Although the performance measures and the targets/floors for each performance measure may vary each year, MQD intends to maintain some consistency in performance measures to trend progress in achieving improved outcomes. Performance measures selected are expected to include quality, VBP, and other financial metrics of interest.

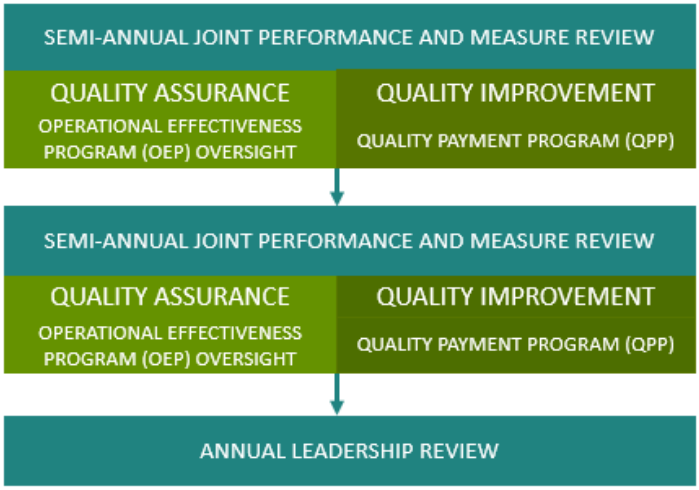
The Quality Payment Program may be implemented based on a withhold arrangement with potential for Health Plans to earn dollars back as the Health Plan meets performance targets in accordance §438.6(b)(3) or implemented as an incentive arrangement program in accordance §438.6(b)(2).

Joint Performance and Measure Reviews

Semi-annually, the Quality Assurance team and Quality Improvement team will hold Joint Performance and Measure (J-PAM) review meetings to thoroughly discuss the status, findings and trends of the Operational Effectiveness Program (OEP) and the Quality Payment Program (QPP). Together, these two programs expansively monitor the standards, objectives and initiatives that make up the Quality Program. The teams will jointly assess cross-functional topics and identify program enhancements that may be implemented in the near term.

Following the second of these J-PAM meetings, results will be brought forward to the QSLT. Teams will 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 QSLT will have final authority to approve recommendations, including adjustments to performance measurements.

Figure 3 - Quality Improvement



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 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 plan is expected to be focused on rigorous outcome measurement against relevant targets and benchmarks, and that appropriately supports 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 receive 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.

Through the Quality Program, MQD reviews at least annually the impact and effectiveness of the Health Plan's QAPI program areas.

Along with the OEP and QPP incentive programs, MQD has outlined plans to further enhance clinical and non-clinical care areas through optional initiatives.

- **Innovation Advancement Initiative.** This initiative may be implemented at MQD's discretion as an incentive arrangement program in accordance with § 438.6(b)(2). The goal of this program, if implemented, would be to create performance incentives for Health Plans to succeed in implementing new strategies such as the Advancing Primary Care Initiative, increasing value-based purchasing adoption, or the development of an SDOH Work Plan.
- **Community Investment Program.** MQD may, at its discretion, create a Community Investment Program made up of the remainder of the dollars allotted to the QPP and the Innovation Advancement Initiative but not earned. MQD would consult with Health

Plans and stakeholders to make grants to entities and programs that support the goals of the HOPE initiative.

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:

- The 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 Care Services Branch (HCSB) at MQD receives and reviews all monitoring and quality reports contractually required to be submitted from the Health Plans. The HCSB 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 committees composed of subject matter experts and HCSB reviewers. 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. MQD maintains measures relating to quality of life, rebalancing, and community integration activities. 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 may be 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. 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 intends to implement 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 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 J-PAM are critical to decision making because the J-PAM staff is critically engaged with Health Plans in ongoing reporting and quality monitoring processes. The J-PAM is 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.
- A third factor is the extent of the proposed measure's relationship to MQD goals and objectives, although it is anticipated that program implementation and measurement will by design be in alignment with the quality strategy, and therefore the program's goals and objectives.
- A fourth 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.
- 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.
- Another factor is considering the impact of administrative burden on providers, the Health Plans, and MQD.

These factors will be considered collectively by the QSLT 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. In previous years, MQD has collected aggregate measure data, along with a sampling of beneficiary-level data for measures that the EQRO has flagged for auditing. Moving forward, MQD intends to transition to beneficiary-level reporting of quality measures to support advanced analytics, including analyses of health disparities by sub-population. MQD will also encourage 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 is detailed in Appendix B.

Scorecard

As part of the Quality Program, MQD will assess performance measures that hold the Health Plans accountable for state standard assurances and quality improvement achievement. Overtime, MQD will collaborate with stakeholders to develop a Quality Rating System (QRS) based on a scorecard that has comparative results of operational and clinical quality performance between Health Plans. This scorecard and rating system will be developed in collaboration with stakeholders and made public on MQD's website to support transparency for enrollees, members and providers.

Upon development and adoption of a Quality Rating System by CMS, MQD will align the Scorecard to the Quality Rating System that is adopted.

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 an Health Plan, 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 include 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 to perform 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. • 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 the information 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.

Each Health Plan submits two state-mandated PIPs for EQRO validation per cycle. Most recently, the QUEST Integration Health Plans have conducted the following PIPs that correlate to MQD objectives: *Getting Needed Care, Prenatal and Postpartum Care, and Medication Management for People with Asthma.* The ʻOhana CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness Within 7 Days of Discharge* and *Improving Behavioral Health Assessment Completion Rates.*[11] Interventions included, but were not limited to telephonic, text, and mail reminders to pregnant members and a member rewards program for post-

partum members, reminder calls for ophthalmologic appointments, and improving transportation options for members to obtain a behavioral health evaluation.

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.

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/reports.html