2023

QUEST Integration Section 1115 Demonstration

STATE OF HAWAIʻI, DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION

Released for State Public Notice and Comment on October 16, 2023

Contents

Section 1 – Introduction

Pursuant to Section 1115(a) of the Social Security Act, the State of Hawaiʻi Department of Human Services (the State) is seeking a five-year extension of the QUEST Integration Medicaid Section 1115 Demonstration from the Centers for Medicare and Medicaid Services (CMS). This demonstration began on August 1, 1994, with its current extension starting on August 1, 2019. Absent an extension, the demonstration will expire on July 31, 2024. The State requests a renewal of most components of the current waiver and expenditure authorities, along with new authorities to continue advancing the State's goal of improving health outcomes and reducing health disparities for Medicaid and other low-income populations.

1.1 Hawaiʻi ʻOhana Nui Project Expansion (HOPE) Program and Demonstration Objectives

HOPE Program

The Med-QUEST Division (MQD), Hawaii's Medicaid agency within the Department of Human Services, is committed to supporting and creating healthy families and healthy communities by empowering Hawaiʻi residents to improve and sustain their wellbeing. Developed as a roadmap to achieve this vision, the HOPE program provides a "north star" to guide the development of Hawaii's delivery system reform initiatives, including this Section 1115 Demonstration renewal application. Specifically, Hawaiʻi seeks to implement multigenerational, culturally appropriate innovations that invest in children and families to nurture well-being, improve individual and population health outcomes, and ultimately lower sustainable health care costs.

The principles from the HOPE program reflect the overarching framework that is used to develop a transformative health care system that focuses on healthy families and healthy communities:

- Assuring continued access to health insurance and health care;
- Emphasis on whole person and whole family care over the life course;
- Identifying and addressing the social drivers of health;
- Emphasis on health equity and addressing health disparities;
- Emphasis on health promotion, prevention, and primary care;
- Emphasis on investing in system-wide changes; and
- Leverage and support community initiatives.

Further, HOPE activities—including those reflected in this Section 1115 Demonstration application—are focused on four strategic areas:

- Invest in primary care, prevention, and health promotion;
- Improve outcomes for high-need, high-cost individuals;
- Implement payment reform and alignment; and
- Support community driven initiatives to improve population health.

Lastly, HOPE activities are informed by three foundational building blocks which enable delivery system reform:

- Health information technology that drives transformation;
- Increase workforce capacity and flexibility; and
- Performance measurement and evaluation.

Demonstration Objectives

Building on the HOPE vision and accomplishments of the existing Section 1115 Demonstration, this renewal introduces new strategies to execute on the same overarching objectives:

- Improve health outcomes for Medicaid enrolled individuals covered under the demonstration;
- 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
- Address health determinants to improve health outcomes and lower health care costs.

This renewal also supports several key priorities of Governor Green's administration, including expanding access to health care for children and increasing health-related social services available to individuals experiencing homelessness, particularly those with complex health and behavioral health needs. These priorities further affirm the State's commitment to supporting improved health outcomes for beneficiaries with complex clinical needs and support whole-person care by identifying and addressing social drivers of health.

1.2 Five-Year Renewal Request

Hawaiʻi is requesting a five-year renewal of most of the waiver and expenditure authorities contained in the QUEST Integration 2019 Section 1115 Demonstration and is proposing new authorities to enable the State to support a whole-person approach to care. The proposed authorities reflect the State's commitment to identifying and addressing social drivers of health. New requests include Medicaid matching funds related to:

- **Housing Related Services:** Enhance existing authorities under the Community Integration Services (renamed as Community Integration Services Plus) to provide a continuum of housing-related services, including tenancy support services, rental assistance, and medical respite services for certain eligible individuals who are experiencing or at risk of homelessness.
- **Continuous Eligibility for Children:** Provide continuous eligibility for children ages 0 to 6 and continuous two-year eligibility from the time of first eligibility determination for children ages 6 to 19.
- **Pre-Release Services for Justice-Involved Individuals:** Provide targeted services to eligible justice-involved populations 90 days pre-release from incarceration. Pre-release services include, as clinically appropriate, case management and care coordination, physical and behavioral health clinical consultation services, lab and radiology services, and, for use post-release into the community, durable medical equipment (DME) and a minimum 30-day supply of medications.

- **Nutritional Supports:** Provide nutritional supports for eligible beneficiaries. These nutrition supports include nutrition education, fruit and vegetable prescriptions and/or protein boxes, meals or pantry restocking, and medically tailored meals or groceries.
- **Native Hawaiian Traditional Healing Practices:** Provide Native Hawaiian Traditional Healing Practices for eligible beneficiaries meeting certain medical appropriateness and social needs criteria, not limited to those identifying as Native Hawaiian. Native Hawaiian Traditional Healing Practices include:
    - ***Lomilomi***: Practice of physiotherapy and massage;
    - ***Hula***: Form of dance offering physical movement classes that seek to improve health through physical activity, mindfulness practices, and social interaction;
    - ***Ho‘oponopono***: Practice of peacemaking, intended to restore and maintain healthy relationships;
    - ***‘Ai pono***: Practice of holistic nutrition therapy;
    - ***Lā’au lapa’au***: Practice of herbalist healing; and
    - ***Hāpai hānau***: Practice of midwifery.
- **Contingency Management:** Pilot Contingency Management (CM) for beneficiaries with a qualifying substance use disorder (SUD), including stimulant use disorders (StimUDs) and opioid use disorders (OUDs). CM will consist of a complementary course of SUD treatment and a series of motivational incentives to advance SUD treatment goals. The State intends to determine the size, nature, and distribution of all motivational incentives in detailed guidance, procedures, and protocols issued in advance of implementation.
- **Infrastructure Funding:** Claim Medicaid matching funds on infrastructure spending to support capacity building for and implementation of the health-related social need (HRSN) services requested in this renewal.
- **Designated State Health Programs (DSHP):** Claim Medicaid matching funds for State expenditures on DSHP and leverage those matching funds to support the development and implementation of 1115 Demonstration initiatives that address health-related social needs.

Table 1 provides an overview of the current Section 1115 Demonstration initiatives that Hawai‘i is renewing and also new demonstration proposals. As Hawai‘i works with CMS to advance its QUEST Integration Section 1115 Demonstration, the federal authorities sought or the federal approval vehicle required may change.

Table 1: Summary of Section 1115 Demonstration Requests.

Initiatives for which Hawai‘i Seeks to Renew without Modification
Behavioral Health
Initiatives for which Hawai‘i Seeks to Renew with Modification
QUEST Integration Mandatory Managed Care

Community Integration Services
Home and Community Based Services
Initiatives for which Hawaiʻi Requests New Section 1115 Demonstration Authority
Continuous Eligibility
Pre-Release Medicaid Services for Justice-Involved Individuals
Nutrition Supports
Native Hawaiian Traditional Healing Practices
Contingency Management
Designated State Health Program

1.3 Related Activities

In concert with this Section 1115 Demonstration amendment and renewal, the State may separately seek new or exercise existing authorities via the State Plan, Section 1915(c) Waiver, and managed care contracts to expand or modify certain benefits, eligibility criteria, or enrollment processes for select Medicaid beneficiaries. Together, these authorities will enable the State to continue championing its mission of empowering Hawaiʻi residents to improve and sustain wellbeing. Specifically, as described in more detail within this application, Hawaiʻi:

- Will maintain 1915(c) authority to provide certain home and community-based services (HCBS) in fee-for-service (FFS) for individuals with developmental disabilities or intellectual disabilities.
- Will expand the scope and provide transition transitional case management services outside of the Section 1115 Demonstration using existing authorities. Compared to the limited scope described in the existing Community Integration Services (CIS) program, Hawaiʻi intends to expand the scope of transitional case management so they more comprehensively address the clinical, social, and other coordination needs of individuals engaged in the CIS program (renamed in this renewal as Community Integration Services Plus).
- May create a new optional coverage group to cover children up to 400 percent of the federal poverty line (FPL) who do not currently qualify for Hawaii's Medicaid-expansion Children's Health Insurance Program (CHIP).

1.4 Stakeholder Engagement

Hawaiʻi developed and refined elements of its QUEST Integration Section 1115 Demonstration renewal through a robust stakeholder and public engagement process. Key to Hawaii's stakeholder engagement process has been its high-touch, accessible, and responsive engagement with local communities and organizations. In total, Hawaiʻi engaged dozens of stakeholder organizations and conducted over 30 stakeholder meetings to ideate, iterate, and vet details of the new initiatives proposed in this renewal application. For example, through stakeholder workgroups, Hawaiʻi cooperatively developed and obtained consensus for the design of nutrition supports, Native Hawaiian traditional healing practices, and CIS+ proposals.

Key stakeholder groups that were engaged leading to the 30-day public comment period include:

- **Providers, provider associations, medical centers**, **and community health centers** with a vested interest in benefits and services being expanded or pursued through this Section 1115 Demonstration renewal (e.g., Native Hawaiian traditional healing practices, nutritional supports, housing-related services, and pre-release services);
- **Community-based organizations**, including advocacy organizations and community-based providers of social services (e.g., nutritional and housing supports);
- **Med-QUEST Healthcare Advisory Committee,** a federally mandated body, per 42 CFR 431.12, soliciting input and perspective from beneficiaries and health care providers, among other stakeholders;
- **Other governmental agencies**, including the Department of Health, the Division of Public Safety, and the Statewide Office on Homelessness and Housing Solutions; and
- **Quest Integration (QI) health plans**, which provide valuable lessons learned from their experiences in delivering value-add initiatives being pursued in this Section 1115 Demonstration renewal (e.g., Native Hawaiian traditional healing practices, nutritional supports, and pre-release services).

Section 2 – Hawaiʻi QUEST History & the Current Demonstration

The State of Hawaiʻi implemented QUEST on August 1, 1994. QUEST was a statewide Section 1115 Demonstration project that initially provided medical, dental, and behavioral health services through a competitive managed care delivery system. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. It has also served as a mechanism for delivery system innovation, enabling Hawaiʻi to advance its policy goals and improve the health and well-being of Hawaiʻi residents.

QUEST stands for:

Quality care
Universal access
Efficient utilization
Stabilizing costs, and
Transforming the way health care is provided to QUEST beneficiaries.

2.1 Waiver History

Since its implementation, CMS has renewed the QUEST demonstration six times. Over the years, the State has made significant changes to the demonstration, as described in Table 2. Note, the major goals of each extension or renewal are outlined in the table, but not all provisions remain in effect.

Table 2. Summary of Section 1115 Demonstration Program Changes Over Time.

Approval Date	Summary of Program Changes
July 1995	CMS approved an amendment that allowed the State to deem parental income for tax dependents up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing for expansion populations, impose a premium for self-employed individuals, and change the fee-for-service (FFS) window from the date of coverage to the date of enrollment.
September 1995	CMS approved an amendment to cap QUEST enrollment at 125,000 expansion eligibles.
May 1996	CMS approved an amendment to reinstate the asset test, establish the QUEST-Net program, and require participants to pay a premium.
March 1997	CMS approved an amendment to lower the income thresholds to the mandatory coverage groups and allowed the State to implement its medically needy option for the Aid to Families with Dependent Children (AFDC)-related coverage groups for individuals who become ineligible for QUEST and QUEST-Net.
July 2001	CMS approved an amendment to allow the State to expand the QUEST-Net program to children who were previously enrolled in the State Children's Health Insurance Program (SCHIP), when their family income exceeds the Title XXI income eligibility limit of 200 percent of the federal poverty level (FPL).[1]
July 2005	In January 2006, CMS approved an extension (with a retroactive start date of July 1, 2005) of the 1115 waiver for the demonstration, which incorporated the existing program with some significant changes, including: • Extension of coverage to all Medicaid-eligible children in the child welfare system; • Extension of coverage to adults up to 100 percent of the FPL who meet Medicaid asset limits through the QUEST Adult Coverage Expansion (QUEST-ACE); • Elimination of premium contributions for children with income at or below 250 percent of the FPL; • Elimination of the requirement that children have prior QUEST coverage as a condition to qualifying for QUEST-Net; and • Increase SCHIP eligibility from 200 percent of the FPL to 300 percent of the FPL.
February 2008	The demonstration was renewed, and as part of the renewal, the State implemented the QUEST Expanded Access (QExA) program and

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[1] In 2007, the State Children's Health Insurance Program (SCHIP) was renamed to the Children's Health Insurance Program (CHIP).

Approval Date	Summary of Program Changes
	increased the eligibility level for QUEST-ACE from 100 percent to 200 percent of the FPL.
April 2012	CMS approved the State’s request to limit eligibility for non-pregnant, nondisabled adults not otherwise Medicaid eligible at 133 percent of the FPL.
June 2012	CMS approved an amendment to align QUEST-Net and QUEST-ACE benefits with the QUEST benefits package and to add certain benefits to the QExA benefit package.
December 2012	CMS approved the requested demonstration extension under the same terms and conditions as were in effect at the time.
March 2013	CMS approved an amendment to expand coverage to certain former foster children in advance of 2014 when that group becomes Medicaid eligible under changes in the Affordable Care Act (ACA).
September 2013	CMS approved a waiver extension that included the following changes to the demonstration: • Consolidation of the four QUEST programs (QUEST Expanded, QUEST-ACE, QExA, and QUEST-Net) into a single QUEST Integration demonstration program which, beginning on January 1, 2014, provided the full Medicaid state plan benefit package to all beneficiaries in the demonstration; • Transition of childless adults and former foster care children to the new adult group in the Medicaid state plan; • Expansion of covered benefits to include cognitive rehabilitation, habilitation, and specialized behavioral health services to comply with federal requirements; • Increase the retroactive eligibility period from five to 10 days; • Elimination of state enrollment limits; • Removal of QUEST ACE enrollment benchmark for uncompensated care (UCC) pool; and • The addition of evaluation requirements and a June 2016 sunset date for UCC authority.
October 2018	CMS approved an amendment to the demonstration to provide supportive housing services, called Community Integration Services (CIS), to certain eligible individuals who are homeless or at risk of homelessness and who also have a behavioral or physical illness or a substance abuse diagnosis.
July 2019	CMS approved an extension of the demonstration, which authorized Hawaiʻi to continue providing benefits through its managed care delivery system, continue providing HCBS to certain populations, and expand access to and benefits of CIS for beneficiaries who meet specified needs-based criteria.

Approval Date	Summary of Program Changes
April 2020	CMS approved Attachment K, which granted certain flexibilities during the COVID-19 public health emergency (PHE)
December 2021	CMS approved a temporary authority that permitted Hawaiʻi to add or modify risk sharing mechanisms such as reinsurance, risk corridors, or stop-loss limits after the start of a rating period, provided that the contract and rating period(s) begin or end during the COVID-19 PHE.

The current Section 1115 Demonstration for the State of Hawaiʻi, entitled "Hawaiʻi QUEST Integration" (Project Number 11-W-00001/9), began on August 1, 2019 and is effective through July 31, 2024. The State's core objectives for the demonstration were to:

- Improve health outcomes for Medicaid enrolled individuals covered under the demonstration;
- 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
- Address health determinants to improve health outcomes and lower healthcare costs.

It accomplished several programmatic changes, including:

- Authorized Hawaiʻi to continue providing benefits through its managed care delivery system, continue providing HCBS to certain populations, and expand access to and benefits of community integration services (CIS) for beneficiaries who meet specified needs-based criteria.
- Continued the HCBS component of the demonstration to provide services similar to those authorized under sections 1915(c) and 1915(i) of the Social Security Act to individuals who need HCBS, either as an alternative to institutionalization or otherwise based on medical need.
- Extended the CIS benefit by adding expenditure authority for a pilot rental assistance program for beneficiaries who are homeless or at risk for homelessness and meet specific needs-based criteria, such as having a mental health need, substance use disorder, or a complex physical health need.

The interim evaluation for the current waiver, which evaluates progress against the above objectives, can be found in Attachment B.

2.2 Care Delivery System

Through the demonstration, the State previously operated four separate managed care programs based on eligibility groups but has since consolidated into a single fully capitated managed care program, with five managed care organizations currently operating in Hawaiʻi. QUEST Integration successfully implemented managed care for more than 99 percent of the Medicaid population.

Most benefits are provided through capitated managed care and mandated managed care enrollment for most beneficiaries. All beneficiaries are eligible for state plan benefits (or, in the case of the Affordable Care Act childless adult group, approved benefits under the alternative benefit plan) and additional benefits (including HCBS and specialized behavioral health services) based on medical necessity and clinical criteria provided through an integrated managed care delivery system. For certain individuals, behavioral health services are provided through Community Care Services (CCS), a separate behavioral health organization (BHO).[2]

The State also uses a FFS delivery system for long-term care services for individuals with developmental or intellectual disabilities (via Section 1915(c) Waiver), Intermediate Care Facilities for the Intellectually Disabled (ICF-ID), services for applicants eligible for retroactive coverage only, services for certain medically needy non aged, blind, and disabled (ABD) individuals, medical services under the State of Hawaiʻi Organ and Tissue Transplant (SHOTT) program, targeted case management services, school-based services, early intervention services, and dental services.

The State continues to focus on a comprehensive health care delivery system transformation called the Hawaiʻi ʻOhana Nui Project Expansion (HOPE) strategic initiative. The goal of the initiative is to achieve the Triple Aim of better health, better care, and sustainable costs using a whole person, whole family (ʻohana), and whole community approach to health and well-being. The State anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and a continued sustainable growth rate in healthcare spending from reductions in unnecessary care and shifts of care to appropriate settings. As reflected in the new authorities requested within this application, Hawaiʻi focuses on the investment in and integration of behavioral health and health-related social risk factors, taking a whole-person, whole-family health approach.

2.3 Eligibility and Enrollment

Eligibility

The State provides coverage to children and adults who are eligible under the Medicaid state plan as well as additional children and adults (including former adoption assistance children, certain parents, and certain individuals who receive home and community based HCBS services). The groups currently eligible for Medicaid are described in Table 3; this table does not reflect the proposed eligibility changes requested in this demonstration application.

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[2] If a beneficiary is enrolled in CCS, they receive both their standard and specialized behavioral health services through CCS to ensure a more integrated experience for the beneficiary across their spectrum of behavioral health and/or SUD treatment needs.

Table 3. Medicaid Eligibility Groups.

Mandatory State Plan Groups		
Eligibility Group Name	Authority	Qualifying Criteria
Parents or Caretaker Relatives	Sections 1902(a)(10)(A)(i)(I), (IV), (V) and 1931(b), (d) of the Social Security Act 42 CFR 435.110	Up to and including 100 percent FPL
Pregnant Women	Section 1902(a)(10)(A)(i)(III)-(IV) of the Social Security Act 42 CFR 435.116	Up to and including 191 percent FPL
	Section 1902(e)(5)-(6) of the Social Security Act 42 CFR 435.170	Extended and continuous eligibility for pregnant women
Infants	Sections 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(B) of the Social Security Act 42 CFR 435.118(c)(2)(iii)	Infants up to age 1, up to and including 191 percent FPL
	Section 1902(e)(4) of the Social Security Act 42 CFR 435.117	Deemed newborn children
	Section 1902(e)(7) of the Social Security Act 42 CFR 435.172	Continuous eligibility for hospitalized children
Children	Sections 1902(a)(10)(A)(i)(VI)-(VII) and 1902(l)(1)(C)-(D) of the Social Security Act 42 CFR 435.118	Children ages 1 through 18, up to and including 133 percent FPL
	Section 1902(e)(7) of the Social Security Act 42 CFR 435.172	Continuous eligibility for hospitalized children
Low-Income Adults aged 19 through 64	Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act 42 CFR 435.119	Up to and including 133 percent FPL
Children with Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E	Sections 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Social Security Act 42 CFR 435.145	An adoption assistance agreement is in effect under title IV-E of the Act; or foster care or kinship guardianship assistance maintenance payments are being made by a State under title IV-E

Mandatory State Plan Groups		
Former Foster Care Children to age 26	Section 1902(a)(10)(A)(i)(IX) of the Social Security Act 42 CFR 435.150	No income limit
State Plan Mandatory Aged, Blind, or Disabled Groups	Section 1902(a)(10)(A)(i)(II) of the Social Security Act 42 CFR 435.120	ABD individuals who meet more restrictive requirements for Medicaid than the Supplemental Security Income (SSI) requirements; uses SSI payment standard
	Sections 1902(a)(10)(A)(i)(II) and 1905(q) of the Social Security Act 42 CFR 435.120	Qualified severely impaired blind and disabled individuals under age 65
	Sections 1634, 1634(a), 1634(b), 1634(c), 1634(d), and 1634(e) of the Social Security Act 42 CFR 435.121-122, 130-135, 138	Other ABD groups as described in the State Plan
Transitional Medical Assistance	Section 1925 of the Social Security Act 42 CFR 435.112	Coverage for one 12-month period due to increased earnings that would otherwise make the individual ineligible under Section 1931
1931 Extension	Section 1931(c)(1)-(2) of the Social Security Act 42 CFR 435.115	Coverage for four months due to receipt of child or spousal support, that would otherwise make the individual ineligible under Section 1931
Qualified Medicare Beneficiaries*	Sections 1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Social Security Act	Standard eligibility provisions for this population as described in the State Plan
Specified Low-Income Medicare Beneficiaries*	Sections 1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Social Security Act	Standard eligibility provisions for this population as described in the State Plan

**Dual eligibles are included as those with full Medicaid benefits are served under QI health plans, and QI health plans pay Part B co-payments and coordinate Medicare services.*

Optional State Plan Groups

Eligibility Group Name	Authority	Qualifying Criteria
Optional Coverage of Families and Children and the Aged, Blind, or Disabled	Sections 1902(a)(10)(ii) and 1905(a) of the Social Security Act 42 CFR 435.210	ABD individuals who do not receive cash assistance but meet income and resource requirements
	42 CFR 435.211	Individuals eligible for assistance but for being in a medical institution
	Section 1902(a)(10)(ii)(VII) of the Social Security Act	Individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care
	Section 1902(a)(10)(ii)(XI) of the Social Security Act 42 CFR 435.121, 435.230	ABD individuals in domiciliary facilities or other group living arrangements
	Sections 1902(a)(10)(ii)(X) and 1902(m) of the Social Security Act	Aged or disabled individuals with income up to and including 100 percent FPL
Optional Targeted Low-Income Children	Section 1902(a)(10)(A)(ii)(XIV) Title XXI of the Social Security Act 42 C.F.R. 435.229	Up to and including 308 percent FPL, including for children for whom the State is claiming Title XXI funding
Certain Women Needing Treatment for Breast or Cervical Cancer	Sections 1902(a)(10)(A) and 1920 of the Social Security Act	No income limit; must have been detected through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and not have creditable coverage
Medically Needy Non- Aged, Blind, or Disabled Children and Adults	Section 1902(a)(10)(C) of the Social Security Act 42 CFR 435.301(b)(1), 435.308	Up to and including 300 percent FPL, if spenddown to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	Section 1902(a)(10)(C) of the Social Security Act 42 CFR 435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology
Foster Children	Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act 42 CFR 435.227	Children with non-IV-E adoption assistance
Foster Children age 19 and 20	Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act 42 CFR 435.227	Receiving foster care maintenance payments or under an adoption assistance

<table>
<tr><td></td><td></td><td>agreement under the state plan</td></tr>
<tr><th colspan="3">Expansion Population</th></tr>
<tr><th>Eligibility Group Name</th><th colspan="2">Qualifying Criteria</th></tr>
<tr><td>Parents or Caretaker Relatives with a Dependent Child age 18</td><td colspan="2">Parents or caretaker relatives who (i) are living with an 18-year-old who would be a dependent child but for the fact that they have reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age</td></tr>
<tr><td>Individuals in the 42 CFR 435.217 like Group Receiving HCBS</td><td colspan="2">Income up to and including 100 percent FPL</td></tr>
<tr><td>Medically Needy ABD Individuals whose Spenddown Exceeds the Plans’ Capitation Payment</td><td colspan="2">Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans’ monthly capitation payment</td></tr>
<tr><td>Individuals age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance</td><td colspan="2">No income limit</td></tr>
<tr><td>Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance</td><td colspan="2">Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in a state plan or waiver while receiving assistance payments</td></tr>
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Enrollment Patterns

The Medicaid redetermination pause during the COVID-19 PHE led to an increase in Medicaid enrollment. Between March 2020 and April 2023, enrollment grew more than 40 percent, from 327,119 to its peak of 468,120 in April 2023. Hawaiʻi began Medicaid redeterminations, also known as unwinding, in May of 2023.

Table 4. Enrollment Growth January 1, 2019 – September 18, 2023.

	2019	2020	2021	2022	2023*
Average Enrollment**	330,758	358,067	417,435	449,541	460,180
Percent Growth Year over Year	-	8 percent	17 percent	8 percent	2 percent

**Data available through September 18, 2023*

***Point in time, measured weekly*

2.4 Post-Award Public Input Process

In accordance with 42 CFR 431.420(c), following CMS approval of the Section 1115 demonstration renewal, which runs August 1, 2019 through July 31, 2024, MQD convened a series of post-award forums. At these webinar forums, MQD shared details on the Section 1115 demonstration's vision and goals, initiatives and activities, enrollment, and other relevant information. Then, time was allotted time for public comment and questions. Post-award forums occurred on the following dates:

- January 30, 2020
- May 5, 2021
- April 20, 2022
- September 20, 2023

Going forward, MQD will remain compliant with federal requirements and conduct the post-award forum for the Section 1115 demonstration within 6 months of the renewal implementation date and on an annual basis thereafter.

Section 3 – Current and Proposed Demonstration Authorities Under the Renewal

This section describes the benefits and authorities Hawaiʻi intends to provide and exercise under the Section 1115 Demonstration. Through this application, Hawaiʻi is requesting to (1) renew certain existing demonstration authorities with no proposed modifications; (2) renew and modify certain existing demonstration authorities; and (3) propose new demonstration authorities.

3.1 QUEST Integration (QI) Mandatory Managed Care

Hawaiʻi is seeking renewal of the QI mandatory managed care program authorities with technical changes to eligibility for former foster youth and certain reporting requirements. The objectives of the QI delivery system, eligibility, and enrollment policies remain the same.

Overview

Since 1994, the foundation of the QUEST programs has been a capitated managed care system. Over the history of the QUEST and QI demonstrations, the State has found that capitated managed care leads to a more predictable and slower rate of expenditure growth, thereby allowing the State to make the most efficient use of taxpayer dollars and provide high-quality care to the maximum number of individuals.[3] The current QI contracts are held by five health plans—AlohaCare, Hawaiʻi Medical Service Association (HMSA), Kaiser Permanente, ʻOhana Health Plan, and UnitedHealthcare Community Plan. The State works closely with the QI health

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[3] For more information, see the Section 1115 Demonstration Evaluation in Attachment B.

plans to facilitate contract implementation and improve healthcare access and services to beneficiaries.

Under this Section 1115 Demonstration, the State will continue its current QI managed care program and provide all beneficiaries enrolled under the demonstration with access to the same single benefit package, of which access to certain services will be based on clinical criteria, medical necessity, and identified health-related social needs (HRSN). The benefit package will include benefits consisting of full State plan benefits (or, in the case of the Affordable Care Act childless adult group, approved benefits under the alternative benefit plan) and will offer certain additional benefits as described in the sections below and in our current Special Terms and Conditions.

For certain individuals, behavioral health services are provided through Community Care Services (CCS), and the Department of Human Services (DHS) contracts with a behavioral health organization (BHO) to provide these services. The State also uses a FFS delivery system for long-term care services for individuals with developmental or intellectual disabilities (via Section 1915(c) Waiver), Intermediate Care Facilities for the Intellectually Disabled, services for applicants eligible for retroactive coverage only, services for certain medically needy non aged, blind, and disabled individuals, medical services under the State of Hawaiʻi Organ and Tissue Transplant program, targeted case management services, school-based services, early intervention services, and dental services.

Continuing Authority Requested

Care Delivery System

Hawaiʻi is requesting continued Medicaid matching funds to provide services through a managed care delivery system. The delivery system used to provide the vast majority of benefits and beneficiaries will be through managed care, with certain benefits and beneficiaries being covered through FFS, as described in the QI managed care overview section above.

Eligibility and Enrollment

Hawaiʻi is requesting continued Medicaid matching funds to continue existing eligibility and enrollment policies, as follows:

- There will be no changes in the demonstration’s **eligibility methodology**. The demonstration extension will continue the application of Modified Adjusted Gross Income (MAGI) eligibility standards as required by applicable law and regulations, which includes not having an asset test for MAGI populations. Eligibility for the Aged, Blind, and Disabled groups will continue to be determined using current income and resource methodologies.
- There will be no **enrollment caps** for the QUEST Integration extension. However, there may be health plan enrollment caps. The State seeks to retain its authority to impose enrollment caps on health plans and to allow health plans to have enrollment limits

subject to State approval, provided that at least two health plans operating on an island do not have an enrollment limit.

- There will be no changes in the demonstration's **post-eligibility treatment of income**. Individuals receiving nursing facility services will be subject to the post-eligibility treatment of income rules set forth in Section 1924 and 42 C.F.R. 435.733. The application of beneficiary income to the cost of care will be made to the nursing facility. Individuals receiving HCBS will be subject to the post-eligibility treatment of income rules set forth in Section 1924 of the Social Security Act and 42 C.F.R. 435.735 if they are medically needy.
- There will be no changes to the **enrollment and health plan selection process**. Upon enrollment, individuals will receive a choice notification and may choose from participating QI health plans. In accordance with federal rules, all individuals will have a single 90-day period from their initial enrollment action to change their health plan; individuals who do not select a health plan within the 90-day enrollment period will be auto-enrolled to a health plan and will have a 15-day window to change plans. An individual enrolled in a health plan who chooses to remain in that plan during the annual open enrollment period will not be given a 90-day change period. However, individuals are able to change health plans for cause at any time.

Monitoring Reports
As a result of implementing and operationalizing the currently approved demonstration, Hawaiʻi has identified technical correction(s) required for Special Term and Condition (STC) 51. This technical correction has already been accepted by CMS and is currently in use by the State. The goal of this technical correction is to memorialize the change in the STCs. Since the federal fiscal years (FFY) and demonstration years are not aligned, the State requests updating the STC to reflect that monitoring reports will be based on the FFY, beginning October 1 and ending September 30.

Proposed Improvements Requested
Hawaiʻi is seeking to waive a condition of Section 1002(a)(2) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, which limits coverage for out-of-state individuals who have aged out of foster care to those that turned 18 years old after January 1, 2023. Instead, Hawaiʻi proposes covering any individual who has aged out of foster care in another state prior to or after January 1, 2023 as eligible for Medicaid, subject to other applicable Medicaid eligibility criteria. Included in this request are individuals who aged out of kinship guardianship or subsidized adoption, as these groups are eligible for the Former Foster Care Child program as an expansion group in this demonstration.

3.2 Behavioral Health (not including proposed Contingency Management pilot)
Hawaiʻi is seeking renewal of the existing behavioral health benefits with no modifications. The objectives and details of the existing behavioral health services remain the same. Further,

details of the services as approved in the protocol from Attachment E in the existing demonstration remain the same.

Overview

Improving behavioral healthcare and bringing innovative services to Hawaiʻi residents is a priority for the State. As part of Hawaii's commitment to improving access to and quality of behavioral healthcare, it will continue to provide robust specialized and non-specialized behavioral health services and strategically introduce new services and innovations in behavioral health care delivery. Central to this approach is Hawaii's commitment to implementing evidence-based services and care delivery innovations at a sustainable rate, ensuring that the delivery system can maintain high levels of quality and access for individuals with behavioral health needs.

As such, under this demonstration renewal, the State intends to provide existing behavioral services the same way it provides them under the current QI program. In addition to these existing services, Hawaiʻi separately proposes piloting contingency management services (as described in Section 3.6 Contingency Management) and is taking steps to expand the availability of medication assisted therapy (MAT) statewide.

Currently, the State provides standard behavioral health services to all beneficiaries. The State also provides specialized behavioral health services for adults with SMI through a program called Community Care Services (CCS).[4] The specialized behavioral health services include intensive case management, partial hospitalization or intensive outpatient hospitalization, psychosocial rehabilitation/clubhouse, therapeutic living supports, supportive housing, representative payee, supportive employment, peer specialist, and behavioral health outpatient services. Additionally, the State provides specialized behavioral health services and supports to children under the age of 21 through a program called Support for Emotional and Behavioral Development (SEBD). The Hawai'i Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD) provides these services. The services include multidimensional treatment for children involved in foster care, family therapy, functional family therapy, parent skills training, intensive home and community-based intervention, community-based residential programs, and hospital-based residential programs.

Proposed Improvements Requested

No improvements or additional authorities are requested for existing behavioral health services.

3.3 HCBS and Personal Care Services

Hawaiʻi is seeking renewal of existing HCBS and personal care services with changes to STC, including those related to expectations that the State transition certain demonstration benefits

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[4] If a beneficiary is enrolled in CCS, they receive both their standard and specialized behavioral health services through CCS to ensure a more integrated experience for the beneficiary across their spectrum of behavioral health and/or SUD treatment needs.

to alternative 1915(c) or 1915(i) authorities. Hawaiʻi is also proposing to expand the assisted living facility benefit to “at risk” beneficiaries and to continue certain Attachment K flexibilities enacted as a result of the COVID-19 PHE. The objectives and other details of HCBS services remain the same.

Overview

Expanding opportunities for individuals to live independently in the least restrictive setting of their choice remains a priority for Hawaiʻi. The current Section 1115 Demonstration supports these priorities by providing access to a comprehensive HCBS benefits package and enabling individuals to have greater choice between institutional services and HCBS. Consistent with the current demonstration, eligibility for certain HCBS will include individuals at risk of deteriorating to an institutional level of care, in addition to those already meeting institutional level of care. State objectives for HCBS authorities remain to:

- Ensure full access to the benefits of community living;
- Protects individuals’ autonomy to make choices and to control the decisions in their lives;
- Prevent a decline in health status; and
- Maintain individuals safely in their homes and communities.

Continuing Authority Requested

Hawaiʻi is requesting continued Medicaid matching funds to continue providing HCBS and personal care services that are not authorized in the Medicaid state plan to eligible individuals. Specifically, the State will continue using Medicaid matching funds for:

- Provision of services, through QI health plans, that could otherwise be provided under the authority of section 1915(c) waivers to individuals who meet an institutional level of care (LOC) requirement; and
- Provision of services, through QI health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, i.e., the “at risk” population.

Consistent with CMS’ approval of the existing Section 1115 Demonstration and pertaining to the provision of services outlined immediately above, Hawaiʻi requests continued authority to (1) allow the QI health plans to establish waiting lists upon approval by the State for the provision of HCBS and personal care services described within the State’s current STCs, and (2) limit the number of hours of HCBS provided to “at risk” individuals or the budget for such services, insofar as such limits are sufficient to meet the assessed needs of the individual.[5]

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[5] The State’s waiting list policies will remain based on objective criteria and applied consistently in all geographic areas served. The State will monitor the waiting lists on a monthly basis and will meet with the QI health plans on a quarterly basis to discuss any issues associated with management of the waiting lists. Beneficiaries who are on a waiting list may opt to change to another health plan if it appears that HCBS are available in the other health plan.

Individuals enrolled in the State’s Section 1915(c) Developmental Disability/Intellectual Disability (DD/ID) waiver will continue receiving HCBS through the 1915(c) waiver and will receive primary and acute care services through a QI health plan. These individuals will not receive any services under the QI demonstration that are covered under the 1915(c) waiver.[6] QI health plans may offer HCBS that are not covered under the 1915(c) waiver to these individuals and may have a waiting list for the provision of those HCBS services.[5]

Additionally, the State has identified the following STC change:

- **STC 24c(vii) (Medicaid Authorities Transition):** During the demonstration period, Hawaiʻi evaluated the feasibility of transitioning authorities to 1915(c) and/or 1915(i) authorities and concluded that, due to the comprehensive, integrated nature of the Section 1115 Demonstration, it is not effective or efficient to transition any portion of the demonstration to other 1915(c) or 1915(i) authorities. Therefore, Hawaiʻi seeks to remove STC 24c(vii) for the upcoming Section 1115 Demonstration renewal.

Proposed Improvements Requested

Assisted Living Facility Services for the “At Risk” Population

Hawaiʻi is seeking to include assisted living facility (ALF) services as a new benefit within the package of HCBS benefits (as currently outlined at STC 21h) available for individuals who are assessed to be at risk of deteriorating to institutional level of care (i.e., the “at risk” population).[7]

This proposed improvement is consistent with the State’s goal of ensuring full access to the benefits of community living so that individuals can maintain independence in the least restrictive setting of their choosing, as clinically appropriate. The State anticipates providing ALF services for the “at risk” population will help avoid or delay nursing facility placement by promoting greater access to the personal care and supportive care services (e.g., homemaker, chore, attendant services, and meal preparation) that enable individuals with activities of daily

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[6] The only exception to this is children who have access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.

[7] ALF services made available to the “at risk” population will align with those currently available to individuals who meet an institutional LOC, as defined and approved in Attachment D within the current waiver: personal care and supportive care services (homemaker, chore, attendant services, and meal preparation) that are furnished to beneficiaries who reside in an assisted living facility. Assisted living facilities are home-like, non-institutional settings. Payment for room and board is prohibited.

living (ADL) needs to reside in the community longer. Evidence indicates that personal care receipt may reduce the likelihood of nursing facility entry by as much as 46 to 84 percent.[8, 9]

Continuation of Attachment K COVID-19 PHE Flexibilities

Pursuant to recent CMS guidance in SMD# 23-004, Hawaiʻi is seeking approval to continue select HCBS-related Attachment K flexibilities enacted as a result of the COVID-19 PHE.[10] While the COVID-19 PHE presented multiple challenges, it also presented states with new opportunities to strengthen and promote expanded access to HCBS, specifically through new telehealth and electronic service delivery methods. Initial research—though of a national sample—suggests such Attachment K flexibilities adopted in response to the COVID-19 PHE may have helped people maintain access to HCBS and support state rebalancing efforts.[11, 12]

To continue these advancements, the requested flexibilities, described more fully in Table 5, would provide the State continued authority to:

- Allow for virtual/remote evaluations, assessments, and person-centered service planning;
- Add an electronic method of signing off on required documents;
- Add electronic service delivery for select services; and
- Allow payment for family caregivers or legally responsible individuals to render services.

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[8] Greiner, Melissa A., Laura G. Qualls, Isao Iwata, Heidi K. White, Sheila L. Molony, M T. Sullivan, Bonnie Burke, Kevin A. Schulman, and Soko Setoguchi. "Predicting Nursing Home Placement among Home- and Community-based Services Program Participants." *Am J Manag Care* 6, no. 1 (2014). https://pubmed.ncbi.nlm.nih.gov/25741870/

[9] Bryant, Melody, Lisa Ellens, Ann Langford, Jim McGuire, and Andrea Mulheisen. "Personal Care and Homemaking Services for Older Adults and Adults with a Disability." *Michigan Area Agency on Aging*, (2013). https://www.aaa1b.org/wp-content/uploads/2010/07/Personal-Care-Homemaking-Outcomes-Final-Report.pdf

[10] State Medicaid Director Letter #23-004: Extension of 1915(C) Home and Community-Based Services Waiver Appendix K Expiration Dates*.* Centers for Medicare & Medicaid Service. 2023. https://www.medicaid.gov/sites/default/files/2023-08/smd23004.pdf

[11] Bernacet, Amarilys, Cleanthe Kordomenos, Sara Karon, Molly Knowles, Nancy Archibald, and Alexandra Kruse. "Examining the Potential for Additional Rebalancing of Long-Term Services and Supports." *RTI International,* (2021). https://www.macpac.gov/wp-content/uploads/2021/05/Examining-the-Potential-for-Additional-Rebalancing-of-Long-Term-Services-and-Supports.pdf

[12] Watts, Molly O., and Priya Chidambaram*. "*Medicaid Home and Community-Based Services Enrollment and Spending*." KFF*, 2020. https://www.kff.org/medicaid/issue-brief/medicaid-home-and-community-based-services-enrollment-and-spending/

Table 5. Attachment K Flexibilities Requested for Continued Approval.

Flexibility	Description of Authority Requested
Modify service scope or coverage	Use telehealth or other electronic methods of service delivery to allow services to continue to be provided remotely in the home setting for: • Case management; • Monthly monitoring (i.e., in order to meet the reasonable indication of the need for services requirement in 1915(c) waivers); • Adult day care; and • Adult day health.
Modify processes for level of care evaluations or re-evaluations	Allow flexibility to remotely conduct a functional assessment to determine initial Level of Care (LOC) for new beneficiaries needing HCBS services.
Modify person-centered service plan development process	If chosen by the beneficiary, health plan service coordinators may use telehealth that meets privacy requirements in lieu of face-to-face meetings to conduct Health and Functional Assessments (HFA) to develop or update service plan.
Permit payment for services rendered by family caregivers or legally responsible individuals	Subject to parameters to be further set by the State in subsequent guidance, allow payment for services rendered by family caregivers or legally responsible individuals for Personal Assistance Level I and Level II as an alternative to agency or independent and unrelated self-direct workers.

In-person will remain the primary mode of delivery, and telehealth will be provided as a secondary option to beneficiaries for select services. As is current practice, beneficiaries must have an active choice in making the selection for telehealth. For adult day care and adult day health, in particular, telehealth will be provided in more limited circumstances to be further detailed by the State in subsequent guidance prior to implementation. Examples might include instances where the beneficiary is temporarily unable to attend in person due to either illness or injury or other structural barriers such as difficulty accessing transportation or there being no physical site within reasonable reach to the beneficiary. To further ensure program integrity and prevent misuse of these flexibilities, the State may also explore a tiered rate structure for adult day care and adult day health services provided remotely.

To ensure the requested flexibilities are exercised as intended, the State will impose guardrails and beneficiary protections similar to those within the State's existing Section 1915(c) DD/ID waiver. As noted earlier, more detailed parameters and guardrails for QI health plans and providers will be determined and issued by the State in guidance, procedures, and protocols to be issued prior to implementation of the requested flexibilities. Such guardrails and protections will consider the below:

- Assurances that telehealth will meet Health Insurance Portability and Accountability Act (HIPAA) requirements;
- How the remote service will be delivered in a way that respects privacy of the beneficiary;
- The process for electronic signatures for virtual/remote evaluations, assessments, and service plan meetings;
- How beneficiaries who need assistance with using the technology required for telehealth delivery of the service be supported;
- How remote service delivery will ensure the health and safety of a beneficiary;
- How telehealth will ensure the successful delivery of services for beneficiaries who need hands-on/physical assistance; and
- How remote service delivery increases access to services that support improved health and welfare.

In addition to telehealth flexibilities, the State requests to continue permitting payment for services rendered by family caregivers or legally responsible individuals. To similarly ensure program integrity and prevent misuse of these flexibilities and/or harm to beneficiaries, the State will further structure and delineate the bounds of this flexibility in subsequent guidance, procedures, and protocols prior to implementation. For example, establishing processes to monitor for fraud and abuse will be a priority for the State as it prepares to implement these flexibilities.

The State will further update guidance, procedures, and protocols as necessary pending CMS terms of approval for the requested telehealth and electronic service delivery flexibilities.

3.4 Community Integration Services (or CIS+)

Hawaiʻi is seeking renewal of the Community Integration Services (CIS) benefits with STC technical changes to eligibility, benefits, program integrity, value-based purchasing (VBP) pathway, and evaluation details. Hawaiʻi is also proposing to expand the scope of services for existing rental assistance authorities and proposes authority for new medical respite services within the CIS program. The objectives and cost sharing details of CIS remain the same.

Overview

Hawaiʻi continues to experience one of the highest rates of homelessness in the nation, with 41 out of every 10,000 people being homeless as of 2022. Further, the rate of individuals experiencing chronic patterns of homelessness in Hawaiʻi has increased by more than 90 percent since 2007.[13] According to State data, most chronically homeless individuals in Hawaiʻi are enrolled in Medicaid and have significantly higher health care costs than individuals who have stable housing.

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[13] Sousa, Tanya D., Alyssa Andrichik, Marissa Cuellar, Jhenelle Marson, Ed Prestera, and Katherine Rush. "The 2022 Annual Homelessness Assessment Report (AHAR) to Congress." *The U.S. Department of Housing and Urban Development,* (2022). https://www.huduser.gov/portal/sites/default/files/pdf/2022-AHAR-Part-1.pdf

This finding is supported by research which shows that individuals experiencing homelessness utilize significantly more healthcare resources, require more hospitalizations, experience higher mortality rates, are subject to traumatic violence, and present with more advanced chronic and acute conditions—including traumatic brain injuries, substance use disorders, serious mental illnesses, cardiovascular diseases, infectious diseases such as human immunodeficiency virus (HIV), hepatitis, and tuberculosis, bacterial and skin infections, and exposure-related conditions such as heat stroke—than housed individuals.[14, 15, 16, 17, 18, 19]

To combat this growing issue and mitigate the resulting impacts of homelessness, Hawai‘i continues to execute on and refine its multi-faceted “health and housing” approach towards homelessness, which brings together public and private collaborations to meet the housing and health related social needs of individuals experiencing homelessness.[20, 21] A key component of this strategic plan is to leverage Medicaid in identifying and engaging individuals experiencing homelessness and connecting them with both Medicaid and non-Medicaid housing related services. During the most recent State legislative session, Hawai‘i enacted House Bill 1397, which provides the State funding and authority for the State Office on Homelessness and Housing Solutions to collaborate with various state agencies—including the Departments of Health and Human Services—to implement supportive housing solutions.[22]

Under the CIS program currently approved in Hawaii’s Section 1115 Demonstration, Hawai‘i is authorized to provide eligible Medicaid beneficiaries with housing-related services. These services include outreach, pre-tenancy supports, tenancy sustaining supports, and limited

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[14] Szymkowiak, Dorota, Ann E. Montgomery, Erin E. Johnson, Todd Manning, and Thomas P. O'Toole. "Persistent Super-Utilization of Acute Care Services Among Subgroups of Veterans Experiencing Homelessness." *Med Care*, (2017). https://doi.org/10.1097/MLR.0000000000000796

[15] Auerswald, Colette L., Jessica S. Lin, and Andrea Parriott. "Six-year Mortality in a Street-recruited Cohort of Homeless Youth in San Francisco, California." *PeerJ*, (2016). https://doi.org/10.7717/peerj.1909

[16] Maness, David L., and Muneeza Khan. "Care of the Homeless: An Overview." *Am Fam Physician,* (2014). https://pubmed.ncbi.nlm.nih.gov/24784122/

[17] Oppenheimer, Sarah C., Paula S. Nurius, and Sara Green. "Homelessness History Impacts on Health Outcomes and Economic and Risk Behavior Intermediaries: New Insights from Population Data." *HHS Author Manuscripts,* (2017). https://doi.org/10.1606/1044-3894.2016.97.21

[18] Mitchell, Matthew S., Casey L. K. Leon, Thomas H. Byrne, Wen-Chieh Lin, and Monica Bharel. "Cost of Health Care Utilization among Homeless Frequent Emergency Department Users." *Psychol Serv,* (2017). https://doi.org/10.1037/ser0000113

[19] Rosenheck, R, and C L. Seibyl. "Homelessness: Health Service Use and Related Costs." *Med Care,* (1998). https://doi.org/10.1097/00005650-199808000-00013

[20] Hawaii Interagency Council on Homelessness. "Pressing the Levers of Change: Hawai’i State Framework to Address Homelessness." *The State of Hawai'I,* (2018). https://homelessness.hawaii.gov/wp-content/uploads/2019/03/Hawaii-State-Framework-to-Address-Homelessness-July-2016.pdf

[21] Hawaii Interagency Council on Homelessness. "Expanding Housing Supports through Medicaid Community Integration Services." *Hawaii Interagency Council on Homelessness,* (2022). https://homelessness.hawaii.gov/wp-content/uploads/2022/05/Policy-Brief-Medicaid-CIS-FINAL-052522.pdf#:~:text=Community%20Integration%20Services%20are%20available%20to%20Medicaid%20members,and%20is%20coordinated%20through%20the%20QI%20health%20plans

[22] House Bill 1397: Relating to Supportive Housing. https://legiscan.com/HI/bill/HB1397/2023

rental assistance supports (referred to as the Community Transition Services (CTS) pilot in current Section 1115 Demonstration materials).[23]

In line with recent state legislative efforts and to advance the State's policy goal of reducing the magnitude and impact of homelessness in Hawaiʻi, Hawaiʻi seeks to continue and expand the services authorized under CIS. With these enhancements, the State has renamed the program "Community Integration Services Plus (CIS+)" and will no longer refer to the rental assistance supports as "CTS." Under CIS+, eligible individuals will have access to a suite of housing-related services that can support sustainable transitions into permanent housing.

As described in Section 4.2 Hypotheses and Evaluation Approach, the State expects that CIS+ beneficiaries will receive different combinations of CIS+ services to match their needs, and that tailoring these services to fit their needs will result in increased housing stability, improved wellbeing, and decreased cost of care.

Continuing Authority Requested

Hawaiʻi is requesting continued Medicaid matching funds for existing CIS+ services approved under the Section 1115 Demonstration, including outreach, pre-tenancy supports, and tenancy sustaining supports, as described in STC 22c. The objectives and cost sharing details of the CIS program remain the same.

As a result of implementing and operationalizing these services, Hawaiʻi has identified several STCs requiring technical changes. The goal of these changes is to simplify the administration of the program and remove unnecessary barriers to beneficiary access. The State is proposing the following technical corrections to the related STCs:

- **STC 22a (Eligibility):** Hawaiʻi proposes modifying the requirement for a notification of loss of residence to include both written and verbal notifications.
- **STC 22c (CIS Benefits):** Hawaiʻi proposes modifying the scope of service to include outreach services, which are required to engage with and obtain participation consent from individuals who are referred to or otherwise identified as eligible for CIS+ prior to initiating program services.
- **STC 22e (Program Integrity):** Hawaiʻi proposes modifying certain data elements to more accurately reflect the service delivery details and data availability. Specifically, Hawaiʻi proposes removing the mention of "encounter data," recognizing that data are coming from multiple sources, including but not limited to encounter data. Further, Hawaiʻi proposes broadening specific data elements beyond specific units, costs, and duration of services rendered so that the STC is more reflective of a capitated managed care delivery system.

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[23] As a result of operational constraints, stemming from the COVID-19 PHE, Hawaiʻi has not yet implemented the authorized rental assistance supports, currently known as CTS.

- **STC 22i (Pathway to VBP):** Hawaiʻi proposes removing this STC, which outlines the pathway and implementation timeline toward operationalizing VBP arrangements for the CIS program. During the last demonstration period amid the COVID-19 PHE, the State worked closely with stakeholders, providers, and community-based organizations to implement the CIS program. During the process, the State recognized the need for additional capacity building activities, a longer implementation period, and more consistent utilization to inform future baseline data. As a result, the State requires additional time and experience in delivering these services before integrating VBP components and, as such, seeks to remove this STC.
- **STC 22j (Evaluation):** Hawai'i proposes removing this STC, which requires the incorporation of rapid cycle assessments (RCAs) into the CIS evaluation approach, and to instead incorporate the assessment of CIS+ into the State's broader Section 1115 Demonstration evaluation approach. Under the current Section 1115 Demonstration, the State conducted RCAs as outlined in the STC. This allowed the State to quickly adapt operational processes in response to RCA results and also informed proposed changes to the program, as outlined in this document.

Proposed Improvements Requested

Hawaiʻi is seeking to expand the set of services available under the CIS+ program. The proposed improvements described below build on existing authority and are modeled after similar Section 1115 Demonstration benefits approved in other states, such as Oregon and Washington.

Scope of Service: Rental Assistance Supports

Hawaiʻi is requesting continued Medicaid matching funds for the provision of rental assistance supports, currently known as the "CTS pilot" and as described in STC 23a, within the CIS+ program.

As discussed, the intersection between housing and health is well documented, with scores of research highlighting the poor health outcomes and higher healthcare costs associated with housing instability. However, preliminary experience from other states that invest in permanent housing for beneficiaries shows promising results with significant reductions in healthcare, correctional, and other public costs.[24, 25] A California permanent supportive housing program was shown to reduce the use of high cost medical and mental health services and resulted in an estimated 20 percent net savings of total public costs.[26] Additionally, Oregon has reported a

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[24] Sandel, Megan, and Matthew Desmond. "Investing in Housing for Health Improves Both Mission and Margin." *JAMA,* (2017). https://doi.org/10.1001/jama.2017.15771

[25] "Multnomah County FUSE Report." *Corporation for Supportive Housing (CSH),* (2021). https://www.healthshareoregon.org/storage/app/media/documents/Blog/Multnomah-FUSE-Report.FINAL_.WEB_.5.25.pdf

[26] Hunter, Sarah B., Melody Harvey, Brian Briscombe, and Matthew Cefalu, Evaluation of Housing for Health Permanent Supportive Housing Program. Santa Monica, CA: RAND Corporation, 2017. https://www.rand.org/pubs/research_reports/RR1694.html

reduction in emergency department visits, increase in primary care visits, and 12 percent savings in Medicaid expenditures among beneficiaries receiving permanent housing supports.[27]

As a result of operational and capacity constraints stemming from the COVID-19 PHE, Hawaiʻi has not yet implemented the existing rental assistance support authorities and seeks renewed authorization to implement this program, with newly proposed modifications to the scope of service. Hawaiʻi is seeking to implement these services, inclusive of requested changes outlined below, following approval by CMS and effective as soon as operational and technical infrastructures allow.

- **Remove Transitional Case Management (TCM) Services from the Demonstration:** The current Section 1115 Demonstration authorizes and describes a limited scope of housing-related TCM services intended to support an individual moving into stable housing. Moving forward, Hawaiʻi will provide TCM services outside of 1115 authority and expand the scope of TCM so that the services more comprehensively address the clinical, social, and other needs of individuals engaged in CIS+, regardless of which services they receive or their status in transitioning to stable housing.
- **Expand the Scope and Duration of Rental Assistance Funding Services:** The current Section 1115 Demonstration authorizes funding related to moving costs, utility setup, and security deposits or the first month's rent. As part of this renewal, Hawaiʻi proposes expanding both the scope and duration of these funding services so that it covers any combination of the following:
    - Moving costs;
    - Utility set up and up to 6 months of utility payments, including past due utility payments;
    - A one-time security deposit;
    - Up to 6 months of rent, including past due rental payments; and
    - Housing application costs, including document recovery and application fees.

Scope of Service: Medical Respite

Hawaiʻi is requesting approval for Medicaid matching funds for the provision of medical respite services within the CIS+ program. The addition of these services builds on existing efforts in Hawaiʻi to expand the availability of and access to medical respite. This year, for example,

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[27] "Addressing Housing Needs through Health-Related Services: A Guide for Oregon CCOs." *Oregon Housing Authority,* (2021). https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Guide-Housing.pdf

Hawaiʻi constructed and opened its first medical respite facility, locally called a medical respite kauhale. [28,29,30]

Medical respite models and programs vary but are defined generally by the National Health Care for the Homeless Council (NHCHC) as "acute and post-acute medical care for people experiencing homelessness who are too ill or frail to recover […] on the street."[31] This framework for medical respite builds upon a wealth of existing evidence demonstrating that secure housing for persons at risk of or experiencing homelessness is critical to improving health care outcomes and decreasing health care costs, particularly for those recovering from hospitalization or chronic illness.[32] A literature review of clinical evidence on medical respite services conducted by NHCHC found that provision of these services, including recuperative care and short-term post-hospitalization housing, reduced hospital readmission rates, reduced costs to health systems, and further reduced the likelihood of hospital or emergency department visit in the period following discharge from hospitalization.[33] This large-scale literature review provides an evidence-base that demonstrates the efficacy of medical respite in improving health outcomes for eligible populations and reducing costs to health systems and state Medicaid programs, validated by numerous reports of pilot respite programs that similarly found reduced readmission rates, reduced emergency department visits, and increased engagement with primary care.[34, 35, 36]

In addition to meeting the CIS+ eligibility criteria, individuals requiring medical respite may be subject to additional eligibility or medical appropriateness criteria. Hawaiʻi will work with CMS

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[28] "Housing Is Healthcare." *Governor Josh Green,* (2023). https://governor.hawaii.gov/wp-content/uploads/2023/07/Housing-is-Healthcare-2023-no-crops.pdf

[29] "First Medical Respite Kauhale Prepares to Open." State of Hawaii. May 26, 2023. https://homelessness.hawaii.gov/main/first-medical-respite-kauhale-prepares-to-open/

[30] "State of Hawaiʻi Kauhale Initiative." State of Hawaii. https://homelessness.hawaii.gov/kauhale/

[31] "Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care." *National Institute for Medical Respite Care,* (2021). https://nimrc.org/wp-content/uploads/2021/08/NIMRC_Medical-Respite-Literature-Review.pdf

[32] Taylor, Lauren A. "Housing And Health: An Overview Of The Literature." *HealthAffairs,* (2018). https://doi.org/10.1377/hpb20180313.396577

[33] "Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care." *National Institute for Medical Respite Care,* (2021). https://nimrc.org/wp-content/uploads/2021/08/NIMRC_Medical-Respite-Literature-Review.pdf

[34] Wright, Bill, Grace Li, Maggie Weller, and Keri Vartanian. "Health in Housing: Exploring the Intersection between Housing and Health Care." *Center for Outcomes Research and Education and Enterprise Community Partners, Inc.,* (2020). https://www.enterprisecommunity.org/sites/default/files/2021-06/Health%20in%20Housing%20Exploring%20the%20Intersection%20between%20Housing%20and%20Healthcare.pdf

[35] Takahashi, Paul Y., James M. Naessens, Stephanie M. Peterson, Parvez A. Rahman, Nilay D. Shah, Dawn M. Finnie, Audrey J. Weymiller, Bjorg Thorsteinsdottir, and Gregory Hanson. "Short-term and Long-term Effectiveness of a Post-hospital Care Transitions Program in an Older, Medically Complex Population." *Healthcare*, (2016). https://doi.org/10.1016/j.hjdsi.2015.06.006

[36] Lawson, Lauren V., Bonnie Bowie, and Melanie Neufeld. "Program Evaluation of a Recuperative Care Pilot Project." *Public Health Nursing*, (2020). https://doi.org/10.1111/phn.12834

to establish this additional criterion as it relates to authorization for medical respite services. Hawaiʻi is seeking to implement the CIS+ program, inclusive of requested changes outlined below, following approval by CMS and as soon as operational and technical infrastructures allow.

Hawaiʻi proposes including the following respite services within the CIS+ program:

- **Recuperative Care**
    - ***Scope of Services:*** Up to 90 days of short-term residential care that provides for ongoing medical and psychiatric needs. Such care may include monitoring vital signs, conducting assessments, wound care, medication monitoring, coordinating transportation to discharge appointments, connecting individuals to other needed medical or psychiatric services, support in accessing other social services and benefits, monitoring and supporting nutrition and diet, and other support services.
    - ***Provider Types:*** Hawaiʻi will allow the following to provide recuperative care services: (1) interim housing facilities with additional on-site support; (2) shelter beds with additional on-site support; (3) converted homes with additional on-site support; and (4) publicly operated or contracted recuperative care facilities.[37]
- **Short-Term Post-Hospitalization Housing**
    - ***Scope of Services:*** Up to 6 months of short-term housing for individuals who do not have a residence to continue recovery for physical, psychiatric, or substance use conditions following discharge or exit from an institution. Based on the individual's level of care needs, the services provided may include appropriate physical and behavioral healthcare.

Provider Types: Hawaiʻi will allow the following to provide short-term post-hospitalization housing services: (1) interim housing facilities with additional on-site support; (2) shelter beds with additional on-site support; (3) converted homes with additional on-site support; (4) publicly operated or contracted recuperative care facilities; (5) supportive housing providers; (6) county agencies; (7) public hospital systems;[38] (8) social service agencies; and (9) providers of services for individuals experiencing homelessness.[14]

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[37] Consistent with CMS guidance, MQD will ensure via guidance, procedures, and protocols issued well in advance of implementation, that Medicaid matching funds used towards the CIS+ program will supplement, and not substitute housing-related funds from state and/or local agencies. Further, MQD will ensure that Medicaid matching funds requested for the CIS+ program work seamlessly with the State's existing housing resources and programs. "All-State Medicaid and CHIP Call." Centers for Medicare & Medicaid Services. December 6, 2022. https://www.medicaid.gov/sites/default/files/2022-12/covid19allstatecall12062022.pdf

[38] "Public hospital systems" are not inclusive of Hawaiʻi State Hospital, Hawaii's only public psychiatric hospital that provides inpatient psychiatric services for court ordered individuals.

3.5 Continuous Eligibility

Hawaiʻi is seeking new authority for the continuous eligibility policies described below.

Request

Hawaiʻi is requesting approval for Medicaid matching funds for the provision of continuous eligibility for children ages 0 to 6 (through the end of the month in which their 6th birthday falls), regardless of when they first enrolled in Medicaid or CHIP and regardless of changes in circumstances that would otherwise cause a loss of eligibility, except when eligibility was granted erroneously or when the beneficiary requests termination of benefits, dies, or is no longer a resident of Hawaiʻi.

Hawaiʻi also seeks approval to authorize Medicaid matching funds for the provision of continuous two-year eligibility from the time of first eligibility determination for children ages 6 to 19 (through the end of the month in which their 19th birthday falls), regardless of changes in circumstances that would otherwise cause a loss of eligibility, except when eligibility was granted erroneously or when the beneficiary requests termination of benefits, dies, or is no longer a resident of Hawaiʻi.

Overview of Continuous Eligibility Provisions

Hawaiʻi recognizes the critical importance of consistent health insurance coverage to promote continuity of care for children and has enacted State policies that support comprehensive coverage options to children, as evidenced by Hawaii’s low child uninsurance rate of 2.8 percent and high income eligibility threshold for Medicaid and CHIP.[39,40] Prior to the COVID-19 PHE continuous eligibility provisions, analysis of Hawaii’s Medicaid and CHIP enrollment indicated that approximately one fourth of children who were disenrolled from Medicaid or CHIP re-enrolled within three months, indicating high levels of “churn” as a result of family income changes.[41] Churn often results in periods of uninsurance, delayed care, and higher administrative costs to Medicaid and CHIP due to disenrollment and reenrollment activities.[42] As such, Hawaiʻi proposes implementing continuous eligibility policies for children to maintain consistent coverage and mitigate the high rates of churn experienced prior to the COVID-19 PHE.

Coverage gaps among children eligible for Medicaid and CHIP as a consequence of churn have been shown to reduce children’s access to preventive and primary care, increase their unmet health care needs, and result in disruptions in continuity of health care services.[42]This is

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[39] "Hawaii." Children's Health Care Report Card. *Center for Children & Families (CCF) of the Georgetown University Health Policy Institute*, (2023). https://kidshealthcarereport.ccf.georgetown.edu/states/hawaii/#coverage-trends

[40] "Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels." Medicaid.Gov. (2023). https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html

[41] Unpublished evaluations of 2017-2019 TMSIS Analytic File data provided by CMS. October 13, 2021.

[42] Sugar, Sarah, Christie Peters, Nancy De Lew, and Benjamin D. Sommers. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic." *ASPE*, (2021). Accessed October 12, 2023. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

particularly problematic for young children, given how significantly the early years impact lifelong growth and development.[43] For example, early detection of and timely intervention for developmental delays, including screenings conducted during early childhood well visits, has been shown to positively impact health, language and communication skills, and overall cognitive development.[44] There is also considerable evidence that a strong foundation of coverage and continuity of care can help children be school-ready, ensure timely referrals for early intervention and prevention of chronic illnesses and developmental disorders, and potentially lower special education and child welfare costs.[45] The American Academy of Pediatrics reaffirms the importance of early screening and preventative care for children to address chronic health problems and support physical, mental, behavioral, and developmental health through adolescence into adulthood: consistent coverage and early access to preventative care not only lead to better social and health outcomes during adulthood, but they also demonstrate capacity to help address health disparities and social drivers of health that can have negative lifelong impacts for those with fewer social and economic resources.[46]

This proposed continuous Medicaid and CHIP eligibility policy for children seeks to address these coverage gaps and aligns with recently approved Section 1115 Demonstrations in Oregon and Washington, which include continuous eligibility provisions for children.[47, 48] Oregon and Washington both received approval from CMS for continuous eligibility for Medicaid and CHIP eligible children up to age 6, and Oregon also received approval to provide 24 months of continuous eligibility to children ages 6 to 19. This proposed continuous eligibility policy most closely follows Oregon's model to ensure continuity of care and consistent coverage for all children eligible for Medicaid or CHIP in Hawaiʻi.

This continuous eligibility policy also aligns with recently enacted federal legislation. H.R. 2617, known as the "Consolidated Appropriations Act of 2023," requires that starting January 1, 2024,

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[43] Somers, Stephen A., and Alexandra Maul. "Preventing Early Childhood Adversity Before It Starts: Maximizing Medicaid." *Center for Health Care Strategies*, (2017). Accessed October 12, 2023. https://www.chcs.org/maximize-medicaid-opportunities-prevent-early-childhood-adversity-starts/

[44] "The Foundations of Lifelong Health are Built in Early Childhood." *Center on the Developing Child at Harvard University*, (2010). Accessed October 12, 2023. https://developingchild.harvard.edu/resources/the-foundations-of-lifelong-health-are-built-in-early-childhood/

[45] Currie, Janet. "Early Childhood Intervention Programs: What Do We Know?" 2000. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.492.8316&rep=rep1&type=pdf

[46] Hagan, Joseph F., Judith S. Shaw, and Paula M. Duncan. 2017. *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. American Academy of Pediatrics. https://doi.org/10.1542/9781610020237

[47] "Oregon Health Plan Demonstration Approval." Centers for Medicare & Medicaid Services. September 28, 2022. https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-1115-Demonstration-Approval.pdf

[48] "Washington State Medicaid Transformation Project 2.0 Demonstration Approval." Centers for Medicare & Medicaid Services. June 30, 2023. https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf

all states must provide 12-month continuous eligibility for children.[49] In alignment with this legislation and CMS guidance provided in State Health Official (SHO) #23-004, Hawaiʻi is currently in the process of submitting a State Plan Amendment to enact 12-month continuous eligibility for children ages 0 to 19, with a target retroactive effective date of 7/1/2023, the start of the State Fiscal Year 2024.[50] This application seeks waiver and expenditure authority to go beyond the Consolidated Appropriations Act of 2023 and expand continuous eligibility for children beyond 12 months. In compliance with federal guidance and as described further in this section, the State will still determine state residency at least once per 12 months, and children who move out of state will not retain coverage.

The proposed continuous eligibility policy will apply to all children enrolled in Medicaid or CHIP. This proposal is aimed at promoting continuity of care and preventing coverage gaps for children and is not designed to change eligibility limits for Hawaii's Medicaid and CHIP programs. However, as a complement to this policy and in its efforts to further expand coverage for low-income children, Hawaiʻi is separately considering seeking CMS authority outside of this demonstration waiver to create a new optional coverage group to cover children up to 400 percent FPL, corresponding with New York's 400 percent FPL CHIP eligibility, the upper limit of CHIP eligibility nationally. Currently, Hawaii's Medicaid program covers children up to 133 percent FPL with Medicaid funds and up to 308 percent FPL through the Medicaid expansion Children's Health Insurance Program (CHIP).[51]

Continuity of coverage for children provides an essential base from which providers and health plans can focus their efforts on primary and preventive care and early diagnosis and treatment to improve long-term health and well-being. Over the past three years, COVID-19 disrupted early childhood services and programs, negatively impacting the development and emotional and behavioral health of children and youth. For example, young children with disabilities, those from households with lower incomes, and/or those from racial and ethnic minority populations experienced significant increases in emotional or behavioral problems, including depression.[52] Now that the State has restarted renewals for Medicaid and CHIP eligibility due to the COVID-19 PHE ending, the State seeks to implement this continuous eligibility policy to ensure that gains in coverage and continuity of care for children made during the PHE are not lost.

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[49] House Resolution 2617: Making consolidated appropriations for the fiscal year ending in September 30, 2023, and for providing emergency assistance for the situation in Ukraine, and for other purposes. https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf

[50] CMS State Health Official Letter #23-004. https://www.medicaid.gov/sites/default/files/2023-09/sho23004.pdf

[51] Hawaiʻi covers infants ages 0-1 up to 191 percent FPL and children ages 1-5 up to 139 percent FPL. Eligibility levels do not include the mandatory 5 percent income disregard.

[52] Jones, Kaitlyn. "The Initial Impacts of COVID-19 on Children and Youth (Birth to 24 Years): Literature Review in Brief." *ASPE*, (2021). https://aspe.hhs.gov/sites/default/files/documents/188979bb1b0d0bf669db0188cc4c94b0/impact-of-covid-19-on-children-and-youth.pdf

Eligibility for Continuous Eligibility Provisions

Providing continuous eligibility for children ages 0 to 6:
Hawaiʻi requests authority to provide continuous eligibility for all Medicaid and CHIP eligible and enrolled children ages 0 to 6 (through the end of the month in which their 6th birthday fails), regardless of when they first enroll in Medicaid or CHIP and regardless of changes in circumstances that would otherwise cause a loss of eligibility. Exceptions will be made in the following circumstances, as required by H.R. 2617, the State's verification plan(s), and federal regulations, where the individual's Medicaid eligibility shall be redetermined or terminated:[53]

a. The individual is no longer a Hawaiʻi resident;
b. The individual requests termination of eligibility;
c. The individual dies; or
d. The State determines that eligibility was erroneously granted at the most recent determination, redetermination of renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

The State will attempt to verify residency and that the individual is not deceased at least once every 12 months.

Establishing two-year continuous eligibility for children ages 6 to 19:
Hawaiʻi requests authority to provide two-year continuous eligibility for all Medicaid and CHIP eligible and enrolled children ages 6 to 19, through the end of the month in which their 19th birthday falls, from the time of their first eligibility determination, and regardless of changes in circumstances that would otherwise cause a loss of eligibility. Exceptions will be made in the following circumstances, as required by H.R. 2617, the State's verification plan(s), and federal regulations, where the individual's Medicaid eligibility shall be redetermined or terminated:[54]

a. The individual is no longer a Hawaiʻi resident;
b. The individual requests termination of eligibility;
c. The individual dies; or
d. The State determines that eligibility was erroneously granted at the most recent determination, redetermination of renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

The State will attempt to verify residency and that the individual is not deceased at least once every 12 months.

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[53] Per requirements set by 42 CFR 435.952(d) or 457.380, 42 CFR 435.916(d) or 457.343, 42 CFR 435.940 through 435.960, and 42 CFR 435.945(j) or 457.380.
[54] Per requirements set by 42 CFR 435.952(d) or 457.380, 42 CFR 435.916(d) or 457.343, 42 CFR 435.940 through 435.960, and 42 CFR 435.945(j) or 457.380.

Scope of Services and Cost Sharing

The scope of services and cost sharing will not change with the expansion of the continuous eligibility provisions for children ages 0 to 6 and children ages 6 to 19. During the continuous eligibility period, children will have access to the full range of covered benefits under Medicaid and Medicaid expansion CHIP for enrolled children, including the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit. Hawaii's Medicaid and Medicaid expansion CHIP programs have no cost sharing or premiums for beneficiaries.[55]

Objectives

Enabled by the continuous eligibility authorities requested in this application, and as reflected in corresponding hypotheses in subsequent sections, Hawaiʻi will promote equitable access to care among Medicaid and CHIP eligible children and mitigate costly, administratively burdensome churn associated with termination of their coverage. Specifically, Hawaiʻi aims to:

- Reduce churn and gaps in coverage for children enrolled in Medicaid, including for racial and ethnic minority populations that experience disproportionately high rates of churn;
- Reduce the quantity of redeterminations, resulting in lower administrative burden for eligibility workers and associated costs; and
- Reduce per beneficiary costs of coverage, as children who stay on Medicaid or CHIP longer will have better access to preventive and primary care services that can reduce the need for higher-cost treatments due to delayed care.[56]

The State will monitor and evaluate continuous eligibility to assess progress against the above desired outcomes.

Demonstration Implementation

Hawaiʻi is seeking to implement this demonstration following approval by CMS as soon as eligibility systems and technical infrastructure allow.

3.6 Contingency Management

Hawaiʻi is seeking new authority for the provision of contingency management (CM) services described below.

Request

Hawaiʻi is requesting approval for federal Medicaid matching funds to pilot CM for Medicaid beneficiaries with a qualifying substance use disorder (SUD), which includes stimulant use disorders (StimUDs) and opioid use disorders (OUDs). Hawaii's CM approach is grounded in evidence-based research and aligns with CM delivery strategies used in other states, including

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[55] SPA #22-0010, State of Hawaii. September 16, 2021. https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-chip-state-plan/Approved_CHIP_State_Plan_to_include_SPA_22-0010_approval-includes_2-4_32_and_Appendix_1-2.pdf

[56] "Access to Primary Care." Healthy People 2023. U.S. Department of Health and Human Services, 2023. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

California and Washington, where CMS authorized CM through Section 1115 Demonstrations. The CM pilot will be limited by the number of qualifying providers that elect to and are approved by the State to participate. As described in subsections below, CM will consist of a complementary course of SUD treatment and a series of motivational incentives to advance SUD treatment goals, which may include negative drug tests. Motivational incentives may consist of cash equivalents (e.g., gift cards) and shall not exceed limits established by the State. These motivational incentives are central to CM, based on the best available scientific evidence for treating an SUD (see evidence base further below) and not as an inducement to use other medical services. The State intends to determine the size, nature, and distribution of all motivational incentives in detailed guidance, procedures, and protocols issued well in advance of implementation, which the State envisions as no earlier than January 1, 2026.

Overview of Contingency Management Services

Contingency management is one of the most effective behavioral interventions for treatment of SUDs, with decades of research indicating its ability to increase substance non-use and SUD treatment adherence.[57] As such, CM is a critical component of Hawaii's strategy to support specialized behavioral health services for individuals with SUD.

Over 30 years of evidence indicates that CM is an effective behavioral intervention for a wide range of SUDs, promoting non-use of substances, including cocaine, methamphetamines, tobacco, alcohol, opioids, cannabis, and benzodiazepines.[57] While CM has been used most commonly to address StimUDs, numerous metanalyses of CM clinical research indicate that CM's combination of SUD treatment and motivational incentives is highly effective at addressing SUDs across diverse populations, above and beyond the treatment effects of other evidence-based treatments like cognitive-behavioral therapy or 12-step programs. In a 2021 meta-analysis of long-term efficacy of CM treatments, CM participants were 1.22 times as likely to maintain non-use of substances at the one-year mark compared to those receiving therapies or treatments without motivational incentives.[58] Further, the Veteran's Affairs (VA) health system has embraced CM as a critical means of addressing SUDs: as of 2019, over 100 VA

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[57] McPherson, Sterling M., Sara Parent, Andre Miguel, Michael McDonell, and John M. Roll. "Contingency Management Is a Powerful Clinical Tool for Treating Substance Use Research Evidence and New Practice Guidelines for Use." *Psychiatric Times* 39, no. 9 (2022). https://www.psychiatrictimes.com/view/contingency-management-is-a-powerful-clinical-tool-for-treating-substance-use-research-evidence-and-new-practice-guidelines-for-use

[58] Ginley, M K., R A. Pfund, C J. Rash, and K Zajac. "Long-term Efficacy of Contingency Management Treatment Based on Objective Indicators of Abstinence from Illicit Substance Use up to 1 Year following Treatment: A Meta-analysis." *Journal of Consulting and Clinical Psychology* 89, no. 1 (2021). https://doi.org/10.1037/ccp0000552

Medical Centers offer CM for various SUDs, with a negative-drug screening success rate of 92.6 percent for the target substance during the intervention period.[59, 60]

Hawaiʻi experiences high rates of substance use disorders, with overdose deaths now outpacing auto-accident fatalities.[61] In particular, Hawaiʻi has high rates of methamphetamine use disorders—the most prevalent SUD among adults aside from alcohol—which is responsible for three-quarters of the State's overdose deaths and over five times the emergency department admissions than opioids.[62,63] This is a disquieting trend that has persisted over time. For example, State data from the State of Hawaiʻi Department of Health Alcohol and Drug Abuse Division (ADAD)—MQD's sister agency that is the primary and often sole source of public funds for substance use treatment—indicate that in 2016, methamphetamine was the most frequently reported primary substance at the time of SUD treatment admission (51.6 percent among adults 18 to 49 years), followed by alcohol (19.8 percent among adults 18 to 49 years). This trend held from 2010 through 2016 (most current state data), with methamphetamine continuing to outpace alcohol and other substances as the most frequently reported primary substance at the time of SUD treatment admission (44.3 percent - 51.6 percent).[63]

Hawaiʻi recognizes that access to care for SUD treatment is essential to improve health outcomes for beneficiaries and to stem the tide of chronic addiction. Inter- and intra-agency collaboration, especially continued collaboration and engagement with ADAD, will be critical as Hawaiʻi advances these goals and seeks to augment its existing infrastructure to support access to SUD treatment options. As such, Hawaii's CM proposal is just one lever through which the State intends to respond to this crisis. Hawaiʻi will continue to support a SUD treatment delivery system through Medicaid-covered services, state-only funds, and grant funding. This CM proposal enhances this existing infrastructure by expanding the services eligible for reimbursement to meet a rising need for treatment, to more fully bring standardization and evidence-based practices such as CM to service delivery, and to offer long-term sustainability for providers.

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[59] DePhilippis, D., "How VA Uses Contingency Management to Help Veterans Stay Drug F." *VA News*, August 22, 2019. https://news.va.gov/64870/how-va-uses-contingency-management-help-veterans-stay-drug-free/

[60] "Contingency Management for Supporting Substance Use Treatment and Recovery: An Innovative Practice in VHA Homeless Program Operations." VHA National Homeless Program Office. https://www.va.gov/HOMELESS/docs/White-Paper-Contingenc-Management-with-Homeless-Veterans-508.pdf

[61] Centers for Disease Control and Prevention, National Center for Health Statistics CDC Wonder, Detailed Mortality Adjusted pharmaceutical/synthetic opioid poisoning fatality rates., by state, 2012-2015. https://wonder.cdc.gov/ucd-icd10.html

[62] "State of Hawaiʻl Behavioral Health Dashboard." State of Hawaiʻl, Department of Health. https://bh808.hawaii.gov/

[63] "The Hawaiʻi Opioid Initiative A Statewide Response." The Hawaiʻi Department of Health. 2017. https://health.hawaii.gov/substance-abuse/files/2019/06/THE-HAWAII-OPIOID-INITIATIVE-1.0-A-Statewide-Response-to-Opioid-Use-and-Other-Substance-Misuse.pdf

Eligibility for Contingency Management

Hawaiʻi requests authority to pilot the provision of CM to Medicaid beneficiaries meeting the below criteria and conditions. Qualifying Medicaid beneficiaries must:

- Be assessed and determined by qualifying providers (see subsection further below) to have a qualifying SUD for which CM is medically necessary and appropriate based on the fidelity of treatment to the evidence-based intervention. The presence of additional substance disorders and/or diagnoses shall not disqualify an individual from receiving CM;
- Not be enrolled in another CM program for SUD; and
- Receive services from an eligible provider that offers CM in accordance with the State laws, policies, procedures, and guidance.

Motivational incentive payments shall be excluded from participating Medicaid beneficiaries' modified adjusted gross income (MAGI)-based eligibility determinations.

Scope of Services, Eligible Providers, and Cost Sharing

Scope

Hawaii's proposal to pilot CM reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The CM pilot will provide motivational incentives to advance treatment/medication adherence or non-use of substances as evidenced by, for example, negative point of care drug tests. The State will provide guidance on the frequency of reassessments for eligibility.

As previously noted, the State, neither eligible providers (as defined later within this section) nor QI health plans, will determine the size, nature, and distribution of any CM motivational incentives. The State will issue guidance, procedures, and protocols that all eligible CM providers and QI health plans shall strictly adhere to, including limitations on motivational incentive payments during the course of CM treatment episode. In determining the size, nature, and distribution of motivational incentives, the State will ensure that neither the Federal anti- kickback statute (42 U.S.C. 1320a-7b(b), "AKS") nor the civil monetary penalty provision prohibiting inducements to beneficiaries (42 U.S.C. 1320a-7a(a)(5), "Beneficiary Inducements CMP") are implicated.

To further ensure the integrity of CM and mitigate the risk of fraud, waste, or abuse associated with the motivational incentive, the State intends to:

- Monitor motivational incentives to ensure safeguards against fraud and abuse. Safeguards will be detailed and issued as guidance to eligible providers and managed care plans prior to implementation; and
- Provide guidance that includes instructions on how to calculate and generate motivational incentives.

Hawaii's CM pilot will be offered along with other therapeutic interventions, as appropriate for SUD treatment, such as cognitive behavioral therapy, that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and 42 CFR 440.130(d). While Hawaiʻi will issue guidance strongly encouraging that motivational incentives are provided in concert with other SUD treatments, Hawaii's CM pilot will not require participation in other SUD treatment as an eligibility requirement for participating in CM.

Eligible CM Providers and Qualifying Practitioners

Contingency management providers include a range of behavioral health, substance use, and mental health providers that opt into and are approved by the State to participate in the pilot and meet conditions outlined below.

Eligible CM providers must:

- Be certified to provide Medicaid services in the State, including but not limited to: primary care, behavioral health, and substance use service providers;
- Require the staff providing or overseeing CM to participate in CM-specific training developed and offered by the State and/or the State's designated contractor(s), such as QI health plans;
- Undergo a readiness review by the State and/or the State's designated contractor(s) to ensure that they are capable to offer CM in accordance with State's standards that will be detailed in the State's guidance;
- Participate in ongoing training and technical assistance as requested or identified by the State and/or the State's designated contractor(s) through ongoing monitoring to meet the State's standards; and
- Shall comply with any billing and data reporting requirements established by the State to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation.

Hawaii's CM pilot will also allow the following qualifying practitioners to provide key CM activities such as administering point-of-care drug tests, informing beneficiaries of the results of the evidence/point of care drug test, providing educational information, and distributing motivational incentives. These qualifying practitioners include:

- SUD counselors that are either certified or registered by an organization that is recognized by the State and accredited with the National Commission for Certifying Agencies;
- Certified peer support specialists working under the supervision of a licensed provider; and
- Other trained providers and staff under supervision of a licensed provider in the State.

Cost-Sharing

No cost sharing shall be imposed for CM services.

Objectives

This proposed CM pilot aims to expand access to evidence-based SUD intervention and treatments. Specifically, Hawaiʻi aims to:

- Increase the number of Medicaid beneficiaries engaged in treatment for SUDs; and
- Increase adherence to and retention in SUD treatment among Medicaid beneficiaries with SUDs.

The State will monitor and evaluate the CM pilot to assess progress against the above desired outcomes.

Demonstration Implementation

Hawaiʻi is seeking to implement its CM pilot no earlier than January 1, 2026, pending approval by CMS. Participation is expected to ramp up over the course of the proposed pilot, as more providers elect to and are approved by the State to participate, thereby increasing CM access to more qualifying individuals with SUD diagnoses. Further, a key focus in implementation will be ensuring that Hawaii's CM pilot dovetails and integrates within the existing behavioral health system, inclusive of MQD's sister agencies within the Department of Health.

3.7 Pre-Release Medicaid Services for Justice-Involved Individuals

Hawaiʻi is seeking new authority for the provision of pre-release benefits described below.

Request

Hawaiʻi is requesting approval for federal Medicaid matching funds for the administration and provision of a set of targeted Medicaid services to be provided in the up to 90-day period prior to release for eligible justice-involved individuals. These pre-release Medicaid services include, as clinically appropriate, case management and care coordination; physical and behavioral health clinical consultation services provided by carceral or in-reach community-based providers; lab and radiology services; and, for use upon release, durable medical equipment (DME) and a minimum 30-day supply of medications, including Medication-Assisted Treatment (MAT) for substance use disorders (SUDs).[64] Authority to cover these services is requested for justice-involved individuals in facilities operated by Department of Public Safety (DPS), including State prisons and county jails, as well as Youth Correctional Facilities operated by the Hawaiʻi Department of Human Services. [65]

Overview of Pre-Release Medicaid Services for Justice-Involved Individuals

Ensuring continuity of health coverage and care for justice-involved populations is a high priority for Hawaiʻi. The proposed eligibility group is comprised primarily of low-income adults who are disproportionately from racial or ethnic minority populations (particularly Native

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[64] The medical supply includes both covered outpatient prescribed medications and over-the-counter drugs.

[65] Hawaiʻi expects that coverage for eligible individuals in local jails will be short-term and assist with diversion from further interaction with the criminal legal system, and connections to resources to address substance us disorders, for example.

Hawaiians), have considerable health and health-related social needs, and often have no or limited access to care and needed medications upon release from the carceral system.

Hawaiʻi currently has about 4,000 justice-involved individuals in state prisons, including almost 900 in contracted facilities in Arizona.[66] Data provided to MQD by QI health plans indicates that Native Hawaiians and Pacific Islanders are overrepresented in Hawaii's justice-involved population, with Native Hawaiians and Pacific Islanders accounting for 22.6 percent of the justice-involved population captured by QI health plan data and only 10.3 percent of the total Hawaiian population.[67, 68]

Individuals leaving incarceration are particularly at risk for poor health outcomes, with justice-involved individuals experiencing disproportionately higher rates of physical and behavioral health diagnoses than people who have never been incarcerated.[69] For example, justice-involved individuals have higher rates of hypertension, asthma, tuberculosis, HIV, Hepatitis B and C, arthritis, and sexually transmitted infections than the general population. [70] Data provided by MQD's QI health plans substantiates these national trends, showing similarly high rates of physical and behavioral health conditions among Hawaii's justice-involved population, with more than 50 percent of justice-involved Medicaid enrolled individuals having diagnoses of physical chronic illnesses, such as HIV or diabetes, and/or behavioral health diagnoses, including substance use disorders and mental health conditions.[71] Justice-involved individuals are also at higher risk for injury and death as a result of violence, overdose, and suicide. For example, studies show that 75 percent of formerly incarcerated individuals with an opioid use disorder diagnosis will relapse within three months of release.[72]

Exacerbating chronic physical and behavioral health challenges, a large proportion of justice-involved individuals reenter the community without necessary prescription medications.

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[66] The Hawaiʻi Department of Public Safety currently contracts with an out-of-state private correctional facility, the Saguaro Correctional Center in Pinal County, Arizona, which houses over 850 incarcerated individuals. These individuals are transferred back to carceral institutions in Hawaiʻi prior to their release, and as such, will receive pre-release services once they are transferred back to Hawaiʻi. "Department of Public Safety End of Month Population Report." HawaiʻI Department of Public Safety. June 30, 2023. https://dps.hawaii.gov/wp-content/uploads/2023/07/Pop-Reports-EOM-2023-06-30.pdf

[67] Data provided to MQD by United HealthCare Services, Inc., 2020.

[68] "QuickFacts: Hawaii." United States Census Bureau. July 1, 2022. https://www.census.gov/quickfacts/fact/table/HI/PST045222

[69] Binswanger, Ingrid A., Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, and Thomas D. Koepsell. "Release from Prison — A High Risk of Death for Former Inmates." *The New England Journal of Medicine* 356, no. 2 (2007): 157-165. Accessed October 12, 2023. https://doi.org/10.1056/NEJMsa064115

[70] Camhi, Natasha, Dan Mistak, and Vikki Wachino. "Medicaid's Evolving Role in Advancing the Health of People Involved in the Justice System." *The Commonwealth Fund*, (2020). https://www.commonwealthfund.org/sites/default/files/2020-11/Camhi_Medicaid_role_health_justice_system_ib.pdf

[71] Data provided to MQD by United HealthCare Services, Inc., 2020.

[72] "Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings." *Substance Abuse and Mental Health Services Administration*, (2019). https://store.samhsa.gov/sites/default/files/d7/priv/pep19-matusecjs.pdf

Analysis of existing reentry service programs nationally indicated that 31.6 percent of incarcerated individuals were released without necessary prescription medications.[73] Additionally, gaps in coverage at the time of release, including gaps in Medicaid coverage due to suspension or termination of benefits, have been associated with decreased rates of filling prescriptions and increased rates of emergency department use and hospitalization for chronic illness.[74] By providing a 30-day supply of necessary medications, including MAT, this demonstration seeks to ensure that justice-involved individuals can maintain medication adherence in the time period following release from incarceration, reducing the likelihood of emergency department or inpatient hospitalization utilization as a consequence of missed medications.

Justice-involved individuals also experience adverse social outcomes and are more likely to have been homeless in the year prior to incarceration, less likely to have been employed prior to their arrest, and more likely to report a history of physical or sexual abuse.[75] In Hawaiʻi, data provided by QI health plans indicates that over 60 percent of beneficiaries are currently or were previously homeless, with an additional 20 percent of beneficiaries having other SDOH needs, like legal and employment supports.[76] These myriad physical and behavioral health challenges experienced prior to and after incarceration, the compounding impacts from difficulties with obtaining employment and housing, and other key health-related social needs (HRSN), make effective treatment prior to release and during the period immediately following release critical for interrupting a cycle of recidivism and poor health.

Evidence suggests that improving health outcomes for incarcerated individuals requires focused, high-touch care management to assess needs and connect individuals to the services they need when released into their communities.[77] This proposed reentry demonstration package of benefits includes both in-reach case management and care coordination, in addition to a set of in-reach clinical consultation and pharmacy services to support better continuity of care and improved health outcomes upon release. Specifically, in-reach case management and care coordination facilitate access to and coordination between medical and social needs that are closely tied to health—including facilitating the connection of individuals to housing assistance, nutrition supports, and other demonstration services upon release. Additionally,

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[73] Wang, Emily A., Clemens S. Hong, Shira Shavit, Ronald Sanders, Eric Kessell, and Margot B. Kushel. "Engaging Individuals Recently Released from Prison Into Primary Care: A Randomized Trial." *American Journal of Public Health*. https://doi.org/10.2105/AJPH.2012.300894

[74] Albertson, Elaine M., Christopher Scannell, Neda Ashtari, and Elizabeth Barnert. "Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration." *American Journal of Public Health* 110, no. 3 (2020): 317-321. Accessed October 12, 2023. https://doi.org/10.2105/AJPH.2019.305400

[75] Artiga, Samantha, and Robin Rudowitz. "Health Coverage and Care for the Adult Criminal Justice-Involved Population." *KFF*, (2014). https://www.kff.org/uninsured/issue-brief/health-coverage-and-care-for-the-adult-criminal-justice-involved-population/

[76] Data provided to MQD by United HealthCare Services, Inc., 2020.

[77] "How Strengthening Health Care at Reentry Can Address Behavioral Health and Public Safety: Ohio'S Reentry Program." Community Oriented Correctional Health Services. https://cochs.org/files/medicaid/ohio-reentry.pdf

services—including physical and behavioral health clinical consultations, lab and radiology services, DME, and a minimum 30-day supply of medication—will contribute to improved health and longer-term treatment and medication adherence upon release from incarceration.

The State is requesting to provide Medicaid services for justice-involved individuals up to 90 days pre-release to build familiarity and trust with the community-based health system prior to release.[78] For example, in-reach care coordination by community-based providers can improve engagement and aid in reintegration during the post-release period. The up to 90-day window also provides necessary time pre-release for MQD and its managed care partners to coordinate with correctional agency staff, establish trusted relationships between beneficiaries and care coordination staff, enable consultations for beneficiaries with behavioral and physical health community-based providers, provide lab and radiology services to beneficiaries, identify DME and medication needs, and develop meaningful transition plans that support stabilization and continuity of services post-release. Further, since appointments with community-based providers are usually unavailable on short timelines, longer lead times are necessary to support smoother transitions of care post-release.

Hawaiʻi expects that supporting justice-involved individuals with a stable network of health care services and supports upon discharge will lead to a reduction in emergency department use, hospitalizations, and other medical expenses associated with potential relapses in drug and alcohol dependencies.[79, 80, 81] Moreover, evidence suggests that this suite of pre-release services supports improved health outcomes, including a higher likelihood of adherence to MAT

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[78] CMCS State Medicaid Director Letter #21-002. https://www.medicaid.gov/sites/default/files/2021-12/smd21002.pdf

[79] Analysis of Transition Clinic Network's (TCN) reentry services model, which has supported over 20,000 formerly incarcerated individuals in returning to the community via care coordination, clinical consultations, and peer supports, showed a 51 percent reduction in emergency department utilization and a 50 percent reduction in preventable hospitalizations in the year following release compared to patients in standard primary care. TCN's New Haven, CT location yielded $2.25 back to the state for every $1 of state investment.

[80] "Transitions Clinic Network Model." Transitions Clinic. https://transitionsclinic.org/transitions-clinic-model/

[81] "Evidence & Evaluation." Transitions Clinic. https://transitionsclinic.org/evaluation-quality-improvement/

for SUD which may serve to reduce risk of overdose or death associated with substance use.[82, 83, 84, 85]

Hawaiʻi Efforts to Support Justice-Involved Populations

Hawaiʻi has made notable strides in reducing incarceration and providing targeted reentry and rehabilitation services aimed at reducing recidivism. Hawaii's state legislature has a decade of documented actions taken to reduce incarceration, particularly among youth. In 2014, House Bill 2490 called for reducing Hawaii's youth correctional facility population by 60 percent by 2019 and redirected resources to mental health, substance use treatment, and community-based programs for youth support.[86] In 2018, the Hawaiʻi Youth Correctional Facility partnered with the Vera Institute of Justice to reduce female youth incarceration and rebranded the Youth Correctional Facility as the Kawailoa Youth and Family Wellness Center, signaling its shift from a punitive to a therapeutic model.[87] In 2022, Hawaiʻi announced that for the first time ever, there were no girls incarcerated in Hawaiʻi Youth Correctional Facility, dropping 42 percent from 2018 to 2022; additionally, Hawaiʻi announced that the total population of incarcerated youth was about 15, compared to 100 incarcerated youth in 2014 prior to these state reforms.[88]

The Hawaiʻi state legislature has made additional efforts in recent years to provide diversion, reentry, and rehabilitation services to its adult incarcerated population. In 2022, the Hawaiʻi state legislature enacted two pieces of legislation, House Bill 2309, which appropriates funds to develop and maintain diversion, reentry, and rehabilitation services and programs, and Senate Bill 3294, which appropriates funds for Huikahi Restorative Circles to help incarcerated

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[82] Evidence indicates that those starting methadone or buprenorphine while still incarcerated are more likely to remain engaged in treatment and less likely to use opioids in the year following release from incarceration. Adults with a history of or current SUD that had Medicaid were also more likely to have an outpatient visit and more likely to access SUD-related services in the 30 days following release from incarceration, compared to those without Medicaid coverage.

[83] Moore, Kelly E., Walter Roberts, Holly H. Reid, Kathryn M. Smith, Lindsay M. Oberleitner, and Sherry A. McKee. "Effectiveness of Medication Assisted Treatment for Opioid Use in Prison and Jail Settings: A Meta-analysis and Systematic Review." *Journal of Substance Use & Addiction Treatment* 99, (2019): 32-43. https://doi.org/10.1016/j.jsat.2018.12.003

[84] Gordon, Michael S., Timothy W. Kinlock, Robert P. Schwartz, Kevin E. O'Grady, Terrence T. Fitzgerald, and Frank J. Vocci. "A Randomized Clinical Trial of Buprenorphine for Prisoners: Findings at 12-months Post-release." *Drug and Alcohol Dependence* 172, no. 1 (2017): 34-42. https://doi.org/10.1016/j.drugalcdep.2016.11.03

[85] Burns, Marguerite, Steven Cook, Lars Brown, Karla Hernandez, Steve Tyska, and Ryan Westergaard. "Does Medicaid Coverage Increase Access to Health Care after Release from Prison for Adults with a History of Substance Use?" *Health Services Research* 56, no. S2 (2021): 8. https://doi.org/10.1111/1475-6773.13722

[86] House Bill 2490: Relating to Juvenile Justice. https://www.capitol.hawaii.gov/sessions/session2014/bills/HB2490_SD2_.HTM

[87] Dholakia, Nazish, and Lindsay Rosenthal. "Hawai`i Is So Close to Ending the Incarceration of Young Girls." *Vera*, October 4, 2022. https://www.vera.org/news/hawai-i-is-so-close-to-ending-the-incarceration-of-young-girls

[88] Solina, Samie. "For the First Time, There Are No Girls Incarcerated at Hawaii Youth Correctional Facility." *Hawaii News Now*, June 20, 2022. https://www.hawaiinewsnow.com/2022/06/21/first-time-there-are-no-girls-incarcerated-hawaii-youth-correctional-facility/

individuals develop support systems and transition plans prior to release from incarceration.[89, 90, 91] This decade of state-level reforms resulted in reductions in Hawaii's overall incarcerated population, decreasing by 30 percent from 2014 to 2021, while the number of newly incarcerated persons under jurisdiction of state or federal correctional facilities decreased by 39 percent over that same time period.[92, 93]

Further, this demonstration proposal builds on legislative and administrative initiatives already implemented in Hawaiʻi that are focused on ensuring continuity of coverage through Medicaid pre-release enrollment and suspension strategies. In 2018, Hawaiʻi passed House Bill 2144, requiring that Medicaid eligible and enrolled individuals entering a public institution, such as a state correctional facility, shall have their Medicaid benefits permanently suspended, rather than terminated, so long as other eligibility criteria are met. [94] In accordance with state legislation and CMS SHO #23-004, all justice-involved Medicaid-enrolled beneficiaries, including children, will have their Medicaid eligibility suspended rather than terminated upon incarceration.[95] This demonstration proposal also aligns with MQD's 2020-2030 Social Determinants of Health (SDOH) Transformation Plan, which calls for building stronger networks of community-based resources to address health-related social needs and implementing enhanced screening and referral processes to connect individuals to these resources.[96]

Hawaii's approach to serving justice-involved individuals is aligned with federal priorities. In October 2018, Congress passed the SUPPORT Act, which created a new opportunity for states to leverage 1115 demonstration authority to provide Medicaid coverage in the days pre-release. [97] Section 5032 of the SUPPORT Act required the U.S. Department of Health & Human Services to issue a state Medicaid director letter regarding opportunities to design Section 1115 demonstration projects that allow for Medicaid coverage for justice-involved individuals pre-release. Consistent with the SUPPORT Act, state Medicaid Director Letter #21-002, and recently approved demonstrations in California and Washington, Hawaiʻi is seeking authority to develop

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[89] House Bill 2309: Relating to Incarceration. https://www.capitol.hawaii.gov/sessions/session2022/bills/HB2309_.HTM

[90] Senate Bill 3294: Relating to Reentry Planning Circles. https://www.capitol.hawaii.gov/sessions/session2022/bills/SB3294_.HTM

[91] Walker, Lorenn, and Rebecca Greening. "Huikahi Restorative Circles: A Public Health Approach for Reentry Planning." *Federal Probation Journal 74*, no. 1 (2010). Accessed October 12, 2023. https://www.uscourts.gov/federal-probation-journal/2010/06/huikahi-restorative-circles-public-health-approach-reentry

[92] Carson, E. A., "Prisoners in 2014 – Statistical Tables," *Bureau of Justice Statistics*, September 2015. Available at https://bjs.ojp.gov/content/pub/pdf/p14.pdf

[93] Carson, E. A., "Prisoners in 2021 – Statistical Tables," *Bureau of Justice Statistics*, December 2022. Available at https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/p21st.pdf

[94] House Bill 2144: Related to Medicaid. https://www.capitol.hawaii.gov/sessions/session2018/bills/HB2144_.HTM

[95] CMS State Health Official Letter #23-004. https://www.medicaid.gov/sites/default/files/2023-09/sho23004.pdf

[96] MQD's 2020-2030 Social Determinants of Health (SDOH) Transformational Plan has not yet been published. A publicly accessible version of this SDOH Transformational Plan is forthcoming.

[97] Public Law No: 115-271: SUPPORT for Patients and communities act. https://www.congress.gov/bill/115th-congress/house-bill/6/text

an innovative demonstration program that will enable justice-involved adults and youth to receive necessary coverage and health care services pre- and post-release. [78, 98, 99]

In addition to actions taken by the Congress and the Hawaiʻi state legislature to support justice-involved individuals, collaborative efforts between MQD, community-based organizations, and the Hawaiʻi Department of Public Safety (DPS) demonstrate Hawaii's ongoing commitment to supporting individuals upon their release from incarceration. Community-based organizations in Hawaiʻi currently hold informational sessions for justice-involved individuals in the 60-90 days prior to their release to provide education on and assistance with accessing social services and benefits upon release, such as Medicaid and Supplemental Nutrition Assistance Program (SNAP). MQD's Health Care Outreach Branch additionally coordinates with probations, parole, the courts, and the Reentry Coordination Branch of DPS to identify release dates of Medicaid-eligible or Medicaid-suspended individuals and assist in connecting them to critical health and social supports upon their release. This 1115 Demonstration builds upon existing efforts by MQD and its partners to support justice-involved individuals by allowing Medicaid enrollment and the delivery of targeted pre-release services in the 90 days prior to release, in addition to ongoing education and outreach efforts.

Eligibility for Services

This demonstration proposal will provide limited Medicaid benefits during the 90-day period before an eligible individual's release from incarceration (or fewer days for people who may be released from incarceration earlier). Eligible individuals are adults and children who meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a state prison, local jail, or youth correctional facility, regardless of trial status; and
b. Be enrolled in Medicaid or CHIP or otherwise eligible for Medicaid or CHIP if not for their incarceration status.

Scope of Services and Cost Sharing

In the up to 90-day period prior to release from a State prison, local jail, and/or youth correctional facility, eligible Medicaid enrolled justice-involved individuals will receive, as clinically appropriate:

- Case management and care coordination;
- Physical and behavioral health clinical consultation services provided by carceral or in-reach community-based providers;

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[98] "CalAIM Demonstration Approval." Centers for Medicare & Medicaid Services. January 26, 2023. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf

[99] "Washington State Medicaid Transformation Project 2.0 Demonstration Approval." Centers for Medicare & Medicaid Services. June 30, 2023. https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf

- Laboratory and radiology services;
- Durable Medical Equipment (DME) for use post-release into the community; and
- A 30-day supply of medications, including MAT, for use post-release into the community.

In line with federal guidance, authority for and implementation of these services do not absolve carceral authorities of their constitutional obligation to ensure needed healthcare is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a federal, state, or local carceral authority to the Medicaid program.

The scope of in-reach care management will include a variety of services, including but not limited to: conducting an initial care needs assessment, developing transition plans, making referrals for community-based Medicaid services (including HRSN benefits, such as nutrition supports) and other social services, developing medication management plans in consultation with clinical providers, and other coordination and management supports. Further, this benefit aims to support individuals as they navigate reentry into the community by providing culturally and linguistically appropriate care and education to individuals, families, caretakers, and other circles of support regarding the beneficiary's health care needs and available services.

The care management benefit will be delivered by QI health plans or their contracted care management providers with expertise in working with justice-involved individuals, including peers with lived experience. Delivery of services during the up to 90 days pre-release will require close coordination with state prisons, local jails, and youth correctional facilities to identify and refer beneficiaries and ensure connections to care once individuals are released from incarceration. No cost sharing shall be applied during the up to 90 days pre-release. Following release, the full range of medically necessary services under Medicaid, including ongoing care management, will be delivered by QI health plans and their contracted community providers.

Additionally, capped non-service funding is requested to support the operationalization and implementation of pre-release services. Non-service expenditures include allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure, and other interventions.

Objectives

This demonstration aims to address the health care needs of Hawaii's justice-involved population, advance the State's health equity priorities, and, as reflected in corresponding hypotheses in subsequent sections, promote the objectives of the Medicaid program by ensuring justice-involved individuals—a population at high risk for physical health, behavioral health, and social challenges—receive needed Medicaid coverage and health and health-related social services pre- and post-release into the community. Specifically, Hawaiʻi aims to:

- Increase collaboration between stakeholders (e.g., QI health plans, MQD, and the State's Public Safety Division);
- Identify unaddressed medical and health-related social needs prior to release;
- Gradually expand access to pre-release services for justice-involved individuals;
- Improve insights into healthcare delivery for this population; and
- Promote continuity of targeted health services upon release to the community, resulting in positive impacts on health outcomes.

The State will monitor and evaluate the provision of pre-release services to assess progress against the above desired outcomes.

Demonstration Implementation

Hawaiʻi is seeking to implement Medicaid coverage up to 90 days pre-release beginning in 2026 and following approval by CMS, with the assumption that there will be a ramp up of individuals receiving services over the course of the demonstration. Due to ongoing challenges with Hawaii's limited MAT provider network, Hawaiʻi has a MAT Services exemption effective until September 30, 2025. As such, Hawaiʻi may seek authority to initiate pre-release services as a pilot program on the three largest islands with the most extensive MAT provider networks: Oahu, Maui, and Hawaiʻi islands. Statewide implementation will follow completion of a successful pilot and as Hawaiʻi continues working to build and expand its MAT provider network on additional islands.

3.8 Nutrition Supports

Hawaiʻi is seeking new authority for the provision of nutrition supports benefits described below.

Request

Hawaiʻi is requesting approval for federal Medicaid matching funds for the provision of nutritional supports for eligible Medicaid-enrolled individuals. These nutrition supports include, but are not limited to, nutrition counseling and education, fruit and vegetable prescriptions and/or protein boxes, meals or pantry restocking, and medically tailored meals or groceries (MTM). Authority to cover these services is requested for individuals meeting certain medical appropriateness and social needs criteria.

Overview of Nutrition Support Provisions

The provision of nutrition supports within Medicaid has gained significant traction in recent years, with robust federal guidance and notable Section 1115 Demonstration approvals in states like Massachusetts and Oregon. This coordinated effort to integrate nutrition supports within Medicaid represents a recognition of the critical impact nutrition has on overall health, disease management, and well-being. Further, it follows the shift towards addressing broader social drivers of health as an essential component of comprehensive healthcare, particularly for vulnerable and underserved populations, to achieve better outcomes and cost-effectiveness. Alongside existing nutrition support programs and resources, leveraging Medicaid to identify and support individuals lacking adequate nutrition will help Hawaiʻi advance its policy goals, including improving health outcomes and reducing health care costs.

A growing body of research finds that nutritional support programs are associated with improvements in health and a reduction in health care costs.[100, 101] By addressing nutritional deficiencies and chronic conditions early, the need for costly medical interventions and hospitalizations may be reduced, ultimately lowering health care expenditures.[102] As a result, nutrition support programs are projected to result in long-term cost savings, as evidenced by a recent study found that increased adoption of nutritional supports nationally could prevent more than 18 million hospitalizations and result in more than $185 billion in savings.[103] Preliminary experience from Massachusetts' 1115 demonstration similarly supports these findings, with substantial reductions in total cost of care and emergency department visits.[104]

In addition to alignment with federal priorities and trends, this proposal aligns with Hawaii's SDOH transformation plan and commitment to addressing health disparities. In Hawaiʻi, families with children and individuals from marginalized ethnic and racial minority populations experience disproportionately high rates of food insecurity. Data from Feeding America show that individuals from racial or ethnic minority populations in Hawaiʻi, including Black, Latino, Native American, and Pacific Islander, experience food insecurity at more than double the rate of non-Hispanic Whites.[105] Moreover, more than 1 in 6 children in Hawaiʻi experiences food insecurity—one of the highest rates nationwide.[106] This data is supported by survey results from the Center for Medicare and Medicaid Innovation (CMMI) Accountable Health Communities project, which found that the most commonly reported HRSN among respondents

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[100] Hall, Cornelia, Samantha Artiga, Kendal Orgera, and Rachel Garfield. "Food Insecurity and Health: Addressing Food Needs for Medicaid Enrollees as Part of Covid-19 Response Efforts - Issue Brief." *KFF*, August 14, 2020. https://www.kff.org/report-section/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts-issue-brief/

[101] Feinberg, Andrea T., Allison Hess, Michelle Passaretti, Stacy Coolbaugh, and Thomas H. Lee. "Prescribing Food as a Specialty Drug." *NEJM Catalyst,* (April 18, 2018). https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0212

[102] Harline-Grafton, Heather, and Olivia Dean. "The Impact of Poverty, Food Insecurity, and Poor Nutrition on Health and Well-Being." Food Research & Action Center, December 2017. https://frac.org/wp-content/uploads/hunger-health-impact-poverty-food-insecurity-health-well-being.pdf

[103] Hager Kurt, Frederick P. Cudhea, John B. Wong, Seth A. Berkowitz, Sarah Downer, Brianna N. Lauren, and Dariush Mozaffarian. "Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US." *JAMA Netw Open* 5*,* no. 10 (2022). https://doi.org/10.1001/jamanetworkopen.2022.36898

[104] "Section 1115 Demonstration Extension Request." Massachusetts Office of Health and Human Services. August 18, 2021. https://www.mass.gov/doc/1115-demonstration-extension-request/download

[105] Oliver, DT, and Lauren Lapinski. "Identifying Racism in the Drivers of Food Insecurity." Feeding America Research, May 13, 2021. https://public.tableau.com/app/profile/feeding.america.research/viz/IdentifyingRacismintheDriversofFoodInsecurity/Introductionv2?publish=yes

[106] "Food Insecurity among Child (>18 years) Population in the United States." Feeding America Research, May 3, 2023. https://map.feedingamerica.org/county/2021/child/hawaii

in Hawaiʻi was food, with Black and Native Hawaiian individuals and children reporting the highest levels of need.[107]

Hawaiʻi proposes offering four types of nutrition supports using 1115 authority—nutrition education, fruit and vegetable prescriptions and/or protein boxes, meals or pantry restocking, and MTM—in addition to the nutrition counseling services already authorized through Hawaii's State Plan. In line with federal guidance for Medicaid programs to complement existing social programs and nutrition resources, most individuals who screen positive for food insecurity will receive only a referral to the SNAP and or Women, Infants, and Children (WIC) programs; and local food banks and other non-Medicaid programs. The proposed nutrition supports within this demonstration are intended to support individuals with medically and socially appropriate needs for whom a simple referral is inadequate. For example, individuals with unique health or clinical needs may not be adequately supported by nutrition supports offered by other programs, like SNAP or WIC. Further, data from Feeding America suggests that more than half of residents of Hawaiʻi with nutrition support needs are ineligible for other nutrition programs, rendering referrals ineffective in addressing food insecurity.[108]

Eligibility for Nutrition Supports

Hawaiʻi proposes offering nutrition supports to eligible Medicaid enrolled individuals who cannot otherwise obtain the needed supports through existing discretionary or entitlement programs. Prior to accessing nutrition support services, beneficiaries must be recommended nutritional supports by a provider or their health care team and assessed for eligibility by a qualified Medicaid provider with knowledge of the principles, methods, and procedures of the services included under nutritional supports. Beneficiary eligibility will be reassessed every six months. To obtain nutrition supports, beneficiaries must demonstrate certain medical and social needs, with eligibility criteria varying by service type.

Medical appropriateness for nutrition supports is defined the presence of at least one of the following:

- Chronic disease in which dietary adjustment has a therapeutic role, such as eating disorders, severe food allergies, gastrointestinal disorders, and other conditions;
- Prescription regimens requiring dietary adjustment to prevent drug-nutrient interactions;
- Acute illness with elevated nutritional needs;
- Discharge from a hospital or skilled nursing facility (or at risk for needing hospitalization or nursing facility placement);
- Extensive care coordination needs;

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[107] "Accountable Health Communities Hawaii Project: Final Report Insights for October 2018 – April 2022." UnitedHealthcare, April 2022.

[108] "Food Insecurity among Overall (all ages) Population in the United States." Feeding America Research, May 3, 2023. https://map.feedingamerica.org/county/2021/overall/hawaii

- Obese (Body Mass Index (BMI) 30+); and
- Overweight (BMI 25+) with an additional cardiovascular risk factor such as hypertension, coronary artery disease, type 2 diabetes, dyslipidemia, or other risk factors.

Health related social need (HRSN) for nutrition supports is defined the presence of at least one of the following:

- Lack of access to transportation;
- Food insecurity;
- Financial insecurity;
- Lack of access to utilities;
- Housing insecurity;
- Experiencing interpersonal violence; and
- Presence of caregiver support and/or the patient's extent of ambulation and limitations of activities of daily living.

Major life transitions for nutritional supports are defined by the presence of at least one of the following:

- Children aging out of foster care;
- Postpartum individuals within one year of labor and delivery;
- Individuals leaving institutional settings such as institutional care, adult or juvenile detention, and congregate care settings;
- Individuals at-risk for or experiencing homelessness; and
- Adults transitioning to dual enrollment in both Medicaid and Medicare.

Table 6. Proposed Nutrition Support Service Eligibility Criteria.

Service	Eligibility Criteria
Nutrition Education	An individual qualifies if they meet one of the following criteria: • Have a medically appropriate need for nutrition supports; or • Are experiencing a major life transition; or • Have a qualifying HRSN.
Fruit and Vegetable Prescriptions/ Protein Boxes	An individual qualifies if they meet both of the following criteria: • Have a medically appropriate need for nutrition supports; or • Are experiencing a major life transition; or • Have a qualifying HRSN.
Meals or Pantry Restocking	An individual qualifies if they meet either of the following criteria: • Are experiencing a major life transition; or • Are a child under 21 or pregnant woman with a qualifying HRSN.
Medically Tailored Meals (MTM)	An individual qualifies if they meet both of the following criteria: • Have a medically appropriate need for MTM; and

	• Are experiencing a major life transition; or • Have a qualifying HRSN.

Scope of Services, Provider Eligibility, and Cost Sharing

As noted, Hawaiʻi proposes offering four types of nutrition supports using 1115 authority—nutrition education, fruit and vegetable prescriptions and/or protein boxes, meals or pantry restocking, and MTM—in addition to the nutrition counseling services already authorized through Hawaii's State Plan. These services shall supplement and not supplant services received by the Medicaid beneficiary through other State, local, or federally funded programs, in accordance with federal guidance.

Each benefit will be available separately but may be combined for a given individual when appropriate and allowable. Since several nutrition supports benefits as well as ʻai pono benefits (discussed under Section 3.9 Native Hawaiian Traditional Healing Practices) may be leveraged to provide for the nutritional needs for the patient, Hawaiʻi proposes to allow qualifying individuals to receive any combination of benefits that when administered simultaneously do not exceed the full daily nutritional needs of the individual (e.g., maximum of 3 meals per day or equivalent pantry restocking/vouchers, etc.). Where multiple nutrition supports are appropriate and allowable, Hawaiʻi will encourage, but not require services to be bundled.

No cost sharing shall be applied to individuals for nutrition supports.

Nutrition Education

Nutritional education teaches people about nutrition and nutrition-related concepts, such as food preparation, reading food labels, budgeting for meals, navigating grocery stores and farmer's markets, gardening, and other topics to support access to healthy foods. When appropriate, this service may also include a one-time provision of cooking supplies required for food preparation (e.g., pots, pans, a blender, and other necessary supplies) and/or gardening supplies (e.g., gloves, shovel, seedlings, and other necessary supplies).

Individuals may receive one course with up to 12 sessions per six-month period. Eligibility will be reassessed every six months by a qualified Medicaid provider with knowledge of the principles, methods, and procedures of the services included under nutritional supports.

Hawaiʻi will allow the following individuals or organizations to deliver nutrition education services either in-person or via telehealth:

- Registered dieticians or registered dieticians;
- Health care facilities, such as Federally Qualified Health Centers (FQHCs) and hospitals;
- Educational institutions, such as community colleges;
- Existing nutrition management programs, such as Diabetes Self-Management Education and Support (DSME), Diabetes Prevention Program (DPP) programs, and other chronic disease prevention and self-management programs;

- Other community-based organizations and food pharmacies, which may also be located within one of these organizations; and
- QI health plans.

Fruit and Vegetable Prescription/Protein Box

Fruit and vegetable prescriptions and protein boxes provide fruits, vegetables, supplies to grow fruits and vegetables, and proteins through any combination of vouchers, cash-back rebates, and direct provision (e.g., subsidized food boxes, garden-based deliveries, etc.). These prescriptions and boxes may be delivered, accessed at the organization site, or offered through other arrangements. This service is not intended to cover all costs of all meals, but rather to support a beneficiary in increasing their consumption of healthy foods. Further, this benefit may be used to supplement and augment the nutritional value of any other benefit that fully meets an individual's nutritional needs.

Individuals may receive this benefit for up to six months. Eligibility will be reassessed every six months by a qualified Medicaid provider with knowledge of the principles, methods, and procedures of the services included under nutritional supports.

Hawai'i will allow the following organizations to deliver fruit and vegetable prescription and protein box services. Hawai'i will encourage the inclusion of local growers, community gardens, and other community-based organizations to support the purchase of locally grown food and strengthen Hawaii's intrinsic food system.

- Meal delivery services;
- Grocery store and grocery delivery services;
- Farms and Farmers markets;
- Community gardens and seedling stores;
- Food "hubs" and distributors that contract with local farms;
- Health care providers, such as FQHCs and hospitals;
- Educational institutions, such as community colleges;
- QI health plans; and
- Other community-based organizations and food pharmacies, which may also be located within one of these organizations.

Meals or Pantry Restocking

Meals or pantry restocking services provide healthy meals or groceries, supplies to grow fruits and vegetables, and a one-time provision of cooking or gardening supplies, as needed, to provide adequate food for an individual for up to three meals per day, seven days per week. Meals and pantry restocking may be provided through any combination of vouchers, cash-back rebates, and direct provision (e.g., pre-made meal delivery) and may be accessed via delivery, at the provider site, or through other arrangements.

Eligibility will be reassessed every six months by a qualified Medicaid provider with knowledge of the principles, methods, and procedures of the services included under nutritional supports.

Hawaiʻi will allow the following organization types to deliver meals or pantry restocking services. Hawaiʻi will encourage the inclusion of local growers, community gardens, and other community-based organizations to support the purchase of locally grown food and strengthen Hawaii's intrinsic food system.

- Meal delivery services;
- Grocery store and grocery delivery services;
- Farms and farmers markets;
- Community gardens and seedling stores;
- Food "hubs" and distributors that contract with local farms;
- QI health plans;
- Health care providers, such as FQHCs and hospitals;
- Educational institutions, such as community colleges; and
- Other community-based organizations and food pharmacies, which may also be located within one of these organizations.

Medically Tailored Meals and Groceries (MTM)
MTM provides either pre-made meals or the provision of groceries and cooking supplies, as needed, to support a beneficiary in adhering to a meal plan that is tailored to their medical needs based on a comprehensive nutritional assessment of the patient. MTMs are intended to provide adequate food for an individual for up to three meals per day, seven days per week.

A pre-requisite for the provision of MTM is the development of a medically tailored meal plan (MTMP), which is developed by a registered dietician or registered dietary technician through the nutritional counseling benefit authorized in Hawaii's State Plan. The MTMP should reflect appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.

Eligibility will be reassessed every six months by a qualified Medicaid provider with knowledge of the principles, methods, and procedures of the services included under nutritional supports.

Hawaiʻi will allow the following organization types to deliver MTM services. Hawaiʻi will encourage the inclusion of local growers, community gardens, and other community-based organizations to support the purchase of locally grown food and strengthen Hawaii's intrinsic food system.

- Meal delivery services;
- Grocery store and grocery delivery services;
- Farms and farmers markets;
- Food "hubs" and distributors that contract with local farms;

- QI health plans;
- Health care providers, such as FQHCs and hospitals; and
- Other community-based organizations and food pharmacies, which may also be located within one of these organizations

Objectives

Through the provision of Nutrition Supports, Hawaiʻi aims to:

- Increase collaboration between stakeholders (e.g., QI health plans, SNAP program, MQD, and providers of nutrition support services);
- Gradually expand access to nutrition support services for qualifying individuals;
- Improve the infrastructure for the provision of nutrition support services;
- Reduce food insecurity; and
- Improve disease management for participating individuals.

The State will monitor and evaluate the provision of Nutrition Supports to assess progress against the above desired outcomes.

Demonstration Implementation

The State will monitor, evaluate, and make changes to these initiatives over time. Prior to the launch of nutrition supports, the State will support infrastructure and network building. The State may elect to establish a limited pilot program or implement nutrition supports using a phased approach so that program policy and operational details may be refined based on early learnings. Hawaiʻi is seeking to implement the nutritional supports services following approval by CMS and as soon as operational and technical infrastructures allow.

3.9 Native Hawaiian Traditional Healing Practices

Hawaiʻi is seeking new authorization for the provision of Native Hawaiian traditional healing practices described below.

Request

Hawaiʻi is requesting approval for federal Medicaid matching funds for the provision of Native Hawaiian Traditional Healing Practices for eligible Medicaid-enrolled individuals. Native Hawaiian Traditional Healing Practices to be covered by this demonstration include:

- Lomilomi: Native Hawaiian Traditional Healing Practice of physiotherapy and massage;
- Hula: Native Hawaiian form of dance, offering physical movement classes that seek to improve health through physical activity, mindfulness practices, and social interaction;
- Hoʻoponopono: Native Hawaiian Traditional Healing Practice of peacemaking, intended to restore and maintain healthy relationships;[109]

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[109] Kaulukukui, C. M., and Lorenn Walker. "Comparison of Native Hawaiian Traditional Ho'oponopono and Modern Restorative Justice Practices." *Comparative Restorative Justice,* (September 21, 2021). https://link.springer.com/chapter/10.1007/978-3-030-74874-6_15

- ʻAi pono: Native Hawaiian Traditional Healing Practice of holistic nutrition therapy;
- Lāʻau lapaʻau: Native Hawaiian Traditional herbalist healing practice; and
- Hāpai hānau (pale keiki): Native Hawaiian Traditional midwifery practices.

Authority to cover Native Hawaiian Traditional Healing Practices is requested for individuals meeting certain medical appropriateness and social needs criteria and is not limited to those identifying as Native Hawaiian. Native Hawaiian Traditional Healing Practices will be delivered by Native Hawaiian Healing Providers who are practitioners recognized by any council of kupuna convened by Papa Ola Lōkahi, a nonprofit organization charged by the Hawaiʻi state legislature to promote Native Hawaiian Health and to train and certify Native Hawaiian Traditional Healers.[110] This definition of eligible providers aligns with Hawaiʻi state law relating to Traditional Hawaiian Healing Practices, which defines Native Hawaiian Traditional Healers as those both recognized and certified as such by any council of kupuna convened by Papa Ola Lōkahi.[111]

Overview of Traditional Healing Practices

Background

Significant proportions of Native Hawaiians and other Pacific Islanders live in Hawaiʻi. While Hawaiʻi is one of the healthiest states in the United States with the longest life expectancy in the country, aggregate statistics hide profound disparities in health outcomes and access to care, particularly relating to culturally relevant care.[112]

Native Hawaiians and other Pacific Islanders (which includes Samoan, Guamanian/Chamorro, Fijian, Tongan, Micronesian, Chuukese, and Marshallese identity) have some of the highest rates of diagnosed chronic conditions both nationally and in the state of Hawaiʻi.[113] Compared to overall rates in Hawaiʻi, Native Hawaiians have higher rates of diagnosed asthma, diabetes, hypertension, cancer, heart disease, and lung disease, and further, 44.4 percent of Native Hawaiian adults are considered obese, compared to 23.6 percent of the state population.[114] Moreover, these racial and ethnic minority populations experience higher preventable

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[110] "Our Kuleana." Papa Ola Lōkahi. https://www.papaolalokahi.org/kuleana

[111] SB 1285: A Bill for an Act Relating to Traditional Hawaiian Healing Practices. https://www.capitol.hawaii.gov/slh/Years/SLH2005/SLH2005_Act153.pdf

[112] Life Expectancy at Birth by State." Centers for Disease Control and Prevention*,* August 24, 2022. https://www.cdc.gov/nchs/pressroom/sosmap/life_expectancy/life_expectancy.htm

[113] "Profile: Native Hawaiians/Pacific Islanders." US Department of Health and Human Services Office of Minority Health*,* February 24, 2023. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=65

[114] "2015 Native Hawaiian Health Fact Sheet." Office of Hawaiian Affairs*,* 2015. https://www.oha.org/wp-content/uploads/Volume-I-Chronic-Diseases-FINAL.pdf

hospitalization rates for diabetes and heart disease, preventable readmissions, hospitalization costs, mortality, and severity of illness.[115]

Native Hawaiians and other Pacific Islander populations also experience disproportionate behavioral and mental health disease burdens, including stress and depression, which adds to chronic disease burden. Data shows high rates of depression, anxiety, family adversity, substance use, adverse childhood events, and distress for Native Hawaiians, with the highest overall suicide rate compared to all of Hawaii's major ethnic groups.[116] While Native Hawaiians and Pacific Islanders are overrepresented in many mental health-related statistics, these populations tend to underutilize existing mental health services, seek therapy only after their illness has become severe, or leave treatment prematurely.[117] These racial and ethnic minority populations also experience disproportionate disability disease burden, with a higher risk for disability compared to many other racial and ethnic groups.[118, 119]

Beyond addressing the needs of populations experiencing disparate rates of these aforementioned health conditions, Hawaiʻi understands the critical need for culturally relevant and medically appropriate health services that prevent and mitigate the risk of future physical and behavioral health conditions. Often, these health services can also improve the control and management of chronic conditions as well. In Hawaiʻi, only 25 percent of adults meet national physical activity guidelines.[120, 121] Physical inactivity is a risk factor for chronic diseases, including obesity, diabetes, and cancer, and is the fourth-leading risk factor for mortality worldwide, decreasing life expectancy.[122] These risks are preventable, as physical activity reduces disease burden and morbidity risk factors by improving physiological and psychological

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[115] Sentell, Tetine L., Hyeong Jun Ahn, Deborah T. Juarez, Chien-Wen Tseng, John J. Chen, Florentina R. Salvail, Jill Miyamura, and Marjorie L. M. Mau. "Comparison of Potentially Preventable Hospitalizations Related to Diabetes Among Native Hawaiian, Chinese, Filipino, and Japanese Elderly Compared with Whites, Hawaiʻi, December 2006–December 2010." *Prev Chronic Disease,* (2013). http://dx.doi.org/10.5888/pcd10.120340

[116] Look, Mele A., Shelley Soong, and J. K. Kaholokula. "Assessment and Priorities for the Health and Well-Being in Native Hawaiians and Pacific Islanders," *Department of Native Hawaiian Healthi, John A. Burns School of Medicine,* 2020. https://www.hawaii.edu/aging/phac/wp-content/uploads/2021/06/2020_NHOPI_Assessment_and_Priority_Rpt.pdf

[117] "Mental and Behavioral Health – Native Hawaiian/Pacific Islanders," US Department of Health and Human Services Office of Minority Health, May 20, 2021. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=172

[118] Seto, Jason, James Davis, and Deborah A. Taira "Examining the Association Between Different Aspects of Socioeconomic Status, Race, and Disability in Hawaii." *J Racial Ethn Health Disparities* 5, no 6 (2018). https://doi.org/10.1007/s40615-018-0471-4

[119] Taira, Deborah. "Examining Disability Rates for Native Hawaiian, Pacific Islander, and Asian American Subgroups," *APHA*, 2022. https://apha.confex.com/apha/2022/meetingapp.cgi/Paper/513763

[120] An, Ruopeng, Xiaoling Xiang, Yan Yang, and Hai Yan. "Mapping the Prevalence of Physical Inactivity in U.S. States, 1984-2015." *PLoS One,* (2016). https://doi.org/10.1371/journal.pone.0168175

[121] "Query Result - Hawaii's Behavioral Risk Factor Surveillance System (BRFSS) Data - Physical activity - Met Aerobic and Strengthening Recommendations, Age Adjusted." Hawaiʻi Health Data Warehouse, 2023. https://hhdw.org/report/query/result/brfss/RecPhysicalAct/RecPhysicalActAA11_.html

[122] "Explore Physical Inactivity in the United States: 2020 Annual Report." America's Health Rankings, 2021. https://www.americashealthrankings.org/explore/annual/measure/Sedentary/state/ALL

well-being as well as quality of life.[123] Qualitative data shows that culturally relevant physical activity practices have multifaceted impacts on health and well-being for Native Hawaiians and other populations in the state of Hawaiʻi, extending past intrapersonal characteristics to proximal connections, distal connections, structural environmental factors, macro-social factors, and spiritual factors.[124, 125]

Childbirth is the most common reason women are hospitalized in the US, with childbirth hospitalizations representing a major expense for public and private insurers at a total cost of over $15 billion a year.[126] Medicaid cares for a high proportion of total births in the state of Hawaiʻi. Despite their high costs, U.S. maternal and child outcomes are worse than most other developed countries across such critical factors as maternal and infant mortality and low birth weight, and outcomes are notably unequal by race and ethnicity. For instance, Native Hawaiians have high rates of preterm delivery, and macrosomia is higher in Pacific Islander birthing parents.[126] In recent studies, other Pacific Islander populations also had significantly higher percentages of complicated births overall compared to white residents of Hawaiʻi for reasons that may be linked, in part, to limited access to culturally or linguistically relevant care.[127]

Incorporating Native Hawaiian Traditional Healing Practices as Medicaid Reimbursable Practices
Studies have documented that Western medical approaches to health, wellness, and treatment of chronic diseases and behavioral health conditions may not be consistent with the full, rich perspectives of healing for Native Hawaiian and Pacific Islander populations.[128] Native Hawaiian and Pacific Islander communities strongly prefer healing practices, exercise programs, and lifestyles that are culturally grounded, spiritually aligned, and adherent to their values and beliefs.[129] The provision of traditional healing options offers alternatives to those who are

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[123] Reed, Paul. "Physical Activity is Good for the Mind and the Body." Office of Disease Prevention and Health Promotion, December 15, 2021. https://health.gov/news/202112/physical-activity-good-mind-and-body

[124] Schmid, S., Finn, J., Philipps, M., Thompson, M., et al., "OUTRIGGER CANOE PADDLING: Culturally-Relevant Physical Activity for the People of Hawaiʻi," Poster at Biomedical Symposium JABSOM Hawaii, 2023.

[125] Look, Mele. A., Gregory G. Maskarinec, Mapuana de Silva, Todd Seto, Marjorie L. Mau, and Joseph K. Kaholokula. "Kumu Hula Perspectives on Health." *Hawaii J Med Public Health* 73, suppl. 3 (2014). http://www.ncbi.nlm.nih.gov/pmc/articles/pmc4271348/

[126] Sentell, Tetine, Ann Chang, Yongjun Cheng, and Jill Miyamura. "Maternal quality and safety outcomes for Asians and Pacific Islanders in Hawaiʻi: an observational study from five years of statewide data." *BMC Pregnancy Childbirth* 14, no. 298 (2014). https://doi.org/10.1186/1471-2393-14-298

[127] Delafield, Rebecca, Jennifer Elia, and Catherine M. Pirkle. "Perspectives and Experiences of Obstetricians Who Provide Labor and Delivery Care for Micronesian Women in Hawaiʻi: What Is Driving Cesarean Delivery Rates?." *Qualitative Health Research* 30, no. 14 (2020). https://doi.org/10.1177/1049732320942484

[128] Kawakami, Keilyn. L., Shelley Muneoka, Rachel L. Burrage, Leslie Tanoue, Kilohana Haitsuka, and Kathryn L. Braun. "The Lives of Native Hawaiian Elders and Their Experiences with Healthcare: A Qualitative Analysis." *Front. Public Health* 10 (2022). https://www.frontiersin.org/articles/10.3389/fpubh.2022.787215

[129] Walters, Karina L., Michelle Johnson-Jennings, M, Sandra Stroud, Stacy Rasmus, Billy Charles, Simeon John, James Allen, et al. "Growing from Our Roots: Strategies for Developing Culturally Grounded Health Promotion Interventions in American Indian, Alaska Native, and Native Hawaiian Communities." *Prev Sci* 2020, suppl. 1 (2020). https://doi.org/10.1007/s11121-018-0952-z

hesitant to use or do not get their needs met within the Western medicine system.[130] For instance, distrust of Western medicine has been seen as a reason to use lāʻau lapaʻau (a Native Hawaiian healing practice that uses native plants, herbs, and spirituality to treat ailments and injuries) instead of Western medicine.[131]

Native Hawaiians and Pacific Islanders have traditional health and healing practices that have existed for over 2,000 years. These practices were often challenged and suppressed following European contact but are now formally recognized as deeply valuable practices and cultural assets. For instance, both Federal and State legislation acknowledge the significance of traditional Hawaiian health arts (e.g., Native Hawaiian Health Care Act of 1988 and Native Hawaiian Healthcare Improvement Act 1992).[132]

For many across in Hawaiʻi, there are significant gaps in access to healthcare, even among those who are insured. This can include supply challenges, including a shortage of clinicians, especially those with underrepresented racial and ethnic backgrounds, that are concordant with patient populations and/or have adequate cultural competency. There are also language barriers to accessing care, as well as possible stigmatization and negative cultural conceptualization of behavioral health.

Native Hawaiian Healing Practices, when provided as viable treatment options, become an important treatment modality not just for Native Hawaiians and other Pacific Islanders, but also for all populations in Hawaiʻi, and in particular for populations with high health disparities who have less access to or trust in Western healthcare.[133] Reducing barriers to accessing these practices, such as cost, can have profound impacts on access to care, health, and wellbeing.

Therefore, the provision of Native Hawaiian Healing Practices (lomilomi, hula, hoʻoponopono, ʻai pono, lāʻau lapaʻau, and hāpai hānau) as Medicaid-covered benefits is an important strategy to improve health outcomes across the State and reduce health inequities for populations that are drawn to these practices and more likely to adopt and utilize them to improve their health

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[130] Sentell, Tetine L., Todd B. Seto, Michelle L. Quensell, Jhon M. Malabed, Mary Guo, May D. Vawer, Kathryn L. Braun, Deborah A. Taira. "Insights in Public Health: Outpatient Care Gaps for Patients Hospitalized with Ambulatory Care Sensitive Conditions in Hawai'i: Beyond Access and Continuity of Care." *Hawaii J Health Soc Welf* 79, no.3, March 2020. https://europepmc.org/article/PMC/PMC7061028

[131] Young, Natalie, and Kathryn L. Braun. "Lā'au lapa'au and Western Medicine in Hawaiʻi: Experiences and Perspectives of Patients Who Use Both." *Hawaii Med J* 66, no. 7 (2007). https://hawaiijournalhealth.org/past_issues/HMJ_Jul07.pdf

[132] Donlin, Amanda L. "When All the Kahuna Are Gone: Evaluating Hawaii's Traditional Hawaiian Healers' Law." *Asian-Pac Law Policy J* (2010). https://manoa.hawaii.edu/aplpj/wp-content/uploads/sites/120/2011/11/APLPJ_12.1_donlin.pdf

[133] "FACT SHEET: Biden-Harris Administration Takes Action to Promote Access to Behavioral Health Care for Asian American, Native Hawaiian, and Pacific Islander Communities." The White House, July 26, 2023. https://www.whitehouse.gov/briefing-room/statements-releases/2023/07/26/fact-sheet-biden-harris-administration-takes-action-to-promote-access-to-behavioral-health-care-for-asian-american-native-hawaiian-and-pacific-islander-communities/

outcomes.[134] While the specific practices for which Hawaiʻi seeks authority may offer different health benefits – for example, massage, exercise, nutrition, or mindfulness – all Native Hawaiian Traditional Healing Practices are designed to embrace whole-person care and treat individuals holistically.

Native Hawaiian Traditional Healing Practices are not simply a one-for-one substitute for their Western counterpart. Rather, each Native Hawaiian Traditional Healing Practice uses a different strategy to approach treatment holistically, offering physical, emotional, and spiritual benefits that extend beyond the treatment of the presenting disease state. Native Hawaiian Traditional Healing Practices may be applied alone or in combination with one another to offer the needed holistic treatment for a given patient. Further, they may be integrated with Western medicine to support, augment, or complement Western treatment modalities.

Several models currently exist for the provision and health-related benefits of Native Hawaiian Traditional Healing Practices; these models vary in their approach to care delivery and level of integration with Western medical practices. For example, at several health centers in Hawaiʻi, Native Hawaiian Healing practitioners have been integrated into their primary care service delivery model.[135] Integrating Native Hawaiian Traditional Healing Practices into primary care can address and mitigate the fear of judgment that some patients may have of sharing their health-related struggles with their providers and reduce discrimination for those who seek Native Hawaiian Traditional Healing Practices instead of or in addition to their Western medical treatments. Integration can lead to acceptance by medical providers of patient choices, improved adherence to care plans by patients, and avoidance of premature termination of services, all of which improve cost-efficiency and health outcomes.[134, 136]

Through this application, Hawaiʻi seeks to provide coverage of Native Hawaiian Traditional Healing Practices as supportive medical services that do not replace, but rather augment and fortify, the provision of outpatient primary and specialty care, with the expectation that doing so will improve health outcomes, decrease health care costs through avoided hospitalizations and emergency room visits, and reduce health inequities for populations seeking to use these services in lieu of exclusively Western medical treatments. Native Hawaiian Traditional Healing Practices serve as both treatment as well as prevention, thereby supporting an additional goal of preventing the incidence of conditions that lead to higher utilization and cost. Encouraging

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[134] Oneha, Mary F., Michael Spencer, Leina’ala Bright, Liza Elkin, Daisy Wong, and Mikyla Sakurai. “Hoʻoilina Pono Aʻe: Integrating Native Hawaiian Healing to Create a Just Legacy for the Next Generation.” *Hawaii J Health Soc Welf* 82, no. 3 (2023). http://www.ncbi.nlm.nih.gov/pmc/articles/pmc9995151/

[135] “Ma’iola Services, Cultural Health Program.” Waimānalo Health Center. https://www.waimanalohealth.org/maiola-services

[136] Dillard, Adrienne Y., Dee-Ann L. Carpenter, Ethel F. Mau, and B. P. Kekauoha. “Case Report from the Field: Integrating Hawaiian and Western Healing Arts in Papakolea.” *Hawaii J Med Public Health* 73, suppl. 3 (2014). http://www.ncbi.nlm.nih.gov/pmc/articles/pmc4271349

and supporting these practices in populations with historic disparities in health outcomes provides culturally-supportive ways to address and mitigate health inequities.[137]

As these practices become reimbursable, it is important to ensure equity and care in who is credentialed and how they are reimbursed. To maintain consistency and establish a standard, the State intends to define Native Hawaiian Healing Providers as those recognized by any council of kupuna convened by Papa Ola Lōkahi which adheres to the standard that has been set in state law for a limited set of Native Hawaiian Traditional Healing Practices.[111] As Native Hawaiian Traditional Healing Practices are implemented, the State intends to work closely with the community to thoughtfully design implementation pilots to identify models of care and reimbursement structures that are likely to be adopted and utilized. Reimbursement systems that are mindfully set up and structured well may also increase the motivation of younger generations to seek training in Native Hawaiian Traditional Healing Practices and increase the retention of important cultural practices over time.

Eligibility for Traditional Healing Practices

Hawaiʻi proposes offering Native Hawaiian Traditional Healing Practices to eligible Medicaid enrolled individuals who meet certain clinical and social risk factors.

Eligibility for lomilomi, hula, hoʻoponopono, ʻai pono, and lāʻau lapaʻau is defined as meeting at least one of the following criteria:

- Child or pregnant individuals;
- Obese (BMI 30+) for children and adults;
- Overweight (BMI 25+) with an additional cardiovascular risk factor such as hypertension, coronary artery disease, type 2 diabetes, dyslipidemia, and or other risk factors;
- Presence of a diagnosed behavioral or mental health disorder;
- Presence of a diagnosed joint, mobility, or pain disorder;
- Presence of a chronic disease where the intervention has a therapeutic role, such as COPD, asthma, hypertension, stroke, cancer, and or other chronic conditions;
- Individuals with one or more of the following HRSNs;
    - Lack of access to transportation;
    - Food insecurity;
    - Financial insecurity;
    - Lack of access to utilities;
    - Housing insecurity;
    - Experiencing interpersonal violence; and
    - Presence of caregiver support and/or the patient's extent of ambulation and limitations of activities of daily living;

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[137] Hilgenkamp, Kathryn, and Colleen Pescaia. "Traditional Hawaiian Healing and Western Influence." *Californian J Health Promot* 1, (2003). https://doi.org/10.32398/cjhp.v1iSI.556

- Individuals with stress or stress-related disorders such as post-traumatic stress disorder (PTSD); and
- Individuals experiencing major life transitions, including children aging out of foster care, postpartum individuals, individuals leaving institutional settings, persons at-risk of or experiencing homelessness, and adults transitioning to dual-eligible Medicaid-Medicare status.

Eligibility for hāpai hānau is defined as being a pregnant or postpartum individual within one year of labor and delivery.

Scope of Services, Eligible Providers, and Cost Sharing

As previously noted, Hawaiʻi seeks authority to cover six Native Hawaiian Traditional Healing Practices under Medicaid. These services are lomilomi, hula, hoʻoponopono, ʻai pono, lāʻau lapaʻau, and hāpai hānau. Native Hawaiian Traditional Healing Practices will be delivered by a new provider type, Native Hawaiian Healing Providers, defined as those recognized by any council of kupuna convened by Papa Ola Lōkahi, which adheres to the standard that has been set in state law for a limited set of Native Hawaiian Traditional Healing Practices.[111]

No cost sharing will be applied for individuals receiving covered Native Hawaiian Traditional Healing Practice benefits.

Lomilomi

Lomilomi is the Native Hawaiian Traditional Healing Practice of physiotherapy and massage using physical and spiritual rituals. Lomilomi means to break up into small pieces with the fingers and uses methods like deep tissue massage and stretching to realign the whole body.[137] Compared to other Native Hawaiian Healing Practices, lomilomi is the most commonly practiced Native Hawaiian Healing Practice.

Lomilomi uses methods like deep tissue massage and stretching to support chronic pain management and mobility. As an activity that promotes mindfulness, stress reduction, and improved blood circulation, lomilomi helps address key health challenges like chronic stress, joint pain, and cardiovascular health.[138] Lomilomi is currently integrated as a practice within several medical centers in Hawaiʻi.[136]

Eligible Medicaid enrolled individuals will be eligible for up to 52 sessions of lomilomi for a duration of up to 12 months. Eligibility will be reassessed every 12 months.

Hula

Hula is the Native Hawaiian form of dance and offers physical movement classes that seek to improve health and wellbeing through physical activity, mindfulness practices, and social interaction.

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[138] Posadzki, Paul, Toby O. Smith, and Pawel Lizis. "Lomi Lomi as a massage with movements: a conceptual synthesis?." *Altern Ther Health Med* 15, no. 6 (2009). https://pubmed.ncbi.nlm.nih.gov/19943576/

The health benefits of hula are well-established over decades of research, with randomized controlled trials indicating that hula can help reduce blood pressure and the risk of cardiovascular disease.[139, 140, 141] In qualitative research, hula has also demonstrated its capacity to help achieve a healthy lifestyle and build social connection.[142] These benefits indicate that hula may likely reduce psychological stress in addition to its important capacity to manage physical and behavioral health conditions.

Eligible Medicaid enrolled individuals will be eligible for up to 96 sessions of hula, for a duration of up to 12 months. Eligibility will be reassessed every 12 months.

Hoʻoponopono

Hoʻoponopono is a therapeutic intervention translated as the Native Hawaiian way of peacemaking, currently used primarily for addressing SUD and for conflict resolution and restorative justice for justice-involved individuals.[132, 143] There are two studies and programs that have utilized hoʻoponopono. Substance Abuse Prevention Services for Native Hawaiian Ex-Offenders (SAPSNHEO) utilized hoʻoponopono as a therapeutic intervention to prevent substance use for justice-involved individuals upon their release from incarceration.[144] Of the 341 participants, only nine were rearrested for substance use. The Hawaiian Learning Program taught prospective Native Hawaiian students in Social Work to utilize Native Hawaiian values and cultural-specific training to work with Hawaiian and non-Hawaiian clients. The program successfully graduated 48 students over a six-year period trained in cultural processes and values.[145]

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[139] Kaholokula, Joseph K., Mele A. Look, Thomas A. Wills, Mapuana de Silva, Tricia Mabellos, Todd B. Seto, Hyeong Jun Ahn, Ka'imi A. Sinclair, Dedra Buchwald, and Ka-HOLO Project. "Kā-HOLO Project: a protocol for a randomized controlled trial of a native cultural dance program for cardiovascular disease prevention in Native Hawaiians." *BMC Public Health* 17, no. 1 (2017). https://doi.org/10.1186/s12889-017-4246-3

[140] Kaholokula, Joseph K., Mele A. Look, Tricia Mabellos, Hyong Jun Ahn, So Yung Choi, Ka'imi A. Sinclair, Thomas A. Wills, Todd B. Sto, and Mapuana de Silva. "A Cultural Dance Program Improves Hypertension Control and Cardiovascular Disease Risk in Native Hawaiians: A Randomized Controlled Trial." *Ann Behav Med Publ Soc Behav Med* 55, no. 10 (2021). https://psycnet.apa.org/doi/10.1093/abm/kaaa127

[141] Look, Mele A., Joseph K. Kaholokula, Amy Carvhalo, Todd Seto, and Mapauna de Silva. "Developing a Culturally Based Cardiac Rehabilitation Program: The HELA Study. Prog Community Health Partners." *Res Educ Action* 6, no. 1 (2012). https://doi.org/10.1353/cpr.2012.0012

[142] Maskarinec, Gregory, Mele Look, Kalehua Tolentino, Mililani Trask-Batti, Todd Seto, Mapuana de Silva, and Joseph K. Kaholokula. "Patient Perspectives on the Hula Empowering Lifestyle Adaptation Study: Benefits of Dancing Hula for Cardiac Rehabilitation." *Health Promot Pract* 16, no. 1 (January 2015). https://doi.org/10.1177/1524839914527451

[143] Railey, Ashley, Clemma Muller, Carolyn Noonan, Maureen Schmitter-Edgecombe, Ka'imi Sinclair, Corin Kim, Mele Look, and J. Keaweʻaimoku Kaholokula. "Cost Effectiveness of a Cultural Physical Activity Intervention to Reduce Blood Pressure Among Native Hawaiians with Hypertension." *PharmacoEconomics Open* 6, no.1 (August 13, 2023). https://doi.org/10.1007/s41669-021-00291-6

[144] Mokuau, Noreen, Velma A. Kameoka, Abbie N. Kupuna, Terry Kelly, Paula-Ann Burgess, David Kamiyama, Kawen T. Young, et al. "Responding to Pacific Islanders: Culturally Competent Perspectives for Substance Abuse Prevention." *SAMHSA,* (1998). https://eric.ed.gov/?id=ED449290

[145] Blaisdell, K. and Papa Ola Lōkahi. "Native Hawaiian Health Timeline." Kipuka O Ke Ola, 2016. https://www.kipukaokeola.com

Eligible Medicaid enrolled individuals will be eligible for up to 15 sessions of hoʻoponopono for a duration of up to 12 months. Eligibility will be reassessed every 12 months.

ʻAi pono

ʻAi pono is a traditional Native Hawaiian holistic nutrition therapy program. ʻAi pono explores the interconnectedness of the Native Hawaiian food systems with access, nutrition, and sustainability. It explores one's cultural connectedness through food and Native Hawaiian food as a source of physical, emotional, and spiritual healing beyond its nutritional value. Participants in ʻai pono programs reported several health and well-being benefits, including increased access to healthy foods, improved diet, enhanced family and community connectedness, and other benefits.[146] Other qualitative studies point to additional benefits of ʻai pono, such as connectedness to land, community and social connection, and supporting healing from historical trauma.[147]

ʻAi pono includes many of the nutrition supports outlined in the Nutrition Supports section of this demonstration provided by Native Hawaiian Healing Providers trained in offering culturally-based nutrition support services. ʻAi pono benefits include nutrition counseling, nutrition education, fruit and vegetable prescriptions or protein boxes, culturally-tailored meals or pantry re-stocking, and Medically-Tailored Meals (MTM). ʻAi pono extends beyond the nutrition supports outlined in the Nutrition Supports section of this demonstration, however, and also provides culturally based education, holistic healing support, and traditional Native Hawaiian meals.

Eligible Medicaid enrolled individuals will be eligible for ʻai pono benefits for up to 12 months. Eligibility will be reassessed every 12 months. Each ʻai pono service will be available separately but may be combined for a given individual when appropriate and allowable. Since several nutrition supports benefits, as well as ʻai pono benefits, may be leveraged to provide for the nutritional needs for the patient, Hawaiʻi proposes to allow qualifying individuals to receive any combination of benefits that, when administered simultaneously, do not exceed the full daily nutritional needs of the individual (e.g., maximum of three meals per day or equivalent pantry restocking/vouchers, etc.). Where multiple ʻai pono and other nutrition supports benefits are appropriate and allowable, Hawaiʻi will encourage, but not require services to be bundled. For example, an individual may simultaneously receive nutrition education services using the nutrition support initiative and MTM using ʻai pono; however, an individual may not simultaneously receive pantry restocking using the nutrition support initiative and MTM using ʻai pono.

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[146] Beebe, Jazmine K., Yvette Amshoff, Ilima Ho-Lastimosa, Ghazaleh Moayedi, Asha L. C. Bradley, Inji N. Kim, Napua Casson, et al. "Reconnecting Rural Native Hawaiian Families to Food through Aquaponics." *Genealogy* 4, no. 1 (January 15, 2020). https://doi.org/10.3390/genealogy4010009

[147] Keli'iholokai, LeShay, Samantha Keaulana, Mapauna C. K. Antonio, Ikaika Rogerson, Kirk Deitschman, Joseph Awa Kamai, Luana Albinio, et al., "Reclaiming ʻĀina Health in Waimānalo." *Int J Environ Res Public Health* 17, no. 14 (July 2020). https://doi.org/10.3390/ijerph17145066

Lāʻau lapaʻau

Lāʻau lapaʻau is a Native Hawaiian herbalist healing practice. The practice of lāʻau lapaʻau includes the use of medicinal herbs and other medicines made from plants, animals, and mineral products collected from the land and sea to treat common ailments and chronic conditions.[148]

The clinical effectiveness of lāʻau lapaʻau has been well documented; for example, studies have discovered antiviral properties in specific plants utilized (kopiko, naupaka, mamaki, and ohia'ai).[149] The practices of lāʻau lapaʻau have been integrated into health systems in Hawaiʻi, including Ke Ola Mamo at the Waimānalo Health Center and programs within the Waiʻanae Coast Comprehensive Health Center.[150, 151] Qualitative studies have documented patients' experiences of combining lāʻau lapaʻau (Hawaiian herbal healing) and Western medicine: "Participants felt a higher degree of connectedness and understanding in their relationship with their healer than with their physician, and they felt that healers took more time to listen and clearly explain diagnoses. Lāʻau lapaʻau was more likely than Western medicine to incorporate a spiritual and prayer component, lead to improvements in cultural and personal identity, and foster feelings of connectedness to the land and Hawaiian values."[152]

Eligible Medicaid enrolled individuals will be eligible for lāʻau lapaʻau services for 27 sessions for up to 12 months. Eligibility will be reassessed every 12 months.

Hāpai hānau (pale keiki)

Hāpai hānau (pale keiki) is an important Native Hawaiian birthing practice. Pale keiki are midwives and generally work with the family members of pregnant individuals to provide obstetric care during labor. Native Hawaiian birthing practices simultaneously focus on the health of the child and mother with the intent of providing a holistically supportive experience. The services of the pale keiki extend beyond labor and delivery to support prenatal care, postnatal care, and lactation counseling.[153]

The importance of culturally sensitive birthing and midwifery services is demonstrated by the *Malama Na Wahine Hapai* (Caring for Pregnant Women), a community-based approach to

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[148] "Native Hawaiian Healing." Waikiki Health. https://waikikihc.org/patients/services/traditional-hawaiian-healing/

[149] Locher, C. P., M. T. Burch, H. F. Mower, J. Berestecky, H. Davis, B. Van Poel, A. Lasure, D. A. Vanden Berghe, and A. J. Vlietinck. "Anti-microbial activity and anti-complement activity of extracts obtained from selected Hawaiian medicinal plants." *Journal of Ethnopharmacology* 49, no. 1 (November 17, 1995). https://doi.org/10.1016/0378-8741(95)01299-0

[150] "Healing," Ke Ola Mamo. https://www.keolamamo.org/

[151] "Healing." WaiʻAnae Coast Comprehensive Health Center. https://www.wcchc.com/Healing

[152] Young, Natalie, and Kathryn Bruan. "Lā'au lapa'au and Western Medicine in Hawaiʻi: Experiences and Perspectives of Patients Who Use Both." *Hawaii Med J.* 66, no 7. (2007) https://pubmed.ncbi.nlm.nih.gov/17879854/

[153] Broyles, Harley. "Act 32 and Perpetuating Practices of Hawaiʻi Na Pua Haumea: How Hawaii's Midwifery Licensure Law Adversely Impacts Traditional Hawaiian Birthing Practices." *Asian-Pacific Law & Policy Journal* 23, no. 2 (May 2022). https://manoa.hawaii.edu/aplpj/2022/05/17/volume-23-issue-2/

health-care services for pregnant individuals developed because available care was not tailored to the lifestyles and needs of culturally diverse women in Hawaiʻi. The program recognized that standard “one size fits all” services may not be effective for diverse population groups. Nurses worked in partnership with the community to build culturally sensitive prenatal and postpartum care programs to promote pregnancy and postpartum adaptation.[154]

Eligible Medicaid enrolled individuals will be eligible for hāpai hānau services, which include prenatal, labor and delivery, and postpartum care, in addition to lactation supports. These services may either replace or supplement traditional medical care offered under Hawaii’s state plan for prenatal, labor and delivery, and postpartum care. Hāpai hānau services will be provided to eligible Medicaid enrolled individuals from the beginning of pregnancy until 12 months following labor and delivery.

Objectives

This demonstration aims to address the various health disparities experienced by Native Hawaiian and other Pacific Islander populations outlined above through culturally relevant health practices. Further, it aims to decrease disease and cost burdens, strengthen access to care, and build health equity for all Hawaiians who may benefit from receipt of Native Hawaiian Traditional Healing Practices. This demonstration advances Hawaii’s commitment to promote programs, services, interventions, and activities that address SDOH and reduce health disparities impacting disproportionately affected communities, specifically for Native Hawaiians and other Pacific Islanders.[155] Specifically, Hawaiʻi aims to:

- Integrate Native Hawaiian Traditional Healing Practices within the Medicaid delivery system to result in increased collaboration between stakeholders;
- Gradually expand access to these services;
- Improve the infrastructure for the provision of Native Hawaiian Traditional Healing Practices; and
- Increase engagement in Hawaii’s health care system among Medicaid-enrolled individuals receiving Native Hawaiian Traditional Healing Practices.

The State will monitor and evaluate the provision of Native Hawaiian Traditional Healing Practices to assess progress against the above desired outcomes.

Demonstration Implementation

Hawaiʻi is seeking to implement coverage of Native Hawaiian Traditional Healing Practices including lomilomi, hula, hoʻoponopono, ʻai pono, and lāʻau lapaʻau following CMS approval, following further guidance from CMS on Medicaid coverage of traditional healing practices, and

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[154] Affonso, Dyanne, Linda J. Mayberry, Katherine Graham, June Shibuya, and June Kunimoto. “Prenatal and Postpartum Care in Hawaii: A Community-Based Approach.” *J Obstet Gynecol Neonatal Nurs*. 22, no. 4 (July 1993). https://doi.org/10.1111/j.1552-6909.1993.tb01812.x

[155] House Bill 1616: Relating to Health Planning. https://www.capitol.hawaii.gov/sessions/session2014/bills/HB1616_SD1_.htm

as operational and technical infrastructures allow. The State may choose to implement each benefit separately to leverage lessons learned from each implementation. Prior to the launch of Native Hawaiian Traditional Healing Practices, the State will support infrastructure and provider network building. The State may elect to establish one or more limited pilot program(s) using a phased approach so that program policy and operational details may refined based on early learnings. The State will monitor, evaluate, and make changes to these initiatives over time.

Implementation of the hāpai hānau benefit will take place after implementation of the other Native Hawaiian Traditional Healing Practices listed above and following additional collaboration with Native Hawaiian Healing Providers and a successful pilot delivering this service.

3.10 HRSN Infrastructure Funding

Hawaiʻi is seeking new authority for infrastructure funding to support capacity building for the implementation of HRSN services, as described throughout this application.

Request

Hawaiʻi requests expenditure authority and federal investment of Infrastructure Funding to support capacity-building among Community-Based Organizations (CBOs), governmental agencies, and other organizations to build capacity and develop strategic partnerships necessary for the delivery of HRSN services requested in this application. Hawaiʻi requests a federal investment of $86 million over five years (total computable) to build the necessary infrastructure to successfully implement and maintain these services.

Infrastructure funding for HRSN Services—namely certain components of the CIS+ and Nutrition Supports scope of services—is requested to support capacity building among CBOs, which will be instrumental in delivering housing- and nutrition-related services to eligible individuals, and improving referral and data-sharing processes so that individuals are quickly connected with the services they need. The provision of HRSN services requires collaborative and communicative relationships between MQD, QI health plans, providers, and other CBOs best suited to deliver many HRSN services. As such, the State requests the full allowable amount of infrastructure funding for HRSN services as indicated by CMS—15 percent of total HRSN expenditure authority, or approximately $86 million, over five years (total computable). Any unused infrastructure funding will be used for delivery of HRSN services.

The infrastructure funding may be used for the following activities, among others:

- Invest in data-sharing infrastructure, IT services, personnel, and capacity needed for CBOs to:
    - Establish systems for delivering services;
    - Receive Medicaid reimbursement;

    - Conduct appropriate and safe data sharing, including sharing information needed for care management, outcomes monitoring, referral tracking, and program integrity;
    - Receive technical assistance from MQD and other partners; and
    - Communicate efficiently and accurately among CBOs and between CBOs and MQD;
- Allow the State to assist CBOs in developing the network capacity necessary to deliver the expected volume of HRSN services; and
- Enable the State to develop strong strategic partnerships with CBOs by:
    - Engaging CBOs early and often in the implementation planning process;
    - Providing workforce capacity training, including on Medicaid processes and policies such as benefits, enrollment, care management coordination, etc.; and
    - Preventing the duplication of resources and efforts, including where other federal funds may provide similar services (e.g., SNAP, WIC).

Hawaiʻi will request and use 90 percent Medicaid Enterprise System funding available through an Implementation Advanced Planning Document request, as appropriate.

Demonstration Implementation

Hawaiʻi is seeking to deploy this implementation funding as soon as allowable by CMS and over the course of the demonstration period.

3.11 Designated State Health Program (DSHP)

Hawaiʻi is seeking new authority to claim Medicaid matching funds for designed state health programs (DSHP) expenditures.

Request

Hawaiʻi requests new authority to claim Medicaid matching funds for up to 1.5 percent of total Medicaid expenditures, or approximately $289 million over five years (total computable), in DSHP expenditures to support the continuation of critical state-funded health programs and enable the successful implementation of and investment in newly proposed benefits outlined in this demonstration. Consistent with CMS policy goals and guidance, Hawaiʻi will specifically leverage the additional Medicaid matching funds to support the implementation and provision of nutrition supports and CIS+ housing-related services.

Hawaiʻi is requesting Medicaid matching funds for programs within Hawaii’s Department of Health (DOH) and Department of Human Services (DHS) that are otherwise State funded and subject to the limitations and conditions prescribed by CMS. Supporting these programs with DSHP expenditure authority will support the implementation of new delivery system initiatives aimed at providing whole person care and addressing inequities in outcomes by race and ethnicity. Hawaiʻi will work with CMS to clearly delineate DSHP funding and reimbursement protocols, including the identification of specific expenditures eligible for Medicaid match, and ensure the State meets all CMS conditions of approval for DSHP expenditure authority.

Section 4 – Demonstration Renewal Evaluation and Hypotheses

4.1 Current Section 1115 Demonstration Evaluation

An interim evaluation report of the current demonstration, inclusive of evaluation activities and findings to date, can be found in Attachment B of this Section 1115 Demonstration Application. Evaluation and greater use of data are a key building block underpinning this demonstration.

4.2 Hypotheses and Evaluation Approach

Table 7 presents a set of hypotheses intended to guide the evaluation of the previously described objectives. These hypotheses are formulated to provide a framework for the evaluation, and specific evaluation measures and methodologies will be developed iteratively upon implementation of the intended programs. More specific evaluation measures and methodologies will therefore be submitted upon approval of the application via the revised evaluation design.

Table 7. Hypotheses and Evaluation Approach.

Hypotheses	Evaluation Approach	Data Sources
CIS+		
CIS+ beneficiaries will receive different combinations of CIS+ services that match their needs, and tailoring services to fit needs will result in increased housing stability, improved wellbeing, and decreased cost of care.	Quantitative evaluation of the impact of CIS+ on health outcomes and costs; examination of differences in outcomes and cost among CIS+ sub-populations.	Encounter data, specific outcome metrics of interest (e.g., use of specific types of CIS+ services, inpatient utilization, etc.); cost measures where feasible may consider broader system-level costs; and as feasible, beneficiary self-reported data.
Continuous Eligibility		
Continuous eligibility will reduce churn and gaps in coverage for children enrolled in Medicaid, including for racial and ethnic minority populations that experience disproportionately high rates of churn.	Examine enrollment data by age, race, and ethnicity to determine trends in churn over time.	Measure is likely to be a calculated rate, broken out by multiple variables (e.g., age groups, particularly those that align with eligibility policy). Adjustments may be required to account for continuous enrollment during the PHE and PHE unwinding.
Continuous eligibility will reduce the quantity of redeterminations, resulting	Examine case load of eligibility workers and associated personnel costs over time.	Measure is likely to be hours spent on redeterminations by eligibility workers and

Hypotheses	Evaluation Approach	Data Sources
in lower administrative burden for eligibility workers and associated costs.		associated personnel costs, parsed by eligibility groupings to evaluate differences across Medicaid sub-populations.
Continuous eligibility will result in a slower rate of expenditure growth for children enrolled in Medicaid.	Examine differences in rates of growth in managed care capitation payments across actuarial groups.	Per Member Per Month (PMPM) costs during the waiver demonstration period; comparative populations or periods may be utilized to evaluate the impact of continuous eligibility on children.
Contingency Management		
Increasing the availability of Contingency Management will increase the number of Medicaid beneficiaries engaged in treatment for substance use disorders.	Mixed-methods approach that seeks to evaluate the implementation of guidance for Contingency Management services; network capacity for the provision of contingency management services; screening and identification of Medicaid beneficiaries with a qualifying SUD; and uptake of Contingency Management services among qualifying Medicaid beneficiaries.	Review of guidance, workflows and other documents to examine various aspects of implementation; examination of process metrics to assess progress of implementation; and encounter data to assess screening, identification, and uptake of services.
Participation in Contingency Management among Medicaid beneficiaries with substance use disorders will increase adherence to and retention in SUD treatment.	Evaluate utilization of Contingency Management and other concomitantly delivered SUD treatment services among qualifying Medicaid beneficiaries. Evaluate continued engagement in and adherence to treatment. Examine related and proximal health outcomes (e.g., evidence of ongoing sobriety, Emergency Department (ED) visits/ admissions for relapse).	Encounter data, specific outcome metrics of interest (e.g., ED visits for substance use), and QI health plan reports to capture utilization metrics and other data.
Pre-Release Medicaid Services for Justice-Involved Individuals		

Hypotheses	Evaluation Approach	Data Sources
Implementation of pre-release services will result in increased collaboration between stakeholders, identification of unaddressed medical and health-related social needs prior to release, gradual expansion of access to pre-release services for justice-involved individuals, and improved insights into healthcare delivery for this population.	Use a mixed-methods process evaluation approach to examine the implementation of pre-release services, including the identification of eligible individuals, unaddressed medical and health-related social needs, and provision of Medicaid-covered services in the pre-release setting.	Qualitative interviews of stakeholders (e.g., QI health plans, MQD, and the State's Public Safety Division); review of guidance, workflows, and other documents to examine various aspects of implementation; and examination of health plan reports to assess progress of implementation.
Access to pre-release services will result in continuity of targeted health services upon release to the community, resulting in positive impacts on health outcomes.	Examine the post-release utilization of specific targeted health services including but not limited to CIS+ housing supports, those that address other identified health related social needs, and medication refills among individuals receiving pre-release services. Examine related and short term physical and behavioral health outcomes (e.g., stable housing, medication adherence).	Encounter data, specific outcome metrics of interest (e.g., medication possession ratio), and QI health plan reports to capture utilization metrics and other data.
Nutrition Supports		
Implementation of nutrition supports will result in increased collaboration between stakeholders, gradual expansion of access to nutrition services for qualifying individuals, and improved infrastructure for the provision of nutrition support services.	Use a mixed-methods process evaluation approach to examine the implementation of nutrition support programs including the identification of individuals with food insecurity, referral mechanisms to existing non-Medicaid nutrition programs, and provision of Medicaid-covered nutrition supports to qualifying individuals.	Qualitative interviews of stakeholders (e.g., QI health plans, SNAP program, MQD, and providers of nutrition support services); review of guidance, workflows and other documents to examine various aspects of implementation; and examination of QI health plan reports to assess progress of implementation.

Hypotheses	Evaluation Approach	Data Sources
Nutrition support services will result in reductions in food insecurity and improved disease management for participating individuals.	Assess the impact of each nutrition supports program on targeted outcomes. Examine related and proximal health outcomes (e.g., diabetes control).	Encounter data and QI health plan reports to capture utilization metrics and other qualitative data. Additional data may be collected at target delivery locations as feasible.
Native Hawaiian Traditional Healing Practices		
Integration of Native Hawaiian Traditional Healing Practices within the Medicaid delivery system will result in increased collaboration between stakeholders, gradual expansion of access to these services, and improved infrastructure for the provision of Native Hawaiian Traditional Healing Practices.	Use a mixed-methods process evaluation approach to examine the implementation of Native Hawaiian Traditional Healing Practices, including differences by setting if applicable (e.g., integrated vs. non-integrated settings); evaluate the uptake of Medicaid-covered Native Hawaiian Traditional Healing Practices.	Qualitative interviews of stakeholders (e.g., QI health plans, providers and overseeing bodies of Native Hawaiian Traditional Healing Practices, and MQD); review of guidance, workflows and other documents to examine various aspects of implementation; and examination of QI health plan reports to assess progress of implementation. As feasible, qualitative interviews of beneficiaries receiving services, with the Consumer Assessment of Healthcare Providers & Systems (CAHPS) questions included to provide comparative analytics.
Native Hawaiian Traditional Healing Practices will increase engagement in Hawaii’s health care system among Medicaid-enrolled individuals receiving Native Hawaiian Traditional Healing Practices.	Evaluate utilization of Native Hawaiian Traditional Healing Practices and other health care services (e.g., outpatient primary care and specialist visits, prescription medication use and medication refills, receipt of annual wellness visits, etc.) indicative of increased engagement. Examine related and proximal	Encounter data, specific outcome metrics of interest (e.g., medication possession ratio, receipt of preventive services), and QI health plan reports to capture utilization metrics and other data.

Hypotheses	Evaluation Approach	Data Sources
	health outcomes (e.g., receipt of preventive health services).	
VBP		
Value Based Purchasing (VBP) expectations and requirements implemented by MQD will result in expansion of Alternative Payment Models (APMs) implemented by QI health plans.	Qualitative and quantitative methodologies to evaluate implementation and impacts of select APMs on health outcomes and cost of care.	Qualitative data to investigate APM implementation; encounter data, QI health plan reports on beneficiary and provider attribution, financial outcomes, and survey data on APMs to evaluate quantitative impacts.
Care Coordination		
Increased engagement in Health Coordination Services (HCS) will result in improved chronic disease management and health outcomes for individuals with complex health care needs.	Examine the implementation of HCS for populations with complex health care needs, including but not limited to those in CIS+, long-term services and supports (LTSS), and special health care needs (SHCN)/expanded health care needs (EHCN). Evaluate differences in implementation for specific sub-populations.	Encounter data, specific outcome metrics of interest (e.g., ED visits and inpatient hospitalizations), CMS core set/Healthcare Effectiveness Data and Information Set (HEDIS) metrics, and QI health plan reports to capture utilization metrics and other data. Additional qualitative data collection from QI health plans and/or providers may be conducted.

Section 5 – Enrollment Impact, Financing, and Budget Neutrality

5.1 Enrollment Impact

The State is not proposing any changes that would negatively impact enrollment between Demonstration Year (DY) 31 through DY35. Further, several proposed authorities within this Section 1115 Demonstration, including continuous eligibility and the addition of pre-release services for justice-involved individuals, are expected to increase enrollment, as described in Table 8.

Table 8. Preliminary Estimates of Enrollment Impacts.

	DY31	DY32	DY33	DY34	DY35
Total Projected Medicaid Enrollment	396,427	408,441	418,405	428,814	439,932

QI Mandatory Managed Care	392,079	401,069	410,275	419,703	429,359
Continuous Eligibility	3,024	6,049	6,807	7,788	9,250
Pre-Release Services	1,323	1,323	1,323	1,323	1,323

5.2 Financing

To finance the nonfederal share of this Section 1115 Demonstration, Hawaiʻi may use a combination of state general funds and other funds including DSHP, certified public expenditures, and revenue generated from provider fees.

5.3 Budget Neutrality

For the duration of the existing Section 1115 Demonstration period, the State continued to maintain strong positive variance and met budget neutrality requirements. The tables in Attachment E provide a summary of Hawaii's projected with-waiver, without-waiver, and hypothetical expenditures for its Section 1115 Demonstration renewal, from DY31-DY35. These tables contain considerable detail regarding cost projections associated with each of the various proposed authorities.

Section 6 – Proposed Waiver and Expenditure Authorities

As outlined in Tables 9 and 10, the State is requesting federal waiver and expenditure authorities, some of which have previously been approved in the Section 1115 Demonstration. To the extent that CMS advises the State that different or additional authorities are needed to implement the requested Section 1115 Demonstration improvements, the State is requesting such waiver or expenditure authority, as applicable.

Table 9. Requested Waiver Authorities.

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
Waiver Authority for All Section 1115 Demonstration Benefits	**Amount, Duration, and Scope** To enable the State to offer demonstration benefits that may not be available to all categorically eligible or other individuals.	Section 1902(a)(10)(B) of the Social Security Act and 42 CFR 440.230-250	Yes
Waiver Authority for QI Mandatory Managed Care	**Medically Needy** To enable the State to limit medically needy spend-down eligibility in the case of those individuals who are not aged, blind, or disabled to those individuals whose gross incomes, before any spend-down	Section 1902(a)(10)(C); Section 1902(a)(17) of the Social Security Act and 42 CFR 435.831	Yes

	calculation, are at or below 300 percent of the federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, for whom there is no gross income limit.		
	Freedom of Choice To enable Hawaiʻi to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932.	Section 1902(a)(23)(A) of the Social Security Act and 42 CFR 431.51	Yes
	Out of State Former Foster Youth To enable the State to receive federal financial participation and provide coverage for any individual who has aged out of foster care in another state prior to or after January 1, 2023 as eligible for Medicaid, subject to other applicable Medicaid eligibility criteria.	Section 1902(a)(10)(A)(i)(IX) of the Social Security Act and 42 C.F.R. 435.150	No
	Cost Sharing To enable the State to charge cost sharing up to 5 percent of annual family income. To enable the State to charge an enrollment fee to Medically Needy Aged, Blind, and Disabled QUEST Integration health plan beneficiaries (Demonstration Population 3) whose spend-down liability is estimated to exceed the QI health plan capitation rate, in the amount equal to the estimated spend-down amount or where applicable, the amount of patient income applied to the cost of long-term care.	Section 1902(a)(14) of the Social Security Act insofar as it incorporates 1916 and 1916A and 42 CFR 4472.52	Yes
Waiver Authority for HCBS	**HCBS Waiver**	Section 1915(c) of the Social Security	Yes

	To enable the State to waive certain requirements under home and community based service programs, including provision of services through QI health plans for individuals assessed to be at risk of deteriorating to the institutional level of care.	Act and 42 CFR 441.301	
Waiver Authority for Continuous Eligibility	**Periodic Renewal of Medicaid Eligibility** To allow federal financial participation for the continuous eligibility of children without regard to whether a child's income exceeds eligibility limits; and to enable the State to waive the requirements for individuals to report and for the State act on changes with respect to income eligibility.	Section 1916A(4) of the Social Security Act and 42 C.F.R. 435.916	No
Waiver Authority for Pre-Release Medicaid Services for Justice-Involved Populations	**State Wideness/Uniformity** To permit the State to provide nutrition supports to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No
Waiver Authority for Nutrition Supports	**State Wideness/Uniformity** To permit the State to provide nutrition supports to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No
Waiver Authority for Native Hawaiian Traditional Healing Practices	**State Wideness/Uniformity** To permit the State to provide Native Hawaiian traditional healing practices to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No
Waiver Authority for Contingency Management	**State Wideness/Uniformity** To permit the State to provide contingency management interventions to eligible	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No

	individuals on a geographically limited basis.		

Table 10. Requested Expenditure Authorities.

Expenditure Authority	Use for Expenditure Authority	Currently Approved
Expenditures for QI Mandatory Managed Care	**Managed Care Payments** Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m): Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts beneficiaries' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Beneficiaries may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to beneficiaries on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island. Expenditures for capitation payments to MCOs in non-rural areas that do not provide beneficiaries with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and federal regulations at 42 CFR section 438.52.	Yes
	Quality Review of Eligibility Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.	Yes
	Demonstration Expansion Eligibility Expenditures to provide coverage to the following demonstration expansion populations: <u>Demonstration Population 1</u>: Parents and caretaker relatives who are living with an 18-year-old who would be a dependent child but for the fact that the 18-year-old has	Yes

	reached the age of 18, if such parents would be eligible if the child was under 18 years of age. Demonstration Population 2: Aged, blind, and disabled individuals in the 42 C.F.R. 435.217 like group who are receiving home- and community- based services, with income up to and including 100 percent of the federal poverty limit using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules. Demonstration Population 3: Aged, blind, and disabled medically needy individuals receiving home-and community-based services, who would otherwise be eligible under the State plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income. Demonstration Population 4: Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance, who would not otherwise be eligible under the State plan, with the same income limit that is applied for Foster Children (19 - 20 years old) receiving foster care maintenance payments or under an adoption assistance agreement under the State plan. Demonstration Population 5: Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program (either Title IV-E assistance or non Title IV-E assistance), or would otherwise be eligible under a different eligibility group but for income, and were enrolled in the State plan or waiver while receiving assistance payments.	
Expenditures for HCBS	Expenditures to provide HCBS not included in the Medicaid state plan and furnished to QUEST Integration beneficiaries, as follows:	Yes

	a) Expenditures for the provision of services, through QUEST or QUEST Integration health plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement; b) Expenditures for the provision of services, through QUEST or QUEST Integration health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, i.e., the "at risk" population. The State may maintain a waiting list, through a health plan, for home and community-based services (including personal care services). No waiting list is permissible for other services for QUEST Integration beneficiaries. The State may impose an hour or budget limit on home and community based services provided to individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "at risk" population), as long as such limits are sufficient to meet the assessed needs of the individual.	
Expenditures for CIS+	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for CIS+ services to qualifying individuals.	Yes
Expenditures for Continuous Eligibility	Expenditure authority as necessary to permit the State to implement continuous eligibility and receive Medicaid matching funds for associated expenditures.	No
Expenditures for CM	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for contingency management through small incentives to qualifying individuals.	No
Expenditures for Pre-Release Medicaid Services for Justice Involved Populations	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for costs not otherwise matchable for certain services, as described in this application, rendered to individuals who are incarcerated up to 90 days prior to their release.	No
Expenditures for Administrative Costs Related to Pre-Release Medicaid Services for Justice	Expenditure authority as necessary to permit the State to receive Medicaid matching funds for capped pre-release administrative expenditures for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure, and other interventions.	No

Involved Populations		
Expenditures for Nutrition Supports	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for nutrition supports to qualifying individuals.	No
Expenditures for Native Hawaiian Traditional Healing Practices	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for Native Hawaiian Traditional Healing Practices provided by eligible Native Hawaiian Traditional Healers to qualifying individuals.	No
Expenditures for HRSN Infrastructure Funding	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for allowable infrastructure building expenditures related to HRSN services.	No
Expenditures for DSHP	Expenditure authority as necessary to permit the State to claim Medicaid matching funds for designated programs which are otherwise state-funded and not otherwise eligible for Medicaid payment.	No

Attachments

Attachment A: 2023 Evaluation of Quality Strategy Effectiveness

Attachment B: Interim Demonstration Evaluation Report

Attachment C: Med-QUEST Division Quality Strategy

Attachment D: Current QUEST Integration Special Terms & Conditions

Attachment E: Budget Neutrality

Attachment F: E-mail Notice

Attachment G: Abbreviated Public Notice

Attachment H: Full Public Notice

Attachment A

State of Hawaii
Department of Human Services
Med-QUEST Division

2023 Evaluation of Quality Strategy Effectiveness

October 2023

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1. Quality Strategy

In accordance with 42 Code of Federal Regulations (CFR) §438.340, the Hawaii Department of Human Services, Med-QUEST Division (MQD) implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the five managed care organizations (MCOs) under the QUEST Integration (QI) managed care program and the one prepaid inpatient health plan (PIHP) under the Community Care Services (CCS) program. The CCS program provides behavioral health specialty services for individuals who have been determined by the MQD to have a serious mental illness (SMI). The *Hawaii Quality Strategy 2020* (referred to as Quality Strategy in this report) was filed with and approved by the Centers for Medicare & Medicaid Services (CMS) in 2020. The purpose of the strategy is:

- Monitoring that services provided to members conform to professionally recognized standards of practice and code of ethics.
- Identifying and pursuing opportunities for improvements in health outcomes, accessibility, efficiency, and member and provider satisfaction with care and service, safety, and equitability.
- Providing a framework for the MQD to guide and prioritize activities related to quality.
- Assuring that an information system is in place to support the efforts of the Quality Strategy.

As noted above, the Quality Strategy strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value/quality-based, data-driven, and equitable by providing oversight of health plans and other contracted entities to promote accountability and transparency for improving health outcomes. In 2017, the MQD launched the Hawaii ‘Ohana Nui Project Expansion (HOPE) program to develop and implement a roadmap to achieve a vision of healthy families and healthy communities. The goal of HOPE is to achieve the Triple Aim of better health, better care, and sustainable costs for the community.

HOPE activities are organized into four strategic focus areas, which include multiple targeted initiatives to promote integrated health systems and payment reform initiatives, and three foundational building blocks, which directly support the four strategic areas and also enhance overall system performance as presented in Table 1-1. The HOPE initiative guides the Quality Strategy.

Table 1-1—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 Quality Strategy is centered on the four HOPE strategic areas and then organized into seven overarching goals. Each goal contains one or more objectives for a total of 17 objectives. Most objectives are cross-cutting as they achieve more than one of the MQD's goals. 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. The Quality Strategy goals and associated objectives are described in the next section.

2. Goals and Objectives

The Quality Strategy's identified goals and objectives focus on improving health outcomes of Hawaii Medicaid members and maintaining and improving the managed care delivery system. The goals and supporting objectives are measurable and take into consideration all populations served by the QI and CCS programs. Refer to Table 2-1 for a detailed description of the objectives and performance measures used to support each goal.

Hawaii's Quality Strategy identifies the following seven goals and associated objectives:

Table 2-1—Quality Strategy Goals and Objectives

Goals	Objectives
Goal 1: 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
Goal 2: 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)
Goal 3: 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
Goal 4: Support community initiatives to improve population health	**Objective 11:** Assess and address social determinants of health needs

Goals	Objectives
Goal 5: Enhance care in LTSS settings	**Objective 12:** Enhance community integration/reintegration of LTSS beneficiaries
	Objective 13: Enhance nursing facility and Home and Community Based Services (HCBS); prevent or delay progression to nursing facility level of care
Goal 6: Maintain access to appropriate care	**Objective 14:** Maintain or enhance access to care
	Objective 15: Increase coordination of care and decrease inappropriate care
Goal 7: 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

Each of the 17 objectives is tied to initiatives and interventions used to drive improvements within and across the goals and objectives set forth in the Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR §438.340(b)(3), these interventions are tied to a set of metrics by which progress is assessed. This approach provides for data-driven decision making to identify gaps, formulate solutions, and prioritize quality initiatives.

3. Evaluation

Health Services Advisory Group, Inc. (HSAG), conducted a formal evaluation of the Quality Strategy to assess its overall effectiveness to improve healthcare delivery, accessibility, and quality in the populations served by the managed care program.

Methodology

To evaluate the Quality Strategy, HSAG analyzed the following to determine performance and progress in achieving the goals of the Quality Strategy:

- Quality initiatives
- Performance measure data
- External quality review (EQR) activities
    - Validation of performance measures
    - Validation of performance improvement projects
    - Network adequacy validation
    - Compliance monitoring review
    - Consumer Assessment of Health Plan Satisfaction (CAHPS®)[3-1] surveys
    - Annual EQR technical report

Review Period

The evaluation review period focuses on performance measure data and EQR activity results for measurement year (MY) 2021/reporting year (RY) 2022.

Evaluation Tool

To track the progress of achieving goals and objectives outlined in the Quality Strategy, HSAG developed a Hawaii Medicaid Goals Tracking Table, as shown in Appendix A. The table comprises the metrics included in the Hawaii Quality Strategy 2020 Measures Appendix and is categorized by the State's associated goals and objectives, along with RY 2022 performance measure targets and results.

COVID-19 Implications

During the RY 2022 time frame, Hawaii experienced unprecedented challenges as a result of the declaration of a national public health emergency (PHE) related to the coronavirus disease 2019

[3-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

(COVID-19) outbreak. The PHE resulted in the implementation of innovative methods to ensure continued access to care, such as expanding the use and coverage of telehealth medicine, automatically extending certain service authorizations, and suspending Medicaid disenrollments. However, because of the COVID-19 PHE, many preventive services were negatively affected in Hawaii and across the country as members did not access preventative, non-emergent services in order to slow the spread of COVID-19 and reduce the personal risk of contracting the virus.

Evaluation of Quality Strategy Effectiveness

The MQD uses several mechanisms to monitor and enforce health plan compliance with the standards set forth throughout the Quality Strategy, and to assess the quality and appropriateness of care provided to Medicaid managed care members. The following sections provide an overview of the key mechanisms the MQD uses to enforce these standards and to identify ongoing opportunities for improvement.

Quality Initiatives

Hawaii has implemented a series of initiatives aligned closely to the Quality Strategy and designed to build a person-centered, coordinated system of care that addresses both medical and non-medical drivers of health. These initiatives drive progress toward the Quality Strategy goals and objectives, and are discussed below.

Health Equity and Social Determinants of Health

Given the unique geography and diversity that exists in Hawaii, one of the MQD's priorities is reducing health disparities and assessing and addressing social determinants of health (SDoH). 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, is affected differently by these factors, leading to disparities in health outcomes. The MQD, in partnership with the health plans, has developed an SDoH Transformation Plan that will act as a roadmap for identifying, evaluating, and addressing health disparities. The health plans are currently in the early implementation stages of the Plan and focusing on the collection, analysis, and use of demographic and SDoH data.

Additionally, as part of managed care reporting, health plans are required to analyze performance measure data by various strata, including geography, race/ethnicity, and English language proficiency, and develop tailored quality improvement activities that are then monitored over time for efficacy and impact. Health plans also have developed and implemented SDoH quality activities as part of their quality assurance and program improvement (QAPI) program.

Community Integration Services (CIS)

The CIS program provides members who have physical and/or behavioral health needs and are homeless, or at risk of homelessness, with various housing services that are likely to ameliorate their physical or behavioral health needs. The benefits include pre-tenancy supports, tenancy sustaining services, housing quality and safety improvement services, legal assistance, and house payments, including a one-time payment for a security deposit and/or first month's rent. MQD is looking to expand upon this program through its 1115 waiver renewal. The MQD evaluates the CIS program on an ongoing basis through rapid cycle assessments (RCAs); the MQD recently released updated implementation guidelines to lessen administrative burdens related to the program's implementation based on health plan and provider feedback.

Long-Term Services and Supports (LTSS)

Medicaid members meeting eligibility criteria can receive long-term care services in a nursing facility or home and community-based services (HCBS). To ensure quality care and equitable access to services, the MQD developed an HCBS Quality Strategy that addresses six areas of performance: Administrative Authority, Level of Care, Person-Centered Service Plan, Qualified Providers, Health and Welfare, and Financial Accountability. The MQD established priority goals and performance measures tied to specific HCBS requirements. The health plans are required to report the HCBS performance measures, and the MQD monitors the results quarterly. The performance measures associated with HCBS program assurances have a threshold of 86 percent. Any performance measure with less than 86 percent triggers further analysis and implementation of quality improvement activities.

Behavioral Health Integration

The MQD, health plans, and Department of Health (DOH) agencies work collaboratively to integrate primary care with behavioral health, support the utilization of a Coordinated Addiction Resource Entry System (CARES), and enhance the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT). The MQD uses performance and quality measurement as well as financial incentive programs to support advancements in behavioral healthcare and integration.

Quality-Based Payment Programs

The MQD maintains several quality-based payment programs to enhance the quality and value of care provided across various settings. The MCO pay for performance (P4P) program is a withhold-based program used to incentivize quality, improvement, and progress in selected performance measures and implementation of new initiatives. The MQD also encourages the health plans to align payment structures through value-based purchasing (VBP) strategies to enhance quality and value of care. Finally, the MQD uses quality metrics in its auto-assignment algorithm to further reward health plan performance.

The MQD's Hospital P4P and Nursing Facility P4P programs are administered in close partnership with the Healthcare Association of Hawaii (HAH). Measures are selected in partnership with the facilities to accelerate progress across various MQD quality objectives.

Contract Compliance

The MQD intends to achieve the Quality Strategy goals and objectives 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. Through quality assurance and quality improvement oversight activities, the MQD monitors the health plans to ensure they are operating in accordance with the contract. New reporting packages and key performance indicators were developed and implemented in 2021. When contract requirements are not met, the MQD may initiate corrective action processes or may impose sanctions for non-performance or violations of contract requirements.

Performance Measures

The MQD requires the health plans to report annually on patient outcome performance measures, including Healthcare Effectiveness Data and Information Set (HEDIS®) quality metrics, the CMS Adult and Child Core Set measures, CMS measures for managed long-term services and supports (MLTSS), Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs), CAHPS measures, and other State-specified quality measures. Additionally, as part of its Quality Payment Program, the MQD requires hospitals and nursing facilities to submit performance measure rates, including the American Health Care Association (AHCA) hospital measures and CMS Minimum Data Set (MDS) nursing facility quality measures.

As an appendix to the Quality Strategy, the MQD identifies the required performance measures and links them to each associated objective. The MQD identifies the baseline performance measure rate (if applicable/available) and the target rate, which is based on a goal of 1 percent improvement each year. Table 3-1 summarizes the statewide performance measure results and Quality Strategy targets met as shown in Appendix A—Hawaii Medicaid Goals Tracking Table. Note: Process measures are not included in the summary table below.

Table 3-1—RY 2022 Quality Strategy Goals Statewide Summary of Performance

	Goal 1	Goal 2	Goal 3	Goal 4*	Goal 5	Goal 6	Goal 7
Number of rates reported	59	29	45	6	20	66	21
Rates with an established target	53	27	38	0	9	60	20
Rates achieving the target	**17**	**18**	**21**	**N/A**	**3**	**24**	**5**

	Goal 1	Goal 2	Goal 3	Goal 4*	Goal 5	Goal 6	Goal 7
Percentage of rates achieving the target	**32.08%**	**66.67%**	**55.26%**	**N/A**	**33.33%**	**40.00%**	**25.00%**

*Goal 4 contains a total of seven performance measures. Six measures did not have an established target, as RY 2022 was the first year these MLTSS measures were reported by the MCOs. The remaining performance measure was a process measure where overall performance was determined by the MQD as either *Met* or *Not Met*.

In addition to standard performance measures, the MQD also included the following process measures in its Quality Strategy:

- Social Determinants of Health Collaborative: Design and implement a program to track the SDoH associated with patients
- Perinatal Collaborative: Design and implement a program to improve the quality of care for mothers and babies
- Telehealth Plan: Design and implement a statewide telehealth plan

At the end of the reporting year, the MQD scored progress on these measures with a rating of *Met* or *Not Met*. All three process measures received a rating of *Met*.

Table 3-2 summarizes health plan performance relative to the MQD Quality Strategy targets. Highlighted cells indicate whether QI health plan performance for a given measure rate met or exceeded the target threshold established by the MQD. The performance measures in the table below represent the MY 2021 measures audited by HSAG.

Table 3-2—Percentage of MQD Quality Strategy Targets Met or Exceeded for QI Population

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Access and Risk-Adjusted Utilization					
*Heart Failure Admission Rate—Total**	Met	Not Met	Met	Not Met	Met
*Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total**	Not Met	Not Met	Not Met	Not Met	Not Met
Children's Preventive Health					
Child and Adolescent Well-Care Visits—Total	Met	Met	Met	Met	Not Met
Childhood Immunization Status—Combination 2	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 3	Not Met	Not Met	Met	Not Met	Not Met
Childhood Immunization Status—Combination 4	Not Met	Not Met	Not Met	Not Met	Not Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Childhood Immunization Status—Combination 5	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 6	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 7	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 8	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 9	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 10	Not Met	Not Met	Not Met	Not Met	Not Met
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Si	Not Met	Not Met	Met	Not Met	Met
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Tw	Not Met	Not Met	Not Met	Not Met	Not Met
Women's Health					
Cervical Cancer Screening	Not Met	Not Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Met	Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Postpartum Care	Met	Met	Met	Met	Met
Care for Chronic Conditions					
Comprehensive Diabetes Care—HbA1c Testing	Not Met	Not Met	Not Met	Not Met	Met
*Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)**	Not Met	Not Met	Met	Not Met	Met
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	Not Met	Not Met	Met	Met	Met
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	Not Met	Not Met	Not Met	Not Met	Not Met
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	Not Met	Not Met	Met	Not Met	Met
*Concurrent Use of Opioids and Benzodiazepines—Total**	Not Met	Met	Met	Met	Met
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	Not Met	Met	Met	Met	Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	Not Met	Met	Met	Met	Met
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—Total	Not Met	Met	Met	Met	Not Met
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement—Total—Total	Not Met	Met	Not Met	Not Met	Not Met
Screening for Depression and Follow-Up Plan—18+ Years	Met	Met	Not Met	Not Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Total	Met	Not Met	Met	Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Buprenorphine	Met	Met	Met	Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Oral Naltrexone	Not Met	Not Met	Met	Not Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Long-Acting, Injectable Naltrexone	Not Met	Met	Not Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Methadone	Met	Not Met	Not Met	Met	Met
Total MQD Targets Met	**8**	**11**	**17**	**10**	**14**
Percent MQD Targets Met	**24.24%**	**33.33%**	**51.52%**	**30.30%**	**42.42%**

Table 3-3 summarizes CCS' performance relative to the MQD Quality Strategy targets. Highlighted cells indicate whether CCS performance for a given measure rate met or exceeded the target threshold established by the MQD. The performance measures in the table below represent the MY 2021 measures audited by HSAG.

Table 3-3—Percentage of MQD Quality Strategy Targets Met or Exceeded for CCS

Measure	'Ohana CCS
Access and Risk-Adjusted Utilization	
*Ambulatory Care—Total (per 1,000 Member Months) ED Visits—Total**	Not Met

Measure	‘Ohana CCS
Ambulatory Care—Total (per 1,000 Member Months) Outpatient Visits—Total	Not Met
Mental Health Utilization—Any Service	Met
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Met
Antidepressant Medication Management—Effective Acute Phase Treatment	Not Met
Antidepressant Medication Management—Effective Continuation Phase Treatment	Met
Behavioral Health Assessment—Behavioral Health Assessment completion within 30 days of enrollment	Met
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total	Met
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence—30-Day Follow-Up—Total	Met
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	Met
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	Met
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	Met
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	Met
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—Total	Not Met
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement—Total—Total	Not Met
Total MQD Targets Met	**10**
Percent MQD Targets Met	**66.67%**

External Quality Review Activities

As noted in the Quality Strategy, the external quality review organization (EQRO) plays a critical role in reporting health plan performance in several required areas (meaning federal regulations require that these activities be completed by the EQRO) and some optional areas (meaning that the State has elected to use the EQRO for these activities) under 42 CFR §438.352 and §438.364.

Validation of Performance Measures

HSAG validated each health plan’s performance measure results for a set of HEDIS and non-HEDIS performance measures selected by the MQD to evaluate the accuracy and reliability of the health plans’ data that contributed to the performance measure rate calculations. HSAG assessed the performance measure results and their impact on improving the health outcomes of members. HSAG conducted validation of the performance measure rates following the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ [3-2] guidelines and timeline, which occurred from January 2022 through July 2022. Each audit incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting, analyzing, and reporting performance measure data, including a review of the specific data collection methodologies used to report the required performance measures. The final audited performance measure validation results for each health plan reflected the measurement period of January 1, 2021, through December 31, 2021. HSAG provided final audit reports to the health plans and the MQD in July 2022. HSAG determined all QI health plans and the CCS program to be fully compliant with all NCQA HEDIS IS standards. Overall, the health plans followed the measure specifications required by the State to calculate the required HEDIS and non-HEDIS performance measure rates, and all measures received the audit designation of *Reportable*.

Validation of Performance Improvement Projects (PIPs)

The health plans have an ongoing program of PIPs intended to improve care, services, and member outcomes in each topic area. The MQD-selected PIPs are listed in Table 3-4. The MQD and HSAG continued to work with the health plans in annual PIP submission processes to facilitate more efficient and long-term sustained improvement. The MQD contracted with HSAG to facilitate collaborative workgroups related to the two PIP topics: Behavioral Health Coordination and Plan All-Cause Readmissions. HSAG assisted the health plans with the creation of workgroup charters, provided training on quality improvement strategies, facilitated meetings, and provided ongoing support as the health plans completed quality improvement activities.

The EQRO validated each PIP and provided results and findings for each health plan, along with recommendations for improvement. All health plans achieved a PIP validation status of *Met*.

Table 3-4—PIP Topics by Program

Program	PIP Topics
QUEST Integration	***Behavioral Health Coordination*** Indicator 1. Percent of shared members with eligible trigger events who received a combined review in the past three months. Indicator 2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.
QUEST Integration	***Plan All-Cause Readmissions*** Indicator: Percentage of eligible discharges for which members 18–64 years of age had at least one acute readmission for any diagnosis within 30 days of the index discharge date.
Community Care Services	***Behavioral Health Coordination***

[3-2] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

Program	PIP Topics
	Indicator 1. Percent of shared members with eligible trigger events who received a combined review in the past three months. Indicator 2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.
Community Care Services	***Follow–Up After Emergency Department Visit for Mental Illness*** Indicator: Percentage of ED visits for members (18+ years of age) with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit for mental illness within seven days of the ED visit.

Network Adequacy Validation (NAV)

Within the Quality Strategy, the MQD established provider network standards to ensure that members have timely access to care. Health plans must ensure that their networks have a 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. Additionally, the health plans are required to maintain a minimum number of providers within a particular geographic area. In addition to the minimum required providers, the health plans are required to have a sufficient network to ensure that members can obtain needed health services within acceptable wait times. To monitor network adequacy, the MQD requires that the health plans submit a quarterly Provider Network Adequacy (PNA) Report. The health plans are also required to establish and monitor policies and procedures to ensure that network providers comply with acceptable wait times and take corrective action when they fail to comply.

HSAG administered a Provider Data Structure Questionnaire (PDSQ) to all participating health plans in 2022 and conducted a review of the MQD's existing PNA report and procedures.

PNA methodology review findings: HSAG noted that the MQD has very thorough instructions for the plans regarding the completion of the quarterly provider network adequacy reports. The MQD provides detailed descriptions of the requested classification of providers, defining the rurality of providers, member populations, and the calculation of the travel distance metrics. Based on HSAG's review, the MQD's requirements are well documented for the health plans. HSAG identified suggestions for clarification that might assist the user while reviewing the Health Plan Manual—Reporting Guide, including additional clarification around some terminology or examples that might further explain concepts to the user.

PDSQ findings: HSAG distributed the MQD-approved PDSQ to each health plan to request qualitative responses for 10 questionnaire elements and to provide supplemental documentation supporting the responses (e.g., data dictionaries, data file layouts, or sample reports). All health plans participated in the questionnaire process and responded to HSAG's email requests for clarification, when needed. HSAG noted that data submitted by the health plans for the PNA analysis did not completely align with the instructions in the PNA methodology. HSAG understands that the MQD is continuing to collaborate with the health plans on the quarterly data submission process and understanding of the PNA instructions. HSAG recommends that the MQD continue this process to educate the health plans to ensure a seamless and efficient process in the future.

HSAG provided the MQD with a final NAV report, which included several recommendations based on findings from the PDSQ and PNA report analyses. These activities have laid the foundation for conducting further NAV activities as required by CMS beginning in calendar year 2024.

Compliance Monitoring Review

During 2022, HSAG conducted a compliance review for each QI health plan and the CCS program to review compliance with federal regulations and State contract requirements. In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. One standard was found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—Confidentiality. Additionally, all but one health plan scored 100 percent in Assurances of Adequate Capacity and Services. The Enrollee Information and Enrollee Rights and Protections standards were identified as having the greatest opportunity for improvement with statewide compliance scores of 89 percent and 95 percent, respectively. No health plans achieved 100 percent in the Enrollee Information standard, and only one health plan was found to be fully compliant in the Enrollee Rights and Protections standard. Overall, three of the six health plans achieved a total compliance score at or above the statewide average.

Table 3-5 summarizes the results from the 2022 compliance monitoring reviews. This table contains high-level results used to compare the Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the eight compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plan scores with green shading indicate performance at or above the statewide score.

Table 3-5—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I. Availability of Services	100%	100%	94%	97%	100%	96%	**98%**
II. Assurances of Adequate Capacity and Services	100%	100%	50%	100%	100%	100%	**92%**
III. Coordination and Continuity of Care	90%	95%	95%	90%	100%	100%	**95%**
IV. Confidentiality	100%	100%	100%	100%	100%	100%	**100%**
V. Coverage and Authorization of Services	92%	98%	100%	89%	100%	93%	**95%**
VI. Enrollee Information	89%	89%	92%	84%	95%	86%	**89%**
VII. Enrollee Rights and Protections	94%	100%	94%	94%	94%	93%	**95%**

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
VIII. Grievance and Appeal System	97%	92%	98%	100%	98%	100%	**98%**
Totals	**95%**	**96%**	**96%**	**93%**	**98%**	**95%**	**96%**
Totals: The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.							

For the elements in standards that were not fully compliant, the health plans were required to develop a corrective action plan (CAP), which was reviewed by the EQRO and the MQD. CAPs were approved when it was determined that the CAP would bring the health plan into compliance with the requirements. HSAG provided ongoing monitoring of the implementation of the CAPs.

CAHPS

The MQD contracts with the EQRO to administer CAHPS surveys according to the NCQA HEDIS Specifications for Survey Measures. A survey of CHIP members is administered annually, while the Adult and Child CAHPS surveys are administered in alternating years. This activity assesses member experience with an MCO and its providers, as well as the quality of care members receive. The standard survey instruments are the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with chronic conditions [CCC] measurement set) and the 5.1H Adult Medicaid Health Plan Survey. CAHPS global ratings are for Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, and Rating of Personal Doctor. Additionally, CAHPS composite measures are Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. All sampled members completed the surveys from February to May 2022. HSAG aggregated and produced final reports in September 2022.

Adult Survey

Based on the comparison of the QI Program aggregate and each of the QI health plans' top-box scores to NCQA's 2021 Quality Compass Benchmark and Compare Quality Data[3-3], the QI program did not score at or above the 90th percentile on any of the measures. Additionally, the QI Program scored below the 25th percentile on six measures: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.

One of the goals the MQD identified for the Hawaii Medicaid program is to improve member experience with health plan services. The MQD selected the following three CAHPS measures as part of its Quality Strategy to monitor the QI health plans' performance on members' experience with these areas of service compared to national benchmarks: *Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*. UHC CP QI's member experience ratings met or exceeded the 75th percentile for *Rating of Health Plan*. No QI health plans' member experience ratings met or exceeded

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[3-3] National Committee for Quality Assurance. Quality Compass®: Benchmark and Compare Quality Data 2021.Washington, DC: NCQA, September 2021.

the 75th percentile for *Getting Needed Care* and for *How Well Doctors Communicate*. In recognition of these gaps, these areas are expected to receive a stronger focus in the next Quality Strategy.

CHIP Survey

Based on the comparison of the CHIP population's member experience ratings and 2022 top-box scores for the four global ratings, four composite measures, and one individual item measure to the NCQA's 2021 Quality Compass Benchmark and Compare Quality Data, the CHIP population scored at or above the 90th percentile on one measure: *Coordination of Care*. The CHIP population scored below the 25th percentile on three measures: *Rating of All Health Care*, *Getting Needed Care*, and *Getting Care Quickly*.

When comparing the CHIP population's 2022 scores to the Quality Strategy goal of 1 percent improvement each year, three measures met the 2022 Quality Strategy targets: *Customer Service*, *Getting Needed Care*, and *Rating of All Health Care*.

Annual EQR Technical Report

To ensure the MQD's compliance with 42 CFR §438.364, an annual aggregate technical report is prepared and includes all required components as outlined in the EQR protocols. Aggregated and analyzed data from the 2022 EQR activities was included, and conclusions were drawn with regard to the quality of, access to, and timeliness of health services furnished to QI and CCS members. Conclusions were described in detail and actionable recommendations, as applicable, were provided. Additionally, based on the assessment, notable strengths were included so that the health plans will be able to build upon identified performance improvement and recommendations for identified opportunities for improvement. The health plans provided a summary of the quality improvement initiatives implemented as a result of the previous year's EQR recommendations.

Actions on EQR Recommendations

In accordance with 42 CFR §438.364(a)(4), the EQR technical report included recommendations for how the MQD can target goals and objectives in the Quality Strategy to better support improvement in the quality of, access to, and timeliness of health services furnished to Medicaid managed care members. Table 3-6 includes the recommendations made to the MQD in support of the Quality Strategy goals and the subsequent actions taken by the MQD to support program improvement and progress toward meeting the goals of the Quality Strategy.

Table 3-6—EQRO Recommendations and State Actions

2021 EQRO Recommendations	MQD Actions
Goal 1: Advance primary care, prevention, and health promotion. **Objective 2:** Reduce unintended pregnancies and improve pregnancy-related care. To improve program-wide performance in support of Objective 2, HSAG recommends MQD: • Conduct a program-wide focus group of women on Medicaid who have recently given birth or are pregnant to determine potential barriers to timely access to prenatal care.	MQD has a multi-prong strategy to increase timely prenatal and postnatal care. Pregnancy care related measures (i.e., PPC) are included as part of the Health Plan pay for performance (P4P) pool and therefore incentivized with payments for achieving performance improvements as well as for meeting or exceeding quality benchmarks. A perinatal quality collaborative designed to improve the quality of care for mothers and babies in hospitals is included in a Hospital P4P Program. This collaborative joined the American College of Obstetrics (ACOG) Alliance for Innovation on Maternal Health (AIM). "AIM is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improving maternal safety and outcomes. The program provides implementation and data support for the adoption of evidence-based patient safety bundles." (https://www.acog.org/practice-management/patient-safety-and-quality/partnerships/alliance-for-innovation-on-maternal-health-aim). Within the past year, the perinatal quality collaborative introduced a new bundle: CARE FOR PREGNANT AND POSTPARTUM PEOPLE WITH SUBSTANCE USE DISORDER and is in the process of coordinating with various stakeholders across the continuum of care to address this complex AIM bundle. Finally, MQD released updated guidance and methodology for assessing timely access to care requirements. MQD is using a secret shopper to assess appointment availability for a variety of providers across all Health Plans. These data will provide valuable insight on the experiences of members making appointments and potential barriers by type of provider, type of appointment, and island.
Goal 1: Advance primary care, prevention, and health promotion. **Objective 3:** Increase utilization of adult preventive screenings in the primary care setting. To improve program-wide performance in support of Objective 3, HSAG recommends MQD: • Encourage health plans to evaluate the accuracy, completeness, readability level, content, and frequency of member	The new 2021 Managed Care Contract contains robust language around member communications. This includes having information readily available in easily understood and readily accessible formats, including through translation and interpretation services in the member's desired and preferred language. Modalities must include written materials, telephone, internet, and face-to-face communications as requested. The interpretation and translations services report (ITR) has been revised to develop key performance indicators on

2021 EQRO Recommendations	MQD Actions
communications, such as member newsletters, to improve member understanding and engagement in preventive healthcare.	ensuring Health Plans are providing these services timely and of high quality.
Goal 2: 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). To improve program-wide performance in support of Objectives 5 and 6, HSAG recommends MQD: • Continue to encourage information sharing, collaboration, and care coordination among health plans and State agencies that provide services to Medicaid members. • Continue to promote and increase the use of telemedicine. • Consider implementing incentive programs to encourage advanced practice registered nurses and PCPs to obtain mental health training.	To improve care coordination for individuals who receive behavioral health services through DOH, MQD contractually requires Health Plans to develop joint policies and procedures and coordinate closely on the provision of care to their beneficiaries with the DOH. Beginning 2022, QI Health Plans started working on a performance improvement project (PIP) that seeks to improve the coordination of care of Medicaid members enrolled in one of the five managed care organizations (MCOs) that are also receiving behavioral health services from the Prepaid Inpatient Health Plan (PIHP) Community Care Services (CCS) program and/or from the State of Hawaii, Department of Health (DOH) behavioral health agencies. The DOH agencies include the Adult Mental Health Division (AMHD), Child & Adolescent Mental Health Division (CAMHD), Alcohol & Drug Abuse Division (ADAD), and the Developmental Disabilities Division (DDD). Additionally, MQD has developed guidance aimed to increase the adoption of utilization of telehealth and telemedicine. This included numerous flexibilities during the public health emergency. 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 ongoing efforts to promote telehealth have strongly benefited access to care during the 2020 COVID-19 PHE and beyond. For example, post-pandemic, MQD continues to cover mental health services furnished through audio-only telehealth appointments (QI-2306). Finally, SBIRT is a covered benefit as of 2022 and training resources as well as island trainings have allowed providers, including APRNs and PCPs, to obtain behavioral health training.
Goal 3: Improve outcomes for high-need, high-cost individuals. **Objective 7:** Provide appropriate care coordination for populations with special healthcare needs.	MQD supports alignment and coordination of services for individuals with SHCN who independently also qualify for LTSS. MQD works collaboratively with the Health Plans and other stakeholders to further describe roles and responsibilities of members of care teams to

2021 EQRO Recommendations	MQD Actions
To improve program-wide performance in support of Objective 7, HSAG recommends MQD: • Reward creative care coordination programs or initiatives that strive to ensure members receive timely assessments and healthcare services that prevent and treat identified conditions and assess and refer members to appropriate community partners to address social determinants of health (SDoH).	promote shared accountability for whole person care. MQD encourages 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 are used to closely track efforts by Health Plans to reach, engage, and provide appropriate services to beneficiaries.
Goal 3: Improve outcomes for high-need, high-cost individuals. **Objective 8:** Provide team-based care for beneficiaries with high-need, high-cost conditions. To improve program-wide performance in support of Objective 8, HSAG recommends MQD: • Encourage communication and collaboration among health plans, providers, and State agencies in coordinating care among beneficiaries with high-need, high-cost conditions.	To improve care coordination for individuals who receive behavioral health services, including high-need high-cost conditions, through DOH, MQD contractually require Health Plans to develop joint policies and procedures and coordinate closely on the provision of care to their beneficiaries with the DOH. Beginning 2022, QI Health Plans started working on a performance improvement project (PIP) that seeks to improve the coordination of care of Medicaid members enrolled in one of the five managed care organizations (MCOs) that are also receiving behavioral health services from the Prepaid Inpatient Health Plan (PIHP) Community Care Services (CCS) program and/or from the State of Hawaii, Department of Health (DOH) behavioral health agencies. The DOH agencies include the Adult Mental Health Division (AMHD), Child & Adolescent Mental Health Division (CAMHD), Alcohol & Drug Abuse Division (ADAD), and the Developmental Disabilities Division (DDD).
Goal 3: Improve outcomes for high-need, high-cost individuals. **Objective 10:** Provide supportive housing to homeless beneficiaries with complex health needs. To improve program-wide performance in support of Objective 10, HSAG recommends MQD: • Continue to facilitate and enhance relationships with housing agencies.	MQD evaluates the CIS program using a rapid cycle assessment approach through external evaluation support, with frequent and ongoing assessments of implementation progress. A series of key performance indicators (KPIs) designed to measure progressive implementation and achievement of short, intermediate, and long-term outcomes are included in Health Plan reporting requirements to track project progress and performance improvement. Quarterly, Health Plans, MQD, and housing service providers are brought together to discuss the results and discuss next steps. Through these efforts, CIS has undergone major program enhancements. Finally, select measures may be incentivized through P4P programs or other value-based strategies in the future.

2021 EQRO Recommendations	MQD Actions
Goal 4: Support community initiatives to improve population health. **Objective 11:** Assess and address SDoH needs. To improve program-wide performance in support of Objective 11, HSAG recommends MQD: • Continue to strengthen community partnerships and encourage health plans to continue to invest in the communities they serve. • Encourage collaboration among the health plans and the State on program-wide solutions that address SDoH.	MQD worked with its Health Plans and community partners to develop a statewide SDOH Transformation Plan. MQD intends to 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 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 have started identifying SDOH quality improvement activities in their QAPI progress reports. Health Plans may also, in adherence with Medicare requirements, provide supplemental services that support statewide efforts to address SDOH. A series of reporting requirements and performance measurement were established to closely monitor the implementation of various SDOH efforts.
Goal 5: Enhance care in LTSS settings. **Objective 12:** Enhance community integration/reintegration of LTSS beneficiaries. **Objective 13:** Enhance nursing facility and HCBS; prevent or delay progression to nursing facility level of care. To improve program-wide performance in support of Objectives 12 and 13, HSAG recommends MQD: • Consider adding LTSS measures to the list of audited measures to be validated during the PMV activity. Results will help the MQD determine areas to focus on and validated measures/rates may be used in conjunction with the State's incentive programs (P4P, auto-assignment) to drive quality outcomes. • Provide enhanced payment to Community Care Foster Family Homes (CCFFH) that accept LTSS members deemed "difficult to place" due to a combination of challenging physical and behavioral health needs.	MQD has adopted most MLTSS measures. Starting in MY2021, the EQRO began auditing a subset of the MLTSS measure. MQD intends to continue auditing LTSS measures and may expand the number in the future. 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. MQD increased CCFFH reimbursement rates to result in an 8.6% increase over 2021 reimbursement levels, effective 1/1/2023. MQD completed an HCBS rate

2021 EQRO Recommendations	MQD Actions
	study, which included modeled payment rate scenarios that would fully capture the expected resources for CCFFH services. MQD submitted this rate study to the state legislature prior to the 2023 session and is waiting for legislative budget appropriation in order to implement. MQD is working with CCFFH providers to develop a standardized "level 3" enhanced rate for residents with behavioral health needs. Note that MQD is aware of several managed care plans that have already implemented their own enhanced CCFFH rates for select residents, based on negotiations with providers.
Goal 6: Maintain access to appropriate care. **Objective 14:** Maintain or enhance access to care. To improve program-wide performance in support of Objective 14, HSAG recommends MQD: • Consider adding validation of network adequacy activities as part of EQR to ensure access standards are being met. • Select a third PIP topic that focuses on improving members' access to care.	Starting in 2022, MQD worked with HSAG to develop network adequacy validation (NAV) activities. This included plans to conduct a network adequacy analysis on non-participating providers. During this period, the MQD worked with HSAG to plan for the mandatory NAV activities starting in 2024. MQD is actively working on planning for the 3rd PIP.
Goal 7: Align payment structures to improve health outcomes. **Objective 16:** Align payment structures to support work on SDoH. **Objective 17:** Align payment structures to enhance quality and value of care. To improve program-wide performance in support of Objectives 16 and 17, HSAG recommends MQD: • Continue and enhance P4P to the health plans through enhanced payment for meeting key performance indicator goals. • Continue and enhance the quality-based auto-assignment program to incentivize health plans for meeting specified quality measures. • Consider developing a quality-based incentive program targeting the implementation of health plan interventions and initiatives that address SDoH.	MQD has continued the Health Plan P4P program and released updated methodology and guidance in 2022. This program is intended 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, 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. MQD has continued the auto-assignment program and released updated guidance in 2022. The enhanced auto-assignment program contains a 70% quality component and numerous quality measures focused on primary care, behavioral health, and chronic disease management.

2021 EQRO Recommendations	MQD Actions
• Implement strategies to critically evaluate the accuracy of the health plans' encounter data and encourage the health plans to conduct ongoing quality monitoring beyond any EDV activities conducted during EQR.	P4P measures are being utilized to support SDOH; for example, measures that track increased data collection. 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 Hawaii hospitals. Since the 2021 EQRO MQD has implemented a Claims and Encounter Data Quality Improvement (CEDQI) initiative to improve the completeness, accuracy, and timeliness of the encounter data we receive from our health plans. With this initiative MQD meets with Health Plans individually to discuss known data quality issues and identify steps to resolve, including updates to systems, policies, and encounter data submission requirements. In 2023 MQD initiated a new EDV activity to conduct a comparative analysis between the encounters health plans submit to MQD and encounters health plans submit to our actuaries for rate setting. This activity will provide useful findings to further the work of the CEDQI initiative.

* Please note, content included in the "MQD Actions" section is presented verbatim as received from the State and has not been edited or validated by HSAG.

4. Strengths and Recommendations

Strengths

The MQD's Quality Strategy provides the roadmap to achieve its vision of healthy families and healthy communities. The MQD continually monitors, assesses, and implements strategies to improve access to quality care. Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of Hawaii's QI and CCS programs.

The results of the compliance review, NAV, PIP, and HEDIS audit activities indicate that the health plans have established an operational foundation to support the quality of, access to, and timeliness of care and service delivery.

The Hawaii Medicaid managed care program has made significant progress toward achieving Goal 2: Integrate behavioral health with physical health across the continuum of care, as performance measure results indicate that two-thirds of the established Quality Strategy statewide targets were achieved. MQD initiatives, health plan contract requirements, SBIRT screening, and CIS program benefits will support continued improvement in this program area.

Progress was also made toward achieving Goal 3—Improve outcomes for high-need, high-cost individuals, as performance measure results showed that more than 50 percent of the established Quality Strategy statewide targets were achieved. Of note, four of the five PQI measure rates far exceeded the statewide targets. Timely and effective outpatient care, along with care coordination for members with special healthcare needs, will support continued improvement in this program area.

Recommendations

The EQRO has identified the following recommendations for the Quality Strategy:

- HSAG recommends that the MQD consider a change in metric benchmarks so that the health plans strive toward a consistent performance level. HSAG recommends that the MQD remove the 1 percent improvement target and establish benchmarks that align with nationally recognized quality measures (e.g., NCQA Quality Compass) and the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on Medicaid.gov.
- HSAG recommends that the MQD consider updating the Quality Strategy Measure Appendix annually. As performance measures are added or retired and benchmarks change, it is important that the health plans, hospitals, and nursing facilities have current information on measures and performance goals.

- HSAG recommends that the MQD consider adding a measure or measures that target Objective 10: Provide supportive housing to homeless beneficiaries with complex health needs. There are currently no performance measures in the Quality Strategy to evaluate progress on achieving this objective.
- HSAG recommends that the MQD consider evaluating the Hospital P4P and Nursing Facility P4P program goals and associated measures and performance targets. While the process measures achieved a rating of *Met*, none of the performance measures met the RY 2022 statewide targets.
- HSAG recommends that the MQD consider collaborating with the health plans to brainstorm and implement improvement activities to increase utilization of adult and pediatric preventive care. The MQD may consider requiring the health plans to conduct a preventive care PIP in 2024 to address low performance measure rates.
- HSAG recommends that the health plans conduct an analysis to determine why CAHPS scores continue to be low. Adult CAHPS scores decreased from 2020 to 2022, and none of the statewide RY 2022 targets were met.

Appendix A. Hawaii Medicaid Goals Tracking Table

Goal 1—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

PM Code	Performance Measure Name	Measure Steward	Objective				RY2022 Target	RY2022 Result
			1	2	3	4		
AAP	Adults Access to Preventive/Ambulatory Health Services: Total	NCQA		✓	✓	✓	76.74%	71.46%
ABA-AD	Adult Body Mass Index Assessment	NCQA			✓		NT	—
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓				66.22%	46.15%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓				53.62%	61.62%
AMR	Asthma Medication Ratio	NCQA	✓		✓	✓	52.22%	62.46%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓				40.00%	41.10%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓				17.62%	22.65%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓				20.67%	21.68%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓				63.67%	61.54%
AUD-CH	Audiological Diagnosis No Later Than 3 Months of Age	CDC	✓				NT	—
AWC	Adolescent Well-Care Visits	NCQA	✓				52.11%	—
CBP	Controlling High Blood Pressure (<140/90)	NCQA			✓	✓	59.22%	57.78%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Long-Acting Reversible Method of Contraception (LARC)—3 Days	OPA	✓	✓			3.40%	2.92%

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PM Code	Performance Measure Name	Measure Steward	Objective				RY2022 Target	RY2022 Result
			1	2	3	4		
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Long-Acting Reversible Method of Contraception (LARC)—60 Days	OPA	✓	✓			18.70%	15.68%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days	OPA	✓	✓			9.37%	9.05%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—60 Days	OPA	✓	✓			44.21%	42.01%
CCS	Cervical Cancer Screening	NCQA			✓		61.36%	55.81%
CCW-AD; CW-CH	Contraceptive Care—All Women Ages 21 to 44: Most Effective or Moderately Effective Method of Contraception	OPA	✓	✓			24.04%	22.69%
CCW-AD; CW-CH	Contraceptive Care—All Women Ages 21 to 44: Long-Acting Reversible Method of Contraception (LARC)	OPA	✓	✓			5.51%	4.91%
CDC	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA			✓	✓	67.95%	60.34%
CDC	Comprehensive Diabetes Care: HbA1c Control (<8%)	NCQA				✓	50.76%	50.92%
CDC	Comprehensive Diabetes Care: HbA1c Poor Control (>9%)*	NCQA				✓	37.60%	37.10%
CDC	Comprehensive Diabetes Care: HbA1c Testing	NCQA			✓	✓	90.85%	87.29%
CDC	Comprehensive Diabetes Care: BP Control (<140/90 mm Hg)	NCQA				✓	60.56%	58.48%
CDF-CH; CDF-AD	Screening for Depression and Follow-Up Plan: Negative Screen for Depression During an Outpatient Visit Using a Standardized Tool	CMS	✓		✓		NT	22.05%
CHL	Chlamydia Screening in Women: Total	NCQA	✓		✓		53.79%	49.18%
CIS	Childhood Immunization Status: Combination 2	NCQA	✓				69.93%	57.80%

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PM Code	Performance Measure Name	Measure Steward	Objective				RY2022 Target	RY2022 Result
			1	2	3	4		
CIS	Childhood Immunization Status: Combination 3	NCQA	✓				70.65%	55.91%
CIS	Childhood Immunization Status: Combination 4	NCQA	✓				65.93%	55.58%
CIS	Childhood Immunization Status: Combination 5	NCQA	✓				56.77%	48.45%
CIS	Childhood Immunization Status: Combination 6	NCQA	✓				50.54%	43.49%
CIS	Childhood Immunization Status: Combination 7	NCQA	✓				55.88%	48.13%
CIS	Childhood Immunization Status: Combination 8	NCQA	✓				50.20%	43.43%
CIS	Childhood Immunization Status: Combination 9	NCQA	✓				43.43%	38.41%
CIS	Childhood Immunization Status: Combination 10	NCQA	✓				43.15%	38.34%
COL	Colorectal Cancer Screening	NCQA			✓		NT	46.60%
DEV-CH	Developmental Screening in the First Three Years of Life	OHSU	✓				22.63%	24.14%
Falls1	Falls: Screening for Future Fall Risk: Part 1: Screening	NCQA			✓		NT	47.61%
Falls2	Falls: Screening for Future Fall Risk: Part 2: Risk Assessment	NCQA			✓		NT	73.53%
Falls3	Falls: Screening for Future Fall Risk: Part 3: Plan of Care	NCQA			✓		NT	57.35%
HVL-AD	HIV Viral Load Suppression: HIV Viral Load Suppression	HRSA			✓	✓	NT	3.67%
IMA	Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap)	NCQA	✓				66.65%	66.90%
IMA	Immunizations for Adolescents: Combination 2 (Meningococcal, Tdap, HPV)	NCQA	✓				30.29%	38.58%
LBW-CH	Live Births Weighing Less Than 2,500 Grams	CDC	✓	✓			7.97%	9.50%
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA		✓			81.56%	83.78%
PPC	Prenatal and Postpartum Care: Postpartum Care	NCQA		✓			59.12%	77.56%
SBIRT	SBIRT Training	MQD			✓	✓	NT	—
NA	SBIRT Screening: SBIRT screenings provided to a % of Medicaid beneficiaries over age 15 years	MQD			✓	✓	5.67%	—
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA			✓		75.34%	68.78%

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PM Code	Performance Measure Name	Measure Steward	Objective				RY2022 Target	RY2022 Result
			1	2	3	4		
TOB	Preventive Care and Screening: Tobacco Use: Screening and Cessation	PCPI			✓		NT	—
W15	Well-Child Visits in the First 15 Months of Life: 6 or More Visits	NCQA	✓				74.13%	—
W30	Well-Child Visits in the First 30 Months of Life: 15 Months	NCQA	✓				64.42%	63.73%
W30	Well-Child Visits in the First 30 Months of Life: 30 Months	NCQA	✓				76.75%	68.63%
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA	✓				72.89%	—
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: BMI Percentile Documentation	NCQA	✓				88.55%	80.89%
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: Counseling for Nutrition	NCQA	✓				79.52%	77.85%
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: Counseling for Physical Activity	NCQA	✓				74.98%	75.49%
WCV	Child and Adolescent Well-Care Visits	NCQA	✓				45.21%	46.04%
NA	Perinatal Collaborative: Design and implement a program to improve the quality of care for mothers and babies	MQD	✓	✓			Progress along continuum	Met
EPSDT	Screening Ratio: Observed: Expected ratio of number of screenings	CMS	✓				1.0	0.72
EPSDT	Participant Ratio: Observed: Expected ratio of eligibles receiving at least one initial or periodic screen	CMS	✓				88.74%	56.00%
EPSDT	Dental Care: Percent of eligibles receiving any dental or oral health services	CMS	✓				60.04%	52.95%
EPSDT	Dental Care: Percent of eligibles receiving preventive dental services	CMS	✓				45.49%	50.20%
CAHPS 5.0H	Composite Measure: Getting Needed Care (CHIP)	AHRQ	✓				78.28%	80.80%
CAHPS 5.0H	Composite Measure: Getting Care Quickly (CHIP)	AHRQ	✓				87.86%	83.10%
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (CHIP)	AHRQ	✓				98.67%	94.40%

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PM Code	Performance Measure Name	Measure Steward	Objective				RY2022 Target	RY2022 Result
			1	2	3	4		
CAHPS 5.0H	Composite Measure: Customer Service (CHIP)	AHRQ	✓				87.24%	90.00%
CAHPS 5.0H	Composite Measure: Shared Decision Making (CHIP)	AHRQ	✓				78.18%	—
CAHPS 5.0H	Individual Measures: Coordination of Care (CHIP)	AHRQ	✓				93.94%	92.60%
CAHPS 5.0H	Individual Measures: Health Promotion and Education (Adults)	AHRQ		✓	✓		80.50%	—
CAHPS 5.0H	Individual Measures: Health Promotion and Education (CHIP)	AHRQ	✓				77.56%	—

Goal 2—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)

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			5	6		
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓	✓	66.22%	46.15%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓	✓	53.62%	61.62%
AMM	Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA	✓	✓	54.38%	60.33%
AMM	Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA	✓	✓	37.93%	43.67%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓	✓	40.00%	41.10%

Goal 2—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)

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			5	6		
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓	✓	17.62%	22.65%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓	✓	20.67%	21.68%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓	✓	63.67%	61.54%
BHA	Behavioral Health Assessment: Behavioral Health Assessment completion within 30 days of enrollment	MQD		✓	47.59%	61.90%
CDF-CH; CDF-AD	Screening for Depression and Follow-Up Plan: Negative Screen for Depression During an Outpatient Visit Using a Standardized Tool	CMS	✓		NT	22.05%
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA		✓	14.44%	13.25%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA	✓	✓	20.66%	25.21%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA	✓	✓	12.85%	17.70%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA	✓	✓	54.90%	60.47%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA	✓	✓	35.36%	40.01%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA	✓	✓	50.57%	48.22%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA	✓	✓	33.28%	32.13%
FUP	Follow-up With Assigned PCP Following Hospitalization for Mental Illness	MQD	✓	✓	37.50%	—
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*	NCQA	✓	✓	NT	50.20%

Goal 2—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)

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			5	6		
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA	✓	✓	36.30%	37.08%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA	✓	✓	12.04%	11.09%
MPTA	Mental Health Utilization—Total Medicaid—telehealth/access: Mental Health Utilization—Total Medicaid (Any service)	NCQA	✓	✓	10.68%	9.74%
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer*	PQA	✓	✓	11.09%	10.62%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Total (Rate 1)	CMS		✓	48.78%	50.42%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine (Rate 2)	CMS		✓	29.32%	31.21%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone (Rate 3)	CMS		✓	1.43%	0.98%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone (Rate 4)	CMS		✓	0.11%	0.26%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Methadone (Rate 5)	CMS		✓	20.07%	20.20%
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA	✓	✓	69.30%	69.29%
SBIRT	SBIRT Training	MQD	✓		NT	—
NA	SBIRT Screening: SBIRT screenings provided to a % of Medicaid beneficiaries over age 15 years	MQD	✓		5.67%	—
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA		✓	75.34%	68.78%

Goal 3—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

PM Code	Performance Measure Name	Measure Steward	Objective				RY2022 Target	RY2022 Result
			7	8	9	10		
ACP	Advance Care Planning	NCQA			✓		NT	1.96%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓	✓			66.22%	46.15%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓	✓			53.62%	61.62%
AMM	Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA		✓			54.38%	60.33%
AMM	Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA		✓			37.93%	43.67%
AMR	Asthma Medication Ratio	NCQA	✓				52.22%	62.46%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓				40.00%	41.10%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓				17.62%	22.65%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓				20.67%	21.68%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓				63.67%	61.54%
BHA	Behavioral Health Assessment: Behavioral Health Assessment completion within 30 days of enrollment	MQD	✓				47.59%	61.90%
CDC	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA	✓	✓			67.95%	60.34%
CDC	Comprehensive Diabetes Care: HbA1c Control (<8%)	NCQA	✓	✓			50.76%	50.92%
CDC	Comprehensive Diabetes Care: HbA1c Poor Control (>9%)*	NCQA	✓	✓			37.60%	37.10%
CDC	Comprehensive Diabetes Care: HbA1c Testing	NCQA	✓	✓			90.85%	87.29%
CDC	Comprehensive Diabetes Care: BP Control (<140/90 mm Hg)	NCQA	✓	✓			60.56%	58.48%
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA	✓	✓			14.44%	13.25%

Goal 3—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

PM Code	Performance Measure Name	Measure Steward	Objective				RY2022 Target	RY2022 Result
			7	8	9	10		
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA	✓	✓			20.66%	25.21%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA	✓	✓			12.85%	17.70%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA	✓	✓			54.90%	60.47%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA	✓	✓			35.36%	40.01%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA	✓	✓			50.57%	48.22%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA	✓	✓			33.28%	32.13%
FUP	Follow-up With Assigned PCP Following Hospitalization for Mental Illness	MQD	✓	✓			37.50%	—
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*	NCQA	✓	✓			NT	50.20%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA	✓	✓			36.30%	37.08%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA	✓	✓			12.04%	11.09%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓				NT	9.92%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓				NT	9.92%
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner: LTSS Shared Care Plan with Primary Care Practitioner	CMS	✓	✓			NT	18.40%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓				NT	10.63%

Goal 3—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									
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**				**RY2022 Target**	**RY2022 Result**
			7	**8**	**9**	**10**		
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓				NT	1.31%
PQI01-AD	PQI 01: Diabetes Short-Term Complications Admission Rate*	AHRQ	✓	✓			15.23	8.43
PQI05-AD	PQI 05: COPD or Asthma in Older Adults Admission Rate*	AHRQ	✓	✓			49.04	18.87
PQI08-AD	PQI 08: Heart Failure Admission Rate*	AHRQ	✓	✓			59.19	45.65
PQI15-AD	PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ	✓	✓			2.54	2.58
PQI-92	PQI 92: Chronic Conditions Composite*	AHRQ	✓	✓			136.43	88.41
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA	✓	✓			69.30%	69.29%
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA	✓	✓			75.34%	68.78%
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (Adults)	NCQA	✓	✓			97.14%	90.60%
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (CHIP)	NCQA	✓	✓			98.67%	94.40%
CAHPS 5.0H	Composite Measure: Shared Decision Making: Composite Measure: Shared Decision Making (Adults)	NCQA	✓	✓			86.42%	—
CAHPS 5.0H	Composite Measure: Shared Decision Making (CHIP)	NCQA	✓	✓			78.18%	—
CAHPS 5.0H	Individual Measures: Coordination of Care (Adults)	NCQA	✓	✓			87.36%	81.70%
CAHPS 5.0H	Individual Measures: Coordination of Care (CHIP)	NCQA	✓	✓			93.94%	92.60%

Goal 3—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

PM Code	Performance Measure Name	Measure Steward	Objective				RY2022 Target	RY2022 Result
			7	8	9	10		
CAHPS Hospice	Rating of Hospice: % family caregivers rating the hospice agency a 9 or 10 on a scale of 0 (worst) to 10 (best)	CMS			✓		81.20%	83.00%
NA	Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission	CMS			✓		96.60%	88.10%
NA	Hospice Visits when Death is Imminent: % patients receiving at least one visit from a provider in the last 3 days of life	CMS			✓		85.50%	84.60%

Goal 4—Support community initiatives to improve population health

Objective 11—Assess and address social determinants of health needs

PM Code	Performance Measure Name	Measure Steward	Objective	RY2022 Target	RY2022 Result
			11		
LTSS-CA	LTSS Comprehensive Assessment and Update: Assessment of Core Elements	CMS	✓	NT	18.73%
LTSS-CA	LTSS Comprehensive Assessment and Update: Assessment of Supplemental Elements	CMS	✓	NT	17.19%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓	NT	9.92%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓	NT	9.92%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓	NT	10.63%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓	NT	1.31%
NA	Social Determinants of Health Collaborative: Design and implement a program to track the social determinants associated with patients	MQD	✓	Progress along continuum	Met

Goal 5—Enhance care in LTSS settings

Objective 12—Enhance community integration/reintegration of LTSS beneficiaries
Objective 13—Enhance nursing facility and Home and Community Based Services (HCBS); prevent or delay progression to nursing facility level of care

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			12	13		
LTSS-AIF	LTSS Admission to an Institution from the Community: Short Term Stay	CMS	✓	✓	NT	34.78
LTSS-AIF	LTSS Admission to an Institution from the Community: Medium-Term Stay	CMS	✓	✓	NT	7.27
LTSS-AIF	LTSS Admission to an Institution from the Community: Long-Term Stay	CMS		✓	NT	3.85
LTSS-CA	LTSS Comprehensive Assessment and Update: Assessment of Core Elements	CMS	✓	✓	NT	18.73%
LTSS-CA	LTSS Comprehensive Assessment and Update: Assessment of Supplemental Elements	CMS	✓	✓	NT	17.19%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓	✓	NT	9.92%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓	✓	NT	9.92%
LTSS-ILOS	LTSS Minimizing Institutional Length of Stay: Observed Rate	CMS	✓	✓	14.15%	17.02%
LTSS-ILOS	LTSS Minimizing Institutional Length of Stay: Risk-adjusted Ratio	CMS	✓	✓	0.4329	0.5379
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner: LTSS Shared Care Plan with Primary Care Practitioner	CMS	✓	✓	NT	18.40%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Observed Rate	CMS	✓	✓	80.77%	68.48%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Risk-adjusted Ratio	CMS	✓	✓	0.8678	1.0528
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓	✓	NT	10.63%

Goal 5—Enhance care in LTSS settings

Objective 12—Enhance community integration/reintegration of LTSS beneficiaries
Objective 13—Enhance nursing facility and Home and Community Based Services (HCBS); prevent or delay progression to nursing facility level of care

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			12	13		
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓	✓	NT	1.31%
N024.01	Long Stay Urinary Tract Infections: Percentage of long-stay residents with a urinary tract infection*	CMS		✓	2.15%	2.59%
N031.02	Long Stay Antipsychotic Medications: Percent of Residents Who Received an Antipsychotic Medication (Long-Stay)*	CMS		✓	6.95%	9.71%
N015.01	Long Stay Pressure Ulcers: Percent of High-Risk Residents with Pressure Ulcers (Long Stay)*	CMS		✓	4.94%	4.99%
NA	PointRight Pro 30—Rehospitalizations: Risk adjusted rehospitalization rate*	AHCA		✓	8.84%	10.42%
NA	PointRight Pro Long Stay—Hospitalizations: Risk-adjusted rate of hospitalization of long-stay patients*	AHCA		✓	7.86%	8.01%
NA	BONUS: AHCA/NCAL National Quality Award: Number of facilities with an AHCA/NCAL Gold award for excellence in quality	AHCA		✓	NT	0

Goal 6—Maintain access to appropriate care

Objective 14—Maintain or enhance access to care
Objective 15—Increase coordination of care and decrease inappropriate care

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			14	15		
AAP	Adults' Access to Preventive/Ambulatory Health Services: Total	NCQA	✓		76.74%	71.46%
ACP	Advance Care Planning	NCQA	✓	✓	NT	1.96%
AMB	Ambulatory Care: Emergency Department (ED) Visits (per 1,000 member months)*	NCQA	✓	✓	42.42	30.93
AMB	Ambulatory Care: Outpatient Visits Including Telehealth (per 1,000 member months)	NCQA	✓	✓	356.80	330.07
AMR	Asthma Medication Ratio	NCQA		✓	52.22%	62.46%

Goal 6—Maintain access to appropriate care

Objective 14—Maintain or enhance access to care
Objective 15—Increase coordination of care and decrease inappropriate care

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			14	15		
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA		✓	40.00%	41.10%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA		✓	17.62%	22.65%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA		✓	20.67%	21.68%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA		✓	63.67%	61.54%
BHA	Behavioral Health Assessment: Behavioral Health Assessment completion within 30 days of enrollment	MQD		✓	47.59%	61.90%
CDC	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA		✓	67.95%	60.34%
CDC	Comprehensive Diabetes Care: HbA1c Control (<8%)	NCQA		✓	50.76%	50.92%
CDC	Comprehensive Diabetes Care6: HbA1c Poor Control (>9%)	NCQA		✓	37.60%	37.10%
CDC	Comprehensive Diabetes Care: HbA1c Testing	NCQA		✓	90.85%	87.29%
CDC	Comprehensive Diabetes Care: BP Control (<140/90 mm Hg)	NCQA		✓	60.56%	58.48%
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA		✓	14.44%	13.25%
ENPA	Enrollment by Product Line—Total Medicaid: Enrollment by Product Line—Total Medicaid member-months	NCQA	✓		NT	4,834,917
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA		✓	20.66%	25.21%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA		✓	12.85%	17.70%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA		✓	54.90%	60.47%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA		✓	35.36%	40.01%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA		✓	50.57%	48.22%

Goal 6—Maintain access to appropriate care

Objective 14—Maintain or enhance access to care
Objective 15—Increase coordination of care and decrease inappropriate care

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			14	15		
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA		✓	33.28%	32.13%
FUP	Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	MQD		✓	37.50%	—
HPC	Hospitalization for Potentially Preventable Complications	NCQA	✓	✓	NT	—
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*	NCQA		✓	NT	50.20%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA		✓	36.30%	37.08%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA		✓	12.04%	11.09%
IPU	Inpatient Utilization—General Hospital/Acute Care: Inpatient Utilization—General Hospital/Acute Care (Total, Days per 1000 member months)*	NCQA	✓		35.17	32.56
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner	CMS		✓	NT	18.40%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Observed Rate	CMS		✓	80.77%	68.48%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Risk-adjusted Ratio	CMS		✓	0.8678	1.0528
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS		✓	NT	10.63%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS		✓	NT	1.31%
MPTA	Mental Health Utilization—Total Medicaid—telehealth/access: Mental Health Utilization—Total Medicaid (Any service)	NCQA		✓	10.68%	9.74%
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer*	PQA		✓	11.09%	10.62%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Total (Rate 1)	CMS		✓	48.78%	50.42%

Goal 6—Maintain access to appropriate care

Objective 14—Maintain or enhance access to care
Objective 15—Increase coordination of care and decrease inappropriate care

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			14	15		
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine (Rate 2)	CMS		✓	29.32%	31.21%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone (Rate 3)	CMS		✓	1.43%	0.98%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone (Rate 4)	CMS		✓	0.11%	0.26%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Methadone (Rate 5)	CMS		✓	20.07%	20.20%
PCR	Plan All-Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total*	NCQA		✓	0.6923	0.8624
PQI01-AD	PQI 01: Diabetes Short-Term Complications Admission Rate*	AHRQ		✓	15.23	8.43
PQI05-AD	PQI 05: COPD or Asthma in Older Adults Admission Rate*	AHRQ		✓	49.04	18.87
PQI08-AD	PQI 08: Heart Failure Admission Rate*	AHRQ		✓	59.19	45.65
PQI15-AD	PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ		✓	2.54	2.58
THP	Telehealth Plan	MQD	✓		Progress along continuum	Met
N024.01	Long Stay Urinary Tract Infections: Percentage of long-stay residents with a urinary tract infection*	CMS		✓	2.15%	2.59%
N031.02	Long Stay Antipsychotic Medications: Percent of Residents Who Received an Antipsychotic Medication (Long-Stay)*	CMS		✓	6.95%	9.71%
N015.01	Long Stay Pressure Ulcers: Percent of High-Risk Residents with Pressure Ulcers (Long Stay)*	CMS		✓	4.94%	4.99%
NA	PointRight Pro 30—Rehospitalizations: Risk adjusted rehospitalization rate*	AHCA		✓	8.84%	10.42%
NA	PointRight Pro Long Stay—Hospitalizations: Risk-adjusted rate of hospitalization of long-stay patients*	AHCA		✓	7.86%	8.01%

Goal 6—Maintain access to appropriate care

Objective 14—Maintain or enhance access to care
Objective 15—Increase coordination of care and decrease inappropriate care

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			14	15		
NA	30 Day All Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total*	NCQA		✓	1.0243	—
NA	Preventable ER Visits (NYU Algorithm): Total Visits—Number Preventable*	NYU		✓	46.02%	—
NA	Reducing ED Visits for Patients with 4 or more visits: ED treat and release visits for patients with 4+ visits to the same facility in a calendar year*	HAH		✓	15.00%	21.07%
OP-18	Time from ED Admit to Discharge: Average time patients spent in the emergency department before being sent home (Target and Rate are represented as # of minutes)*	CMS	✓	✓	68.31	78.00
CAHPS 5.0H	Composite Measure: Getting Needed Care: (CHIP)	NCQA	✓	✓	78.28%	80.80%
CAHPS 5.0H	Composite Measure: Getting Needed Care (Adults)	NCQA	✓	✓	86.74%	79.20%
CAHPS 5.0H	Composite Measure: Getting Care Quickly (CHIP)	NCQA	✓	✓	87.86%	83.10%
CAHPS 5.0H	Composite Measure: Getting Care Quickly (Adults)	NCQA	✓	✓	85.07%	75.80%
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (Adults)	NCQA		✓	97.14%	90.60%
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (CHIP)	NCQA		✓	98.67%	94.40%
CAHPS 5.0H	Composite Measure: Customer Service (Adults)	NCQA	✓		92.87%	84.70%
CAHPS 5.0H	Composite Measure: Shared Decision Making (Adults)	NCQA		✓	86.42%	—
CAHPS 5.0H	Composite Measure: Shared Decision Making (CHIP)	NCQA		✓	78.18%	—
CAHPS 5.0H	Individual Measures: Coordination of Care (Adults)	NCQA		✓	87.36%	81.70%

Goal 6—Maintain access to appropriate care

Objective 14—Maintain or enhance access to care
Objective 15—Increase coordination of care and decrease inappropriate care

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			14	15		
CAHPS 5.0H	Individual Measures: Coordination of Care (CHIP)	NCQA		✓	93.94%	92.60%
CAHPS 5.0H	Individual Measures: Health Promotion and Education (Adults)	NCQA	✓		80.50%	—
CAHPS 5.0H	Individual Measures: Health Promotion and Education (CHIP)	NCQA	✓		77.56%	—
CAHPS 5.0H	Composite Measure: Rating of Health Plan (Adults)	NCQA	✓		65.62%	61.60%
CAHPS 5.0H	Composite Measure: Rating of All Health Care (Adults)	NCQA	✓		58.76%	58.40%
CAHPS 5.0H	Composite Measure: Rating of Health Plan (CHIP)	NCQA	✓		73.54%	72.30%
CAHPS 5.0H	Composite Measure: Rating of All Health Care (CHIP)	NCQA	✓		68.39%	68.90%
EPSDT	Screening Ratio: Observed: Expected ratio of number of screenings	CMS	✓		1.00	0.72
EPSDT	Participant Ratio: Observed: Expected ratio of eligibles receiving at least one initial or periodic screen	CMS	✓		88.74%	56.00%

Goal 7—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

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			16	17		
AMB	Ambulatory Care: Outpatient Visits Including Telehealth (per 1,000 member months)	NCQA		✓	356.80	330.07
AWC	Adolescent Well-Care Visits	NCQA		✓	52.11%	—
CCS	Cervical Cancer Screening	NCQA		✓	61.36%	55.81%
CDC	Comprehensive Diabetes Care: HbA1c Control (<8%)	NCQA		✓	50.76%	50.92%

Goal 7—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

PM Code	Performance Measure Name	Measure Steward	Objective		RY2022 Target	RY2022 Result
			16	17		
CDC	Comprehensive Diabetes Care: HbA1c Testing	NCQA		✓	90.85%	87.29%
CIS	Childhood Immunization Status: Combination 3	NCQA		✓	70.65%	55.91%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA		✓	35.36%	40.01%
PCR	Plan All-Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total*	NCQA		✓	0.6923	0.8624
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA		✓	81.56%	83.78%
PPC	Prenatal and Postpartum Care: Postpartum Care	NCQA		✓	59.12%	77.56%
SBIRT	SBIRT Training	MQD		✓	NT	—
THP	Telehealth Plan	MQD		✓	Progress along continuum	Met
W15	Well-Child Visits in the First 15 Months of Life: 6 or More Visits	NCQA		✓	74.13%	—
W30	Well-Child Visits in the First 30 Months of Life: 15 Months	NCQA		✓	64.42%	63.73%
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA		✓	72.89%	—
N024.01	Long Stay Urinary Tract Infections: Percentage of long-stay residents with a urinary tract infection*	CMS		✓	2.15%	2.59%
N031.02	Long Stay Antipsychotic Medications: Percent of Residents Who Received an Antipsychotic Medication (Long-Stay)*	CMS		✓	6.95%	9.71%
N015.01	Long Stay Pressure Ulcers: Percent of High-Risk Residents with Pressure Ulcers (Long Stay)*	CMS		✓	4.94%	4.99%
NA	PointRight Pro 30—Rehospitalizations: Risk adjusted rehospitalization rate*	AHCA		✓	8.84%	10.42%
NA	PointRight Pro Long Stay—Hospitalizations: Risk-adjusted rate of hospitalization of long-stay patients*	AHCA		✓	7.86%	8.01%
NA	BONUS: AHCA/NCAL National Quality Award: Number of facilities with an AHCA/NCAL Gold award for excellence in quality	AHCA		✓	NT	0
NA	SBIRT Screening: SBIRT screenings provided to a % of Medicaid beneficiaries over age 15 years	MQD		✓	5.67%	—

Goal 7—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						
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**		**RY2022 Target**	**RY2022 Result**
			16	**17**		
NA	Social Determinants of Health Collaborative: Design and implement a program to track the social determinants associated with patients	MQD	✓	✓	Progress along continuum	Met
NA	Perinatal Collaborative: Design and implement a program to improve the quality of care for mothers and babies	MQD		✓	Progress along continuum	Met
NA	30-Day All Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total*	NCQA		✓	1.0243	—
NA	Preventable ER Visits (NYU Algorithm): Total Visits—Number Preventable*	NYU		✓	46.02%	—
NA	Reducing ED Visits for Patients with 4 or more visits: ED treat and release visits for patients with 4+ visits to the same facility in a calendar year*	HAH		✓	15.00%	21.07%
OP-18	Time from ED Admit to Discharge: Average time patients spent in the emergency department before being sent home (Target and Rate are represented as # of minutes)*	CMS		✓	68.31	78.00
CAHPS 5.0H	Composite Measure: Getting Needed Care (CHIP)	NCQA		✓	78.28%	80.80%
CAHPS 5.0H	Composite Measure: Getting Needed Care (Adults)	NCQA		✓	86.74%	79.20%
EPSDT	Participant Ratio: Observed: Expected ratio of eligibles receiving at least one initial or periodic screen	CMS		✓	88.74%	56.00%

* A lower rate indicates better performance for this measure.

▼ Indicates the measure was only reported by CCS.

Dash (—) indicates that the measure was not required to be reported, the measure was not available during the measurement year, or the measure was retired.

NA (not applicable) indicates that a data element was not applicable to the measure (i.e., no NQF number available, no PM code).

NT (no target) indicates that a target is not established/available.

🟩 Indicates that the RY 2022 performance measure rate was at or above the RY 2022 target.

Attachment B

Hawaiʻi QUEST Integration Section 1115 Waiver Demonstration Evaluation Report

Funded by Centers for Medicare and Medicaid Services (CMS), Project No. I I-W-00001/9

Center for Research and Evaluation in the Social Sciences
Social Science Research Institute
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Suggested Citation:

Reinie Gerrits-Goh, Yan Luo, Hua Zan, Anna Pruitt, Joy Agner, Yan Yan Wu, Krysia Mossakowski, Mark Willingham, Jr, Charles Iwata, Hannah Pearson, Monet Meyer, Karolina Hajkova, Hailey Farago, Nancy Marker, Sanjeev Sridharan & John Barile (2023). Hawaiʻi QUEST Integration Section 1115 Waiver Demonstration Evaluation Report. Prepared for the State of Hawaiʻi Department of Human Services Med-QUEST Division and the U.S. Centers for Medicare & Medicaid Services.

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Acronyms

Acronym	Meaning
AAP	Adults' Access to Preventive/Ambulatory Health Services
ABD	Aged, Blind, & Disabled
ACO	Accountable Care Organization
AIC	Akaike Information Criterion
AMA	American Medical Association
APM	Alternative Payment Model
BHO	Behavioral Health Organization
BIC	Bayesian Information Criterion
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAMHD	Child and Adolescent Mental Health Division
CCFFH	Community Care Foster Family Homes
CCS	Community Care Services
CDC	Comprehensive Diabetes Care
CDPS	Chronic Illness and Disability Payment System
CES	Coordinated Entry System
CFR	Code of Federal Regulations
CI	Confidence Interval
CIS	Community Integration Services
CMS	Centers for Medicare and Medicaid Services
CPI	Consumer Price Index
CTS	Community Transition Services
CY	Calendar Year
DCC	Diabetes & Cardiovascular Class
DHS	Hawaiʻi Department of Human Services
DOH	Hawaiʻi Department of Health
E&M	Evaluation and Management
ED	Emergency Department
EHCN	Expanded Health Care Needs
ER	Emergency Room

FFS	Fee-For-Service
FUH	Follow-up After Hospitalization
FQHC	Federally Qualified Health Center
HAO	Health Analytics Office
HAP	Health Action Plan
HC	Healthy Class
HCBS	Home and Community-Based Services
HCS	Health Coordination Services
HEDIS	Health Effectiveness Data and Information Set
HFA	Health and Functional Assessment
HILOC	Hawaiʻi Level of Care
HIR	Hawaiʻi Immunization Registry
HMIS	Homeless Management Information System
HMSA	Hawaiʻi Medical Service Association
HOPE	Hawaiʻi ʻOhana Nui Project Expansion
HPMMIS	Hawaiʻi Prepaid Medical Management Information System
HSP	Homeless Service Provider
LCA	Latent Class Analysis
LMR-LRT	Lo-Mendell-Rubin Adjusted Likelihood Ratio Test
LTA	Latent Transition Analysis
LTSS	Long-Term Services and Supports
LVC	Low Value Care
MCC	Multimorbidity Class
MCO	Managed Care Organization
MQD	Hawaiʻi Department of Human Services Med-QUEST Division
NFLOC	Nursing Facility Level of Care
NP	Nurse Practitioners
NR	Not Reportable
P4P	Pay for Performance
PA	Physician Assistants
PCG	Public Consulting Group

PCP	Primary Care Provider
PCP-E	Primary Care Provider Enhancement
PCPCC	Patient-Centered Primary Care Collaborative
PHC	Poor Health Class
PIP	Performance/Process Improvement Plan
PLD	Patient Level Detail
PMPM	Per Member Per Month
PQI	Prevention Quality Indicator
PRO	Patient-Reported Health Outcomes
PSC	Psychiatric & Substance Class
QA	Quality Assurance
QI	QUEST Integration
RCA	Rapid Cycle Assessments
RQ	Research Question
SDOH	Social Determinants of Health
SEBD	Support for Emotional and Behavioral Development
SHCN	Special Health Care Needs
SMI	Serious Mental Illness
SNA	Social Network Analysis
SPMI	Persistent Mental Illness
SSRI	Social Sciences Research Institute
TCC	Total Cost of Care
UH	University of Hawaiʻi
VBP	Value-Based Purchasing
VHC	Value-Driven Health Care
WCV	Well Child Visit

List of Tables and Figures

Executive summary

Hawaiʻi was awarded a 5-year renewal of the 1115 waiver with the Centers for Medicare and Medicaid Services (CMS) with the demonstration project titled "Hawaiʻi QUEST Integration" ("demonstration") (Project No. I l-W-00001/9) in July 2019, effective August 1, 2019, and running through July 31, 2024. MQD used this demonstration as a vehicle to implement the Hawaiʻi ʻOhana Nui Project Expansion (HOPE) Initiative, an effort to empower Hawaiʻi's residents to improve and sustain well-being by developing, promoting, and administering innovative and high-quality health care programs with aloha.

The University of Hawaiʻi (UH) Social Science Research Institute (SSRI) was selected to carry out an independent evaluation of this waiver period, and this report presents the results from said evaluation. The 1115 waiver demonstration evaluation focused on six priority areas including 1) Primary Care, 2) Care Coordination for Beneficiaries with Complex Conditions, 3) Home- and Community-Based Services, 4) Value-Based Purchasing, 5) Community Integration Services, and 6) Social Determinants of Health. SSRI assessed data ranging from 2016 to March 2023, capturing data from several years preceding the demonstration period (2016–August 2019), as well as the years during the current demonstration period (August 2019–March 2023). Special caution should be used when interpreting the results of this evaluation, recalling that the COVID-19 pandemic occurred in the midst of the demonstration period and has had unforeseen consequences on implementation of new waiver authorities, costs, and outcomes.

Lessons Learned

As part of the HOPE initiative, MQD, Health Plans and UH SSRI developed ongoing collaborations to transform program development, measurement and reporting across all priority areas. This collaboration advanced novel reporting mechanisms outside traditional administrative data to capture rich clinical data, member quality of life, and financial and provider information for these evaluations. Over the course of the demonstration, MQD developed and implemented these reports, resulting in improvements to data quality, and providing new insights into patient outcomes and provider data. As the reporting transformation continues, the newly-established infrastructure will aid evaluation and program improvement efforts in future demonstrations. Improved monitoring will allow MQD and future evaluators to track health care outcomes for the different priority areas and thus, will support greatly increased capabilities for evidence-based policy changes in the future.

Working independently with the products of those collaborations, the UH SSRI evaluation team analyzed program effectiveness within the six priority areas through 2022. The full impacts theorized in the waiver are not yet detectable at the time of evaluation due to ongoing implementation efforts and multi-year theory of change timelines. However, observations made by the UH evaluation team suggest some progress, specifically for members receiving health coordination services (HCS) and home- and community-based services (HCBS), in the enhancement of primary care services and functional definitions, and Health Plan achievement of quality outcomes set in MQD's value-based pay-for-performance program.

Findings

The demonstration addressed a wide range of strategies and interventions to promote healthy outcomes and reduce costs. Accordingly, the evaluation used a variety of research and statistical approaches to assess the impacts and outcomes of the demonstration interventions and strategies.

To better understand the Medicaid population in Hawaiʻi over the initiative period, the evaluation team conducted a longitudinal analysis of chronic disease treatment history among Med-QUEST Division from 2017–2022. Latent mixture modeling was used to identify subgroups of beneficiaries with similar patterns of chronic condition treatment. Five unique subgroups were identified: 1) the Healthy Class (HC), who had relatively low utilization of healthcare for all conditions, accounting for 69% of the overall sample; 2) the Multimorbidity Class (MCC) who had moderate healthcare utilization for many conditions, including cardiovascular, skeletal, pulmonary, and gastrointestinal, and eye disease—13% of the sample; 3) the Psychiatric & Substance Class (PSC), members with a high probability of being treated for a psychiatric condition (63%) and a substance abuse condition (36%)—10% of the sample; 4) the Diabetes & Cardiovascular Class (DCC), who had a very high probability of being treated for type II diabetes (93%) and cardiovascular disease (73%)—5% of the sample; and 5) the Poor Health Class (PHC), with the highest rates of almost all conditions (with the exceptions of type II diabetes, psychiatric, substance use and eye disease)—accounting for 4% of the sample.

We found that between 2017–2021, the majority of members stated in the same "class" or subgroup but some transitioned to a class of greater or poorer health. Members with low evidence of utilization (the Healthy Class) in 2017 were most likely to continue experiencing low healthcare utilization in 2021, suggesting that they maintained their health in subsequent years. Those members who received psychiatric and substance abuse treatments in 2017 were most likely to transition to the Healthy Class in 2021. Notably, those members in the 2017 Poor Health Class had a high likelihood of having died by 2021.

Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes

Project 1A aimed to increase primary care utilization and the usage of preventive services. MQD hypothesized that the initiative would increase utilization, spending (as a percentage of total spending), and quality of primary care for beneficiaries as measured according to four newly developed definitions of primary care services: 1) primary care visits; 2) beneficial primary care services 3) primary care supports; and 4) low-value primary care.

Results indicate a strong reduction in primary care spending during the demonstration period, showing a decline in spending as well as (to a lesser extent) utilization of primary care visits, beneficial primary care services, and primary care supports. The year-over-year change was not uniform across primary care categories. Average spend per beneficial primary care service and primary care support service reduced over time. However, average spend per primary care visit was relatively stable in comparison. Low-value services decreased strongly from 2020 to 2021. Spend on primary care as a proportion of total spend, remained roughly equal throughout the years, with a slight uptick from 2021 to 2022.

The evaluation team further investigated the relationship between primary care utilization and selected health care outcomes. Across three definitions of primary care, it found a weak positive relationship between primary care utilization and emergency department or inpatient stays within the same year. On the other hand, the receipt of primary care visits showed stronger positive relationships with several quality outcomes, including increased adults' access to preventive services, well-child visits, and improved performance across various measures of comprehensive diabetes care. Nevertheless, many effects of utilization of beneficial services and supports will only be measurable over a longer period of time. The newly developed primary care definitions allowed the evaluation team to identify areas where investment in primary care can be further supported and how to investigate health care outcomes for the different definitions related to these investments. Though evaluation results are mixed, the positive relationships between the receipt of primary care and quality outcomes are encouraging; overall, given that the COVID-19 pandemic may have had a strong impact on the decreasing trends reported, the findings of this evaluation support a continued focus for MQD and its Health Plans on investments in primary care to improve health outcomes.

Project 1B: Care Coordination for Beneficiaries with Complex Conditions

Project 1B aimed to improve care coordination. Establishing team-based care and greater integration of behavioral and physical health are examples of such improvements. MQD hypothesized that care coordination for individuals with complex health needs would result in improved health outcomes and lowered utilization of the healthcare system, and a slower rate of expenditure growth.

Only one Health Plan successfully collected the necessary data to analyze the association between HCS and costs, utilization and outcomes. The analysis revealed that only 15% of members enrolled as Special Health Care Needs/Expanded Health Care Needs members (SHCN/EHCN) were considered actively engaged with health coordination services (HCS). Outputs further suggested that SHCN/EHCN populations who were engaged with HCS have higher expenditure and utilization on home health services and primary care supports compared to SHCN/EHCN populations who remained unengaged with HCS.

The key finding was that the increased spending on home health services and primary care supports was offset by positive impacts on key health outcomes: SHCN/EHCN members engaged in HCS experienced lower expenditure of ED services, as well as lower utilization of ED and inpatient services. While engagement in services appeared low, and the results represent only one out of the five contracted Health Plans, these results suggest positive effects of HCS for those members who are engaged. The evaluation team's findings demonstrate the critical value of HCS for the SHCN/EHCN population, and reinforce the need to identify and remove barriers to engagement in HCS in order for Hawaiʻi to increase the population-level impact of these services on its high-needs, high-cost populations with complex health conditions.

Project 1C: Home- and Community Based Services (HCBS)

Project 1C's primary goal was to enhance HCBS, hypothesizing that the provision of HCBS, including a subset of HCBS to populations at risk for functional declines, could slow the deterioration of the health and functional statuses for these populations. Variations were expected in entry time to nursing homes, patient-reported health outcomes (PROs), and care costs for both the population meeting Nursing Facility Level of Care (NF LOC) and the at-risk population.

Results show that nursing home and foster home residents exhibited higher average Level of Care (LOC) scores (i.e., higher levels of disability/lower functional status and higher acuity of health conditions) in comparison to those residing at home. Among members with high LOC scores, members in home settings displayed stable LOC scores over the demonstration period, while members in nursing homes or Community Care Foster Family Homes (CCFFH) experienced deteriorations in their functional status scores. These findings reiterate the health benefits of home-based care relative to foster home or nursing home based care for individuals who meet criteria for Long Term Services and Supports (LTSS), and reinforced the non-financial strengths of some HCBS settings over nursing home care. Results also identified gaps in outcomes within populations receiving HCBS that require further exploration and intervention.

When comparing individuals meeting NF LOC and the At-Risk population, the evaluation team found differences in the length of time to enter a nursing home, goal attainment, and cost of care. At-Risk individuals spent the longest period of time in community settings before entering nursing homes, had higher goal attainment, and lower cost of care that continued to decline over the demonstration period. At-Risk individuals received HCBS in home-based settings, further underscoring the protective impacts of home-based care on mitigating functional status declines. Members aged between 65 and 75 years, female members, and those with social support tended to spend a longer time in the community setting before they entered a nursing home when compared to those 85 years and older, males, or those without family and friends to continue care at home.

These results underscore the protective impact of HCBS in home-based care settings and emphasize the salutary influence of familiar environments and family support on health outcomes for the LTSS population. The evaluation demonstrated efficacy for the HCBS program, particularly when provided in home settings to improve the health of members meeting NF LOC, and revealed the need for further exploration into the causes of functional status decline among members in community foster home settings. Additionally, it was found that members with lower functional status, and those with dementia or mental illness, were less likely to receive care at home than other LTSS members. This reveals the need for continued rebalancing efforts and investment in HCBS provision to support in-home care when possible. Additionally, the evaluation established a baseline for Hawaiʻi's At-Risk population.

Projects 2A & 2B: Value-based purchasing (VBP) reimbursed at the Health Plan and Provider levels

Projects 2A and 2B evaluated the implementation of alternative payment models (APM) at the provider level and VBP reimbursement methodologies at the Health Plan level. MQD hypothesized that these investments would increase appropriate utilization of the healthcare system and thereby reduce preventable healthcare costs. MQD implemented three main approaches to incentivize Health Plans to focus on improving quality and/or maintaining costs: 1) Health Plan Capitation; 2) Pay-for-Performance (P4P) Programs; and 3) the member auto-assign program with a quality component. MQD implemented multiple methods to incentivize improved outcomes. Data suggests that Health Plans were increasingly reaching P4P benchmarks set by MQD. Whereas in 2016 Health Plans had an average achievement level of 46.3%, P4P performance increased to 63.5% in 2021. Health Plans have now established several programs aimed at improving health outcomes in alignment with MQD intentions. Additionally, most Health Plan initiatives focus on primary care.

Most Health Plans focused on VBP arrangements based on a fee-for-service (FFS) payment structure, with only two initiatives incorporating risk-based payments. Seven arrangements included population-based payments, specifically including per-member, per-month (PMPM) payments. However, these population-based arrangements were generally aimed at additional payments for at-risk populations on top of the prevailing reimbursement model and do not fully integrate population payments for the total patient population.

Despite these successes, much work remains to learn from existing VBP programs, identify their strengths and weaknesses and leverage successful components to build stronger VBP programs in Hawaiʻi. Currently, the effectiveness of the implemented programs on targeted health outcomes has been mostly unstudied. A learning community-based approach where Health Plans collaborate to design stronger VBP programs, paired with a strong focus on evaluation, is recommended to advance VBP in Hawaiʻi.

Project 3A: Community Integration Services

Project 3A evaluated the provision of community integration services (CIS) program to members with qualifying health conditions who experience or are at-risk of experiencing homelessness. MQD hypothesized that these services would result in better health outcomes and lower utilization of acute care services, increase utilization of outpatient care services and lower total cost of care after being stably housed. Participating beneficiaries were expected to improve in health and wellbeing as they progressed through the program. Moreover, MQD expected the effectiveness of the CIS program to vary depending on client characteristics.

Results show that Health Plans targeted the intended population-members with complex health and housing needs for inclusion in CIS program. Members identified for CIS had much higher average annual emergency department visits and total cost of care relative to the average Medicaid member. However, due to reporting inconsistencies, the evaluation team was unable to determine with certainty how many members received tenancy and pre-tenancy services. Reported data suggest that many eligible members have yet to receive services due to backlog and lack of Homeless Service Provider (HSP) capacity. Given that members who were eligible for services but not receiving them had the highest average total cost of care, addressing this backlog will be necessary to have systems-level impact on cost of care which can be attributed to this project. Additionally, while one third of members who were in pre-tenancy had transitioned to tenancy at exit, available recipient-level data does not indicate whether this transition represents stable housing and whether these members ever received services, suggesting the need for better tracking of housing outcomes.

Many of these challenges reflect those seen in other states, and substantial progress has been made in refining the program to address and mitigate these challenges. MQD began ‘rebooting’ CIS in January 2023. The ‘reboot’ approach has resulted in more providers applying for MQD provider status, including clean and sober programs, and increased collaboration among MQD, Health Plans, HSPs, and other systems involved in homelessness services. Additionally, given the complexity of integrating the healthcare and social service sectors, MQD and partners implemented rapid-cycle assessments (RCAs) that provide continuous evaluation in real-time to encourage program and data quality improvement and ongoing collaboration. Continued monitoring and evaluation support after the demonstration period will allow MQD to monitor the CIS project's long-term outcomes.

Project 3B: Assessing process of planning and implementing support strategies addressing social determinants of health

Project 3B aimed to understand how MQD has influenced the ecosystem of strategies and interventions that address social determinants of health (SDOH). The evaluation focused on MQD's development of the statewide SDOH Transformation Plan; MQD's translation of its SDOH goals into its managed care contract and subsequent requirements for Health Plans to develop and adopt SDOH Work Plans; and Health Plans' actual work to date in implementing strategies and interventions on the ground that support SDOH efforts in general, and attempt to reduce identified health disparities specifically.

During the demonstration period, MQD included a number of SDOH requirements in the Health Plans' managed care contracts; implemented reports that require Health Plans to identify, document, and evaluate their SDOH interventions; and developed a statewide SDOH Transformation Plan. This plan is in alignment with the state's HOPE and quality strategies, and serves as a road map to address health disparities comprehensively and systematically.

The evaluation team identified several promising strategies and interventions at multiple levels (i.e., at the levels of members, providers, community, and the healthcare system) that focus on addressing various social risk factors, such as housing insecurity, food insecurity, and other social needs. Foci include strategies and interventions that address the root causes of SDOH and improve SDOH data collection and outcome measurement. However, the quality, depth, and breadth of such strategies varied significantly across Health Plans. Implementation of the State's SDOH Transformation Plan in future demonstration waivers will allow for continued monitoring on the impact of the state's coordinated and systematic approaches to identifying and targeting social risk factors and reducing health disparities.

Project 4A: Improve Data Quality for Immunization-Related Performance Measures

Project 4A aimed to evaluate progress in any area, including quality of care, identified as needing improvement during the previous demonstration period. The joint MQD-Department of Health (DOH) Hawaiʻi Immunization Registry (HIR) project planned to increase the accuracy and completeness of childhood immunization data and increase childhood immunization coverage for Hawaiʻi Medicaid beneficiaries. This particular initiative was not launched and therefore, not evaluated; although MQD obtained funds to support the implementation of a new HIR, the COVID-19 pandemic response reduced DOH's capacity to focus on this project, and funds expired before the work could begin.

Recommendations

Based on findings from this evaluation, and following the goals stated by the HOPE initiative, we make the following thirteen recommendations to MQD to further develop the six priority areas.

General

Recommendation 1. Continue revision and improvements of reporting and measurement methodologies, focused on reducing reporting burden while capturing crucial process and outcome metrics that align across Health Plans that are informed by cross-stakeholder feedback, including members and providers. Expand the use of RCAs to other novel program implementations as needed.

Recommendation 2. Focus on developing a systematic process for incorporating member feedback into evaluation, program development, and program improvement.

Primary Care

Recommendation 3. Implement spend targets that encourage use of primary care visits and increase use of beneficial primary care services. As currently utilization of primary care visits, primary care supports and beneficial care services declined since 2019 (likely in large part due to the COVID-19 pandemic, and potentially a member population shift), Health Plans need to refocus on strengthening the implementation of interventions already in place.

Recommendation 4. Investigate both qualitatively and quantitatively the reasons for the decline in utilization of and spending on primary care, and how these trends might affect outcomes over time.

Care Coordination for Beneficiaries with Complex Conditions

Recommendation 5. Provide increased clarity on conceptualization and operationalization of care coordination. Define which care coordination services are offered, which are most needed, and how members view the impact of care coordination on their own lives. These changes are needed to improve engagement in HCS and consequently increase the impact of the program.

Recommendation 6. Develop a standardized data collection and reporting system for care coordination to support the most parsimonious metrics capturing the delivery and dose of care coordination services on individual, provider, and organizational levels.

Home- and Community-Based Services

Recommendation 7. Tailor care strategies based on the specific characteristics of home-based care and foster home care. By taking into account the differences in these environments, healthcare professionals can provide more effective and personalized care that aligns with the distinct needs and preferences of the individuals receiving support.

Recommendation 8. Continue to offer At-Risk services, and other HCBS in the home setting. Encourage and support home-based care to the extent feasible and evaluate factors contributing to the more rapid functional declines observed in nursing home and community-based foster home settings.

Value-Based Purchasing

Recommendation 9. Increase collaboration to further evaluate and expand APM models to higher levels of the APM Framework amongst Health Plans, providers and MQD. In accordance with the HOPE initiative, further expand risk sharing and population-based payment arrangements beyond currently implemented models that are predominantly pay-for-performance based on fee-for-service structures. Consider the impact of payment models on provider experience, with specific attention to how providers are supported by payment models and how administrative burden on providers can be reduced.

Community Integration Services

Recommendation 10. Continue considering the role of CIS in the context of the overall housing system of care. Given the high level of need and low capacity, it will likely be necessary for Health Plans to prioritize eligible members. The evaluation team suggests that MQD and Health Plans examine existing gaps in the homelessness service system when identifying priority members. CIS might be most effective when paired with other less intensive programs that serve high needs people due to lack of resources.

Recommendation 11. Define ‘stably housed’ and continue to build in mechanisms to capture housing status of CIS members throughout the program. The CIS reboot has already added some of these metrics to the CIS Action Plan, including exit destinations.

Recommendation 12. Strengthen data collection, integrate data to enable more comprehensive views of CIS members, and address data inconsistencies.

Social Determinants of Health

Recommendation 13. Educate MQD and Health Plan staff about SDOH with resources provided by MQD. Additionally, MQD should provide more resources to aid Health Plans in monitoring progress across SDOH interventions.

I. Background

The State of Hawaiʻi, Department of Human Services (DHS), Med-QUEST Division (MQD) is Hawaiʻi's Medicaid agency. MQD first implemented QUEST (Quality care, Universal access, Efficient utilization, Stabilizing costs, and Transforming the way health care is provided) on August 1, 1994. QUEST was a statewide Section 1115 demonstration project that initially provided medical, dental, and behavioral health services through a competitive managed care delivery system.

Since its implementation, CMS has renewed the QUEST demonstration five times. CMS approved Hawaiʻi's most recent request to extend the Section 1115 demonstration project titled "Hawaiʻi QUEST Integration" ("demonstration") (Project No. I l-W-00001/9) in July 2019, with an effective date of August 1, 2019 running through July 31, 2024.

The current demonstration continues to use capitated managed care as a delivery system. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including home and community-based long-term-services and supports) to beneficiaries eligible under the state plan and to the demonstration populations. In addition to the QI Health Plans, a separate behavioral health organization (BHO) provides beneficiaries with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) with specialized and non-specialized behavioral health services.

MQD is using this demonstration as a vehicle to implement the Hawaiʻi ʻOhana Nui Project Expansion (HOPE) Initiative, an effort that furthers MQD's mission to '*empower Hawaiʻi's residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha*.' The following principles guide the HOPE Initiative as well as the provision of services under the demonstration:

- Assuring continued access to health insurance and health care;
- Emphasizing whole person and whole family care over their life course;
- Addressing the social determinants of health;
- Emphasizing health promotion, prevention and primary care;
- Emphasizing investing in system-wide changes; and
- Leveraging and supporting community initiatives.

These principles are implemented through four focused strategies under the HOPE Initiative that are largely the same or related to the objectives under the demonstration. Those strategies include:

- Investing in primary care, prevention, and health promotion;
- Improving outcomes for high-need, high-cost individuals;
- Supporting payment reform and alignment; and
- Supporting community driven initiatives to improve population health.

The HOPE Initiative serves as both the foundation and a primary organizing principle for the demonstration and our evaluation of it. For example, our focus on primary care and social determinants of health is inspired by HOPE and will be effectuated through the managed care authorities in the demonstration. The principles and strategies outlined in HOPE build on the successes of previous reform efforts and are meant to leverage community initiatives and resources, while maximizing return on investment and ensuring broad community support beyond Medicaid.

This evaluation report represents the first four years of the 5-year HOPE Initiative (2019–2023). The report serves as the external evaluation of Hawaii's 1115 waiver and was conducted by the University of Hawaiʻi at

Mānoa (UH) Social Science Research Institute (SSRI). The evaluation encompasses all populations described in the Special Terms & Conditions.

Demonstration Priority Areas

The prior demonstration provided expenditure authority for additional benefits that were continued into the current demonstration term. In addition, the demonstration intended to expand one of the benefits initially approved in the previous demonstration, Community Integration Service (CIS), to add a Community Transition Services (CTS) pilot program, which would provide transitional case management services, housing quality and safety improvement services, legal assistance services, and securing house payments for individuals meeting criteria for CIS. Two priority areas were further articulated by MQD and the evaluation team with regard to the evaluation of Care Coordination and Value-Based Health care, resulting in a total of six evaluation priority areas that align with the planned demonstration projects.

Priority areas included 1) Primary Care, 2) Care Coordination for Beneficiaries with Complex Conditions, 3) Home and Community Based Services, 4) Value-Based Purchasing, 5) Community Integration Services, and 6) Social Determinants of Health. The original evaluation design included a supplemental evaluation priority: improve data quality for immunization-related performed measures; this evaluation remained uninitiated because the project that MQD proposed for evaluation was canceled due to the COVID-19 pandemic.

Evaluation Priority Area 1: Primary Care

Evaluation Priority Area 1 is closely tied to the HOPE Initiative, as well as one of MQD’s demonstration objectives–the promotion of appropriate utilization of the health care delivery system. Specifically, the evaluation focused on the impact of the HOPE “Advancing Primary Care Initiative'' to support this strategy and achieve the overall goals of the demonstration. The Advancing Primary Care Initiative aims to increase utilization of primary care, preventive services, and health promotion; to increase the proportion of healthcare spending on primary care, and to improve the quality of primary care and outpatient services. To achieve these aims, MQD proposed three key activities for Health Plans to conduct: 1) track primary care spending across multiple definitions of primary care spend, 2) incentivize investment in primary care, e.g. through performance incentive payments to providers as well as value-based purchasing, and 3) improve care coordination through supporting and augmenting team-based care in patient-centered medical homes, community health centers, clinically integrated health systems, and other entities.

MQD hypothesized that these activities would increase utilization of, spending on, and quality of primary care services, preventive services, and health promotion services, which in turn would improve measures of relevant health outcomes. The evaluation team planned to test this hypothesis by tracking specific measures related to utilization, spending, and quality of primary care for demonstration populations, using progressively broad definitions of primary care chosen based on consultation with MQD and stakeholder feedback. The evaluation team assessed selected health outcome indicators for meaningful associations with primary care utilization.

Evaluation Priority Area 2: Care Coordination for Beneficiaries with Complex Conditions

MQD has implemented a care coordination program for individuals with complex care needs. The purpose of care coordination is to support individuals with complex health needs to navigate the complexities of our health care system, access high quality preventative care, manage chronic conditions, and address social risk factors. The 1115 waiver demonstration hypothesized that, “improving care coordination (e.g., by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).”

The evaluation plan proposed testing this hypothesis by evaluating health outcomes of two health coordination programs, each with their own research questions. The first (Project 1B) was a new initiative focused on enhancing care coordination for beneficiaries with complex conditions. Members qualify by meeting criteria such as having multiple chronic conditions, comorbid behavioral and physical health conditions, high-risk pregnancies, or unmet social needs. The second care coordination program will be described in Evaluation Priority Area 3.

Further, in collaboration with MQD, the evaluation team guided in developing a reporting system for the Health Plans to report care coordination services provided to special health care needs/enhanced health care needs (SHCN/EHCN) members. This supported the operationalization of care coordination, contract monitoring of these services, and quality improvement.

Evaluation Priority Area 3: Home-and Community-Based Services

MQD provides long-term services and supports (LTSS) in the demonstration by allowing beneficiaries who meet an institutional level of care to choose between institutional services or Home- and Community-Based Services (HCBS). Access to LTSS is based on a functional level of care (LOC) assessment to be performed by the Health Plans or those with delegated authority. Each beneficiary who has a disability and who requests or receives LTSS receives a functional assessment; the assessment is repeated for LTSS members at least every twelve months, or more frequently when there has been a significant change in the beneficiary's condition or circumstances. In addition, an LTSS member may request a functional assessment at any time.

HCBS are offered to both individuals who meet an institutional level of care as well as individuals at risk of deteriorating to an institutional level of care. The at-risk population is defined as Medicaid beneficiaries who do not meet criteria for nursing facility level of care (NF LOC), but who are assessed to be at risk of deteriorating to the nursing facility (also known as institutional) level of care. MQD's goal for beneficiaries meeting criteria for LTSS is to promote independence of LTSS beneficiaries, to the extent feasible and in alignment with the beneficiary's choice, through the utilization of HCBS.

To evaluate the effectiveness of HCBS in meeting its goal of improving health and reducing costs for individuals who meet an institutional level of care requirement and those "at risk" of deteriorating to the institutional level of care, this Evaluation Priority Area (1) compared the population receiving HCBS services that meet criteria for NF LOC with the population receiving institutional care; (2) investigated subgroup differences in health outcomes and total cost of care among HCBS users who meet the criteria for NF LOC; and (3) investigated subgroup differences in health outcomes and total cost of care among the at risk population. Such knowledge is of significance because it lays the foundation for policy efforts to promote independence, community integration/re-integration of LTSS beneficiaries, and re-balancing of LTSS services towards HCBS to the extent feasible.

Evaluation Priority Area 4: Value-Based Purchasing (VBP)

Value-based purchasing (VBP) incentivizes quality and whole-person care. VBP concerns arrangements between the purchaser and the contracted organization that holds a provider, or alternatively a Health Plan, accountable for both the costs and the quality of care. During this demonstration period, MQD strongly emphasized payment transformation and initiated data reporting by Health Plans on their VBP arrangements with providers in order to track advancement towards alternative payment models (APMs) under the Healthcare Payment Learning and Action Network's APM Framework. As such, MQD implemented VBP strategies at the Health Plan level, and encouraged Health Plans to implement VBP arrangements at the provider level. MQD hypothesized that, "implementing APMs at the provider level and VBP methodologies at the Health Plan level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs."

To evaluate the progress towards payment methodologies based in value, the evaluation team used the newly developed reports submitted by Health Plans to map their current VBP/APM implementation status, and used MQD's documentation to map implementation of APMs at the Health Plan level.

Evaluation Priority Area 5: Community Integration Services

Community Integration Services (CIS) aim to decrease utilization of acute services (emergency and inpatient utilization), increase engagement in outpatient care services, and decrease the total cost of care by providing members with tenancy sustaining or pre-tenancy services. To assess progress toward program goals, the evaluation design focused on both program process and outcomes/impacts associated with participation in the CIS program. For the process evaluation, the evaluation team monitored program implementation and assessed program fidelity, providing regular feedback to the program providers, and recommended adaptations when warranted through rapid-cycle assessments (RCAs). The evaluation team held quarterly meetings with MQD, Health Plans, and homeless service providers to discuss quarterly data and to engage in group problem-solving. These quarterly meetings provided opportunities for gathering process measures, discussing challenges with implementation, sharing best practices and success stories, and presenting RCA findings from Health Plans submitted quarterly reports. The evaluation team attended, supported, and participated in quarterly meetings, and used these meetings to engage with stakeholders to help contextualize the findings of RCAs and support performance improvement initiatives. The evaluation team also submitted a quarterly report to MQD detailing these findings and meeting discussions. The outcomes evaluation assessed the effectiveness of the program by examining provider-level and participant-level outcomes (e.g., physical/mental health, health care utilization) as well as healthcare utilization outcomes (e.g., number of emergency department visits).

Evaluation Priority Area 6: Social Determinants of Health

Social determinants of health (SDOH) refer to 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 choices, access to transportation, social support networks and connection to culture, as well as access to healthcare are all determinants of health. These factors impact social groups differently, which leads to disparities in health outcomes. Furthermore, the island geography and historical context of Hawaiʻi has given rise to great diversity at the local community level.

Addressing SDOH has been a key guiding principle for MQD in achieving the goals of the HOPE strategy (MQD, 2017). During the 1115 waiver demonstration period, MQD intended to develop integrated solutions that address SDOH within the context of the healthcare delivery system. The evaluation intended to examine 1) MQD's development of a SDOH transformation plan and the operationalization of this plan at the Health Plan level; 2) MQD's development of a standardized screener to collect SDOH data on beneficiaries and implement strategies to address unmet social needs; 3) MQD's implementation of a payment methodology that incorporates SDOH, its implications on rebalancing/shifting of funding, and its implications for communities/Health Plans; and 4) development of regional health partnerships, and where applicable and feasible, evaluation of impact of these efforts. The evaluation was adjusted to focus on the activities completed by MQD and the Health Plan during this waiver demonstration period.

Supplemental Evaluation Objective (Evaluation Priority Area 7): Improve Data Quality for Immunization-Related Performance Measures

Improving the overall health of children by boosting immunization rates is a goal of both the Department of Human Services (the department that houses MQD) and the State of Hawaiʻi as a whole. To help achieve this goal, MQD entered into a collaborative partnership with the Hawaiʻi State Department of Health's Immunization Branch (housed within the Disease Outbreak Control Division) in 2019 to design, develop, and implement a new immunization information system (IIS), Hawaiʻi Immunization Registry (HIR).

Although an existing IIS was previously in use in the state of Hawaiʻi, that system became non-operational in August 2018. As a result, MQD, MCOs and Medicaid providers were unable to obtain information on childhood immunization status that was necessary to support pay-for-performance clinical quality measures used to determine value-based reimbursement. Historically, MQD plans have been incentivized to promote immunization among Medicaid beneficiaries and relied on the IIS for clinical quality measure values.

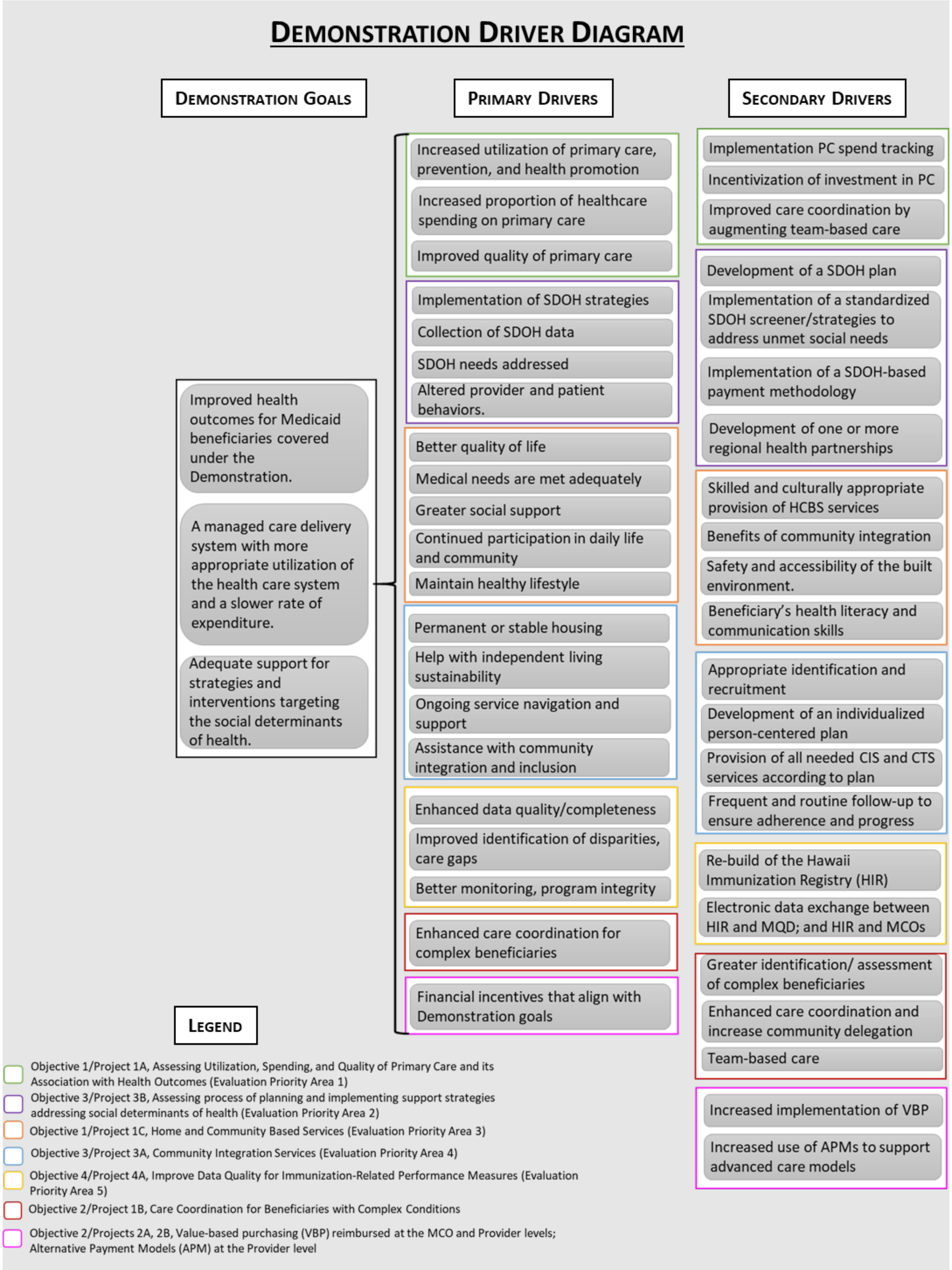
While the previous IIS allowed for basic clinical quality measure reporting, MCOs and Medicaid providers had requested modifications and upgrades be built into any future IIS in order to improve the ease of IIS querying and other functions related to required Medicaid reporting. In early 2019, MQD began working in collaboration with the DOH Immunization Branch to replace the pre-2018 system to support the needs of both MQD and DOH.

This evaluation area intended to report on the collaboration, and resultant improvements to the HIR.

Proposed Demonstration Driver Diagram

MQD developed a demonstration driver diagram, emphasizing the primary and secondary "drivers" to meet demonstration goals (Figure I.2). These drivers can be organized into four priority areas of evaluation: primary care, social determinants of health, home and community-based services, and community integration services. Each priority area is described in detail subsequently. Specific elements of the proposed demonstration required modifications and/or were not fully implemented. These modifications are further discussed in the results section. Key modifications included the removal of a SDOH based payment methodology and vaccine registry from the evaluation performed.

Figure I.1.Proposed Demonstration Driver Diagram



II. Demonstration Objectives and Evaluation Hypotheses

Demonstration Objectives

Med-QUEST Division (MQD) consolidated and updated previous demonstration objectives in order to align past efforts with future goals as framed by the Hawaiʻi ʻOhana Nui Project Expansion (HOPE) Initiative. Through this process, the following objectives for the current extension of the demonstration were proposed:

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 healthcare system and a slower rate of expenditure growth; and
3. Support strategies and interventions targeting the social determinants of health.

Demonstration Evaluation Hypotheses

During initial planning of the HOPE Initiative, MQD worked extensively with internal and external stakeholders to develop a comprehensive plan for measurement and evaluation. This plan was designed to assess the effectiveness of the demonstration in meeting its objectives. The evaluation documents the overall impact of the demonstration on Hawaiʻi's Medicaid delivery system while simultaneously providing a more in-depth examination of the six previously described priority areas: 1) Primary Care, 2) Care Coordination for Beneficiaries with Complex Conditions, 3) Home- and Community-Based Services (HCBS), 4) Value-Based Purchasing, 5) Community Integration Services and 6) Social Determinants of Health. Primary Care, serving beneficiaries with complex conditions, value based purchasing, and Social Determinants of Health were identified as key HOPE strategic areas and the others focus on key authorities and services authorized by the current demonstration. The seventh priority area (improve data quality for immunization-related performance measures) was not evaluated as the project between MQD and DOH was canceled due to the COVID-19 pandemic.

The evaluation of the overall impact of the demonstration on Hawaiʻi's Medicaid delivery system was initially designed to assess post-demonstration changes in statewide performance levels, relative to pre-demonstration baseline performance levels, across the following measurement domains:

- Access to primary care, prevention, and health promotion;
- Outcomes of beneficiaries with complex needs;
- Improved health outcomes across the board;
- Reduction in use of costly institutional care;
- Access to adequate and appropriate care; and
- Overall Medicaid expenditures on a per beneficiary per month basis.

The in-depth evaluation plan for high priority project areas focused on the following aspects:

- Mechanisms to improve primary care with the intent of lowering the total cost of care;
- Impacts on health and costs of providing integrated community services and housing assistance to homeless Medicaid recipients;
- Differential impacts of HCBS on the health and cost of care among individuals receiving HCBS who (a) meet nursing facility level of care, or are (b) "At-Risk" beneficiaries; and

- Potential impacts of addressing social determinants of health on health and patient-reported outcomes such as satisfaction with one's health and quality of care.

The table below summarizes key evaluation projects to support each demonstration objective. Project-level details for each hypothesis, including information on specific target populations, research questions, data strategy, sources and collection frequency, measures, statistical framework, and subgroup analyses (if any) are described in detail in Section IV: Project-Level Detail.

All evaluation research questions and hypotheses promote the objectives of *Title XIX* by assessing whether providing high quality, accessible services to individuals with low income improves their health outcomes during the demonstration. In addition, these hypotheses collectively assess progress toward the Institute for Healthcare Improvement's Triple Aims: improved health, improved quality of care and reduced costs–the primary focus of the demonstration as well as a core tenet of the HOPE Initiative.

Table II.1. Evaluation Projects by Demonstration Objectives and Hypotheses

Demonstration Objectives	Demonstration Hypotheses	Key Evaluation Projects
1. Improve health outcomes for Medicaid beneficiaries covered under the demonstration	H1.1: Increasing utilization for primary care, preventive services, and health promotion will reduce the prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.	Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes
	H1.2: Improving care coordination (e.g., by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).	Project 1B: Care Coordination for Beneficiaries with Complex Conditions
		Project 1C: Home- and Community Based Services (HCBS)
2. Maintain a managed care delivery system that leads to more appropriate utilization of the healthcare system and a slower rate of expenditure growth	H2: Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the Health Plan level will increase appropriate utilization of the healthcare system, which in turn will reduce preventable healthcare costs.	Project 2A: Value-based purchasing (VBP) reimbursed at the Health Plan and Provider levels
		Project 2B: Alternative Payment Models (APM) at the Provider level
3. Support strategies and interventions targeting the social determinants of health	H3: Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.	Project 3A: Community Integration Services (CIS)
		Project 3B: Assessing the process of planning and implementing support strategies addressing social determinants of health

A table providing a comprehensive crosswalk of demonstration objectives, demonstration hypotheses, projects, and research questions is included in Appendix II.

In addition to project-level research questions and hypotheses, the evaluation team assessed overall waiver impacts related to objectives and project activities. In particular, we asked 1) which chronic conditions were most prevalent among Medicaid members; 2) whether members could be grouped into naturally occurring clusters based on which conditions they received treatment for in the past year; and 3) if members transitioned from one group or "class" to another over a four-year period (2017–2021).

III. Evaluation Methodology

The demonstration addresses a wide range of strategies and interventions to promote healthy outcomes and reduce costs. Accordingly, the evaluation utilizes a variety of research and statistical approaches to assess the impacts and outcomes of the demonstration interventions and strategies. This section outlines overarching elements of the evaluation design that cut across several of the research questions and evaluation priorities.

Evaluation Design

The evaluation took a mixed-methods approach using both quantitative and qualitative methods. Random assignment of participants (i.e., Medicaid beneficiaries) to programs (i.e., benefits) to establish control and treatment groups was not feasible and generally not ethical. Therefore, many of the evaluation priority areas used a within-group design. Additionally, the evaluation focused on both process and outcomes. For several of the evaluation questions and priority areas, the evaluation team conducted a process evaluation to better understand program implementation and components, Health Plan-specific differences, progress and process of a new initiative and/or to document program fidelity. For example, the first phase of the Community Integration Services (CIS) evaluation involved a qualitative analysis to increase understanding of a process or to monitor project implementation. The second phase then involved a quantitative study using data reported quarterly by Health Plans, and administrative or claims data. In other cases, the quantitative analyses occurred first, followed by qualitative interviews with Health Plan or Med-QUEST Division (MQD) staff to further clarify the information generated in the quantitative study. When possible, the evaluation design utilized quasi-experimental statistical methods. These methods are discussed in further detail in each priority area section below.

Target and Comparison Populations

Certain evaluation questions necessitated analysis of outcomes for all Medicaid beneficiaries (e.g., when assessing total primary care investments at the state or Health Plan). However, some questions targeted specific subgroups of beneficiaries (e.g., people experiencing homelessness, nursing home residents, groups with chronic conditions, etc.). Therefore, comparison populations chosen for each analysis varied and are described in greater detail in each priority area section below.

Evaluation Period

The evaluation period used data from the current demonstration period (2019-present) and also included data from the past demonstration period where necessary. Years one-through-three (2019–2021) of the evaluation focused primarily on gaining familiarity with the implementation of each priority area objective through the review of guidance materials, meetings with MQD staff, and meetings with Health Plans. This preliminary work permitted the evaluation team to develop logic models and theories of change for each priority area. These materials were vetted by relevant stakeholders and in some cases, adapted over the evolution of the programs.

Next, the evaluation team and MQD collaborated in the design of Health Plan report templates. The purpose of these reports was to acquire process and outcome data not accessible through other data sources. These reports were much more robust than prior reporting tools, and incorporated member- and provider-level data for the first time. The evaluation team assisted with development of key performance indicators and report manuals, and trained MQD staff in the use of the new reporting templates. The evaluation team also began co-reviewing quarterly and annual report submissions alongside MQD staff. These report review sessions allowed for rapid feedback, encouraged data integration, and enhanced the evaluation team's knowledge of programmatic implementation details between and among Health Plans.

Through the review of these reports, it became clear that data quality was a substantial issue. The evaluation team took part in technical assistance sessions to train Health Plan staff on improving data quality, discussing the importance of high-quality data to enhance the ability to assess evaluation outcomes and serve the member population. The evaluation team participated in regular subsequent meetings to review data quality and co-review reports with MQD staff.

Using data collected from these reports, the evaluation team met regularly with Health Plans and MQD staff to discuss findings. For CIS, rapid-cycle assessments (RCAs) were performed quarterly throughout years two, three, and four of the evaluation. RCA activities proved both formative and summative, focusing on early accomplishments as well as identifying areas of concern to be addressed. For MQD care coordination initiatives and long-term services and supports (LTSS), data quality from reports was repeatedly found insufficient to draw conclusions, and the co-review of reports and quarterly feedback to Health Plans focused heavily on strategies to enhance data quality and reduce incompleteness. When possible, the evaluation team asked Health Plans to explain certain service provision metrics, such as the reasons for low enrollment of members in a particular initiative or priority area, or reasons for ostensibly low provision of services. In year four, Health Plans provided the evaluation team with a data extraction of their various systems. These extractions illustrated the diverse data types collected by each Health Plan and were used primarily for the care coordination evaluation.

Over years two and three, the evaluation team began achieving familiarity with the types of administrative, claims, and encounters data available through MQD (see Data Sources below), as well as evaluation used to determine service eligibility in LTSS, CIS, and care coordination programs (including but not limited to the population with special health care needs). In year two, Health Effectiveness Data and Information Set (HEDIS) and other quality measure data were used to define metrics for the social determinants of health disparities report. In year 3, the evaluation team gained access to the Hawaiʻi Level of Care (HILOC) database and began conducting preliminary analyses, understanding the complexities of the data, and working to answer the evaluation questions for LTSS/HCBS. In year four, encounter data were extracted to link process-oriented metrics and outcome metrics to answer the proposed evaluation questions. Year five has focused on developing and refining the report and recommendations.

Evaluation Measures

The evaluation used a variety of data sources and measures, including quantitative and qualitative sources. Much of the quantitative data was collected from existing databases. Quantitative measures included the Level of Care (LOC) and Health and Functional Assessment (HFA) data, measures of patient-reported health outcomes (PRO), reporting tools, quality measures, actuarial risk scores, and demographic and medical background factors, and cost data available in the administrative encounter data set. The evaluation team used data on age, health status, gender, and functional limitation measures from claims, encounter, or assessment sources for matching purposes.

Some of the quantitative data was obtained by the UH evaluation team through Health Plan reports newly implemented over the demonstration period. These data included existing measures reported quarterly or annually by the Health Plans. For example, several CIS assessment items reported quarterly included measures from the Patient Reported Outcomes Measurement Information System (PROMIS; https://commonfund.nih.gov/promis/index) and the Centers for Disease Control and Prevention (Health Days Measure: https://www.cdc.gov/hrqol/hrqol14_measure.htm).

Administrative data from encounters, claims, and beneficiary-level reports were also used to assess the impact of value-based purchasing (VBP) reimbursement methods at the Health Plan and provider levels, as well as improvements in health outcomes for the evaluation of multiple objectives.

Qualitative data was collected both formally and informally through periodic reports from Health Plans regarding program implementation, data limitations and barriers. We also conducted in-depth interviews with Health Plans and presented periodic rapid-cycle assessments to foster dialog with program stakeholders.

Detailed descriptions of evaluation data sources appear in Appendix I.

Analytic Methods

In the absence of adequate control groups (and in some cases, comparison groups), the evaluation relied on quasi-experimental methods, such as within-group pre-post analyses, matching, and subgroup analyses to understand in greater depth how beneficiaries from different subgroups (e.g., age, ethnicity, disease states) respond to the initiatives in the demonstration.

Analytic Considerations

Our evaluation approaches were continually informed by results from the rapid-cycle assessments (e.g., for CIS) and on-going review of Health Plan data submissions and subsequent meetings. Further, interim evaluation report findings contributed to the summative report and our long-term program planning. At each stage of the evaluation process, we reexamined findings from previous reports to consider the interrelations among the demonstration projects and the other aspects of the state’s Medicaid program. We also reexamined findings in relation to those from other Medicaid demonstrations and federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This approach allowed us to consider system-wide impacts that affect service delivery, health outcomes, and cost of care, to make judgments about the demonstration using evaluative reasoning, and inform Medicaid policymakers, advocates, and stakeholders at both the state and national levels.

Ethical and Data Security Considerations

This evaluation was classified as Not Human Subjects Research, as it was considered a Quality Improvement (QI) and Quality Assurance (QA) project. A complete description of methods to determine if a project is Human Subjects Research or QI/QA (or both) can be found in Bass and Maloy (2020). Our project was approved by the University of Hawaiʻi Institutional Data Governance Office to ensure that sensitive data was held, handled and monitored in accordance with strict standards of data confidentiality and security.

Demonstration Hypotheses and Key Evaluation and Key Evaluation Projects

Table III.1. Demonstration Hypotheses and Key Evaluation Projects

Demonstration Hypotheses	Key Evaluation Projects
H1.1: Increasing utilization for primary care, preventive services, and health promotion will reduce the prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.	Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes
H1.2: Improving care coordination (e.g., by establishing team-based care and greater integration of behavioral and physical	Project 1B: Care Coordination for Beneficiaries with Complex Conditions

health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).	Project 1C: Home- and Community Based Services (HCBS)
H2: Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the Health Plan level will increase appropriate utilization of the healthcare system, which in turn will reduce preventable healthcare costs.	Project 2A: Value-based Purchasing (VBP) Reimbursed at the Health Plan and Provider Levels
	Project 2B: Alternative Payment Models (APM) at the Provider Level
H3: Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.	Project 3A: Community Integration Services (CIS)
	Project 3B: Assessing the Process of Planning and Implementing Support Strategies Addressing Social Determinants of Health (SDOH)

IV. Project-Level Overview

A comprehensive overview of the original evaluation plan per project is provided in Appendix II. During the evaluation, we made adjustments to these plans as described in detail in the results section of this report. To provide a concise overview of the planned activities, the following section summarizes the projects individually.

Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes

Project 1A was aimed at increasing utilization for primary care, preventive services, and health promotion. Med-QUEST Division (MQD) hypothesized that the initiative would increase utilization, spending (as a percentage of total spending), and quality of primary care for beneficiaries as measured by progressively broad definitions of primary care. The UH evaluators planned to select relevant outcome indicators based on literature review and stakeholder consultation (i.e., provider and beneficiary). We planned to use administrative data for analysis including encounter, claim, and beneficiary-level report data regarding primary care utilization, spending, and quality measures, as well as beneficiary sociodemographic characteristics in the analyses. Additionally, we planned to use measures of patient satisfaction and patient-reported outcomes e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Project 1B: Care Coordination for Beneficiaries with Complex Conditions

Project 2B was aimed at improving care coordination (e.g., by establishing team-based care and greater integration of behavioral and physical health). MQD hypothesized provision of care coordination for individuals identified as having complex health needs would result in improved health outcomes and lowered utilization of the healthcare system, and a slower rate of expenditure growth. We planned to use administrative data in our analyses. Potential administrative data for analysis include encounter, claim, and beneficiary-level report data regarding utilization, spending, and quality as well as beneficiary sociodemographic characteristics.

Project 1C: Home- and Community-Based Services (HCBS)

Project 1C was aimed at improving home- and community-based services (HCBS). MQD hypothesized that the provision of HCBS would slow the deterioration of health, reflected in the level of care (LOC; measured by the timing of deterioration to a certain LOC level where entry into nursing home care becomes essential), among individuals meeting nursing facility (NF) LOC criteria. Second, length of time to enter a nursing home, patient-reported health outcomes (PROs), and total cost of care would vary depending on a variety of client characteristics among individuals. And third, that length of time to enter a nursing home, PROs, and total cost of care vary depending on a variety of client characteristics among the at-risk population. We planned to base analyses on administrative data for analysis including encounters, claims, and beneficiary-level report data such as long-term services and supports (LTSS) utilization, Hawaiʻi's health and functional assessment used to assess the health status of LTSS beneficiaries, and sociodemographic characteristics. Further, we planned to collect patient-reported health outcomes annually and as changes occurred.

Projects 2A & 2B: Value-based purchasing (VBP) reimbursed at the Health Plan and Provider levels

Projects 2A and 2B were aimed at the implementation of alternative payment models (APMs) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the Health Plan level. MQD hypothesized that these investments would increase appropriate utilization of the healthcare system and thus reduce preventable healthcare costs. The proposed strategy for analyses included the use of administrative data on encounters, Health Plan-level quality data, and beneficiary-level report data (including beneficiary-level quality information). The evaluation team planned to use Health Plan-level VBP data, and Health Plan data on provider-level VBP adoption and results, beneficiary-provider attribution data, and encounter data to identify beneficiaries served and services provided under different VBP structures.

Project 3A: Community Integration Services

Project 3A was aimed at providing a Community Integration Services (CIS) program and similar initiatives for vulnerable and at-risk adults and families. MQD hypothesized that provision of these services would result in better health outcomes and lower utilization of acute services, increased utilization of outpatient care services and lower total cost of care after being stably housed. Participating members were expected to improve in health and well-being as they progressed through the program. MQD expected the effectiveness of the CIS program to vary depending on client characteristics. The evaluation team planned to use administrative data, including encounters, claims, and beneficiary-level report data such as CIS utilization, functional assessments, and sociodemographic characteristics. The evaluation team further planned data collection through the Housing and Case Management Assessment Tool (obtained through direct interview with clients), the Homeless Management Information System (HMIS) and a contact hours and fidelity checklist. Planned data collection also included the eligibility screener and other data collection forms used by Health Plans.

Project 3B: Assessing process of planning and implementing support strategies addressing social determinants of health

Project 3B was aimed at evaluating the implementation of strategies addressing the social determinants of health. MQD formulated three main research questions: 1) What kinds of support strategies and interventions addressing the social determinants are chosen by Health Plans and how do these strategies translate to provider and patient outcomes; 2) in what ways did Health Plans develop and adopt a Social Determinants of Health (SDOH) Work Plan within their Quality Assessment and Performance Improvement (QAPI) plans? and 3) in what ways did the state develop the SDOH Statewide Transformation Plan? The evaluation team planned to approach these questions through a realistic evaluation approach to understanding how MQD has influenced the ecosystem of strategies and interventions that address SDOH in the state. The evaluation team planned to answer the research questions through a qualitative methodology including in-depth interviews with purposely chosen stakeholders from Health Plans, Regional Health Partnerships (if any) and providers.

Project 4A (Supplemental Project): Improve Data Quality for Immunization-Related Performance Measures

Project 4A was aimed at measuring progress in any area, including quality of care, that had been identified as needing improvement during the previous demonstration period. The joint MQD-

Department of Health (DOH) Hawaiʻi Immunization Registry (HIR) project planned to increase the accuracy and completeness of childhood immunization data for Hawaiʻi Medicaid beneficiaries and increase childhood immunization coverage for Hawaiʻi Medicaid beneficiaries. This particular initiative was not launched and therefore not evaluated; although MQD obtained funds to support the implementation of a new HIR, the DOH's capacity changed when the COVID-19 pandemic began and funds expired before the work could begin.

V. Results

The evaluation examined outcomes at the project level as well as across the entire Medicaid population. In this report, we will first provide a brief overview of Medicaid population demographics during the evaluation period. The following description of the Medicaid population demographics is based on an enrollment snapshot taken July 24, 2023. Table V.01a and VI.01b demonstrate the enrollment distribution per population group and Health Plan.

Table V.0.1a. Enrollment characteristics on July 24, 2023

	O‘ahu	Kaua‘i	Hawai‘i	Maui	Moloka‘i	Lāna‘i	Statewide
01-Children	77,461	7,578	27,378	14,866	1,324	342	**128,949**
02-CHIP	12,540	2,167	4,365	3,835	228	99	**23,234**
03-Current and Former Foster Care	3,881	355	1,576	622	89	13	**6,536**
04-Pregnant Women	2,171	209	599	429	24	NR	**3,440**
05-Parents/Caretakers	27,938	3,079	10,768	5,061	480	73	**47,399**
06-Adults	109,385	10,361	34,978	21,254	1,380	315	**177,673**
07-ABD (Adult, Non-Pregnant)	40,592	2,966	12,555	5,655	503	111	**62,382**
09-ABD (State-funded)	762	44	76	86	NR	NR	**976**
10-Medicare Savings Plan	NR	NR	NR	NR	NR	NR	**NR**
12-Other	121	NR	20	NR	NR	NR	**151**
	274,853	**26,761**	**92,315**	**51,818**	**4,028**	**969**	**450,744**

Notes: *Enrolled in managed care or fee-for-service, excludes prisoners/premium only

** 4/10/2023 represents the end of the Public Health Emergency

***Cells with 10 or fewer individuals have been suppressed (NR)

Table V.0.1b. Members distribution by Health Plan on July 24, 2023

	O‘ahu	Kaua‘i	Hawai‘i	Maui	Moloka‘i	Lāna‘i	ABD	NON-ABD	Statewide
Health Plan 1	45,798	6,682	15,573	9,737	2,341	511	8,129	72,513	**80,642**
Health Plan 2	133,454	14,523	55,747	16,433	1,027	232	17,899	203,517	**221,416**
Health Plan 3	34,596	NR	NR	17,019	NR	NR	4,234	47,381	**51,615**
Health Plan 4	23,002	2,334	8,542	3,790	367	106	12,542	25,599	**38,141**
Health Plan 5	37,935	3,209	12,435	4,834	293	120	21,298	37,528	**58,826**
FFS (no Health Plan)	68	13	18	NR	NR	NR	71	33	**104**
Total	**274,853**	**26,761**	**92,315**	**51,818**	**4,028**	**969**	**64,173**	**386,571**	**450,744**

Note: The State Medicaid population is served by five unique Health Plans.

Evaluation population

Analyzing the overall health of the Medicaid population during the current waiver demonstration period, the evaluation team utilized an actuarial dataset from 2021 that provided access to member-level risk scores and diagnostic information to conduct a detailed descriptive analysis of the Medicaid population. Administrative eligibility and enrollment demographic information were also utilized. Overall, the Medicaid population in Hawaiʻi grew from 365,275 members at the end of 2017 to 455,613 members at the end of 2021 (for any enrollment type). At the end of 2021, 448,326 members were enrolled in a managed care plan. Among these, 411,615 were members for at least 6 months, not dually enrolled (Medicaid & Medicare), or members of Community Care Services, a carve-out, specialized behavioral health plan that includes approximately 5,200 Medicaid members. The following demographic description includes only the 411,615 individuals meeting the latter criteria. The Hawaiʻi Medicaid population in 2021 was majority female (51.8% in 2021), with a mean age of 27 years. A breakdown of members' relationship status, ethnic/racial background, and island of residence appear in Table V.0.2.

Table V.0.2. Member characteristics (2021) among adult members for at least 6 months, not dually enrolled (Medicaid & Medicare), or members of Community Care Services

Ethnic and/or Racial Background	N	%
American Indian/Alaskan Native	7,688	1.9
Asian Indian	605	.1
Black	7,053	1.7
Chinese	30,059	7.3
Filipino	60,897	14.8
Guamanian/Chamorro	691	.2
Hawaiian (include part Hawaiian)	57,697	14.0
Japanese	17,697	4.3
Korean	4,762	1.2
Asian not listed	5,819	1.4
Pacific Islander not listed	17,538	4.3
Race/ethnicity not listed	37,197	9.0
Samoan	9,436	2.3
Unknown race/ethnicity	86,400	21.0
Vietnamese	1,915	.5
White	66,161	16.1
Total	411,615	100

Island of Residence	N	%
Oʻahu	242,983	59.0
Kauaʻi	24,512	6.0
Hawaiʻi	81,211	19.7
Maui	48,258	11.7
Molokaʻi	3,638	.9
Lānaʻi	867	.2
Out of State	10,146	2.5
Total	411,615	100

Overall Demonstration Evaluation

Approach

To better understand the Medicaid population in Hawaiʻi over the initiative period, the evaluation team conducted a longitudinal analysis of Med-QUEST Division (MQD) data from 2017–2022 to understand 1) which chronic and acute conditions were most prevalent among Medicaid members age 18 and above; 2) whether members could be grouped into naturally occurring clusters based on which conditions they received treatment for in the previous year; and 3) if members transitioned from one group or "class" to another over a four year period (2017–2021). We also examined the demographic composition and deaths between 2017–2022 for each group. Finally, we examined whether participation in specific initiatives during this period was associated with transitioning to a new class/group.

Evaluation Methods

Sample

We leveraged a cohort of 217,378 Medicaid members aged 18 and above. Our sample was composed of members enrolled in Medicaid at any point in 2017, with a mean of 10.17 months of enrollment (*SD* = 3.28). We incorporated encounter data extracted from the Hawaiʻi Prepaid Medical Management Information System (HPMMIS) in 2017, 2019, and 2021. We identified a broad range of chronic conditions that were collapsed into 17 specific indicators based on Chronic Disease and Disability Payment System (CDPS) diagnosis related groups. These condition groups served as the primary indicators for classification into latent groups using latent class analysis. The evaluation team then examined changes over time in class membership using latent transition analysis. These indicators were determined by whether an individual received treatment for each chronic condition within each respective year regardless of level of severity. See Table V.0.3 for the 17 conditions and corresponding prevalence rates across years.

Table V.0.3. Rate of Chronic Conditions among Med-QUEST Members in 2017, 2019 & 2021

	2017	2019	2021
Cardiovascular	17%	20%	20%
Psychiatric	13%	16%	16%
Skeletal	9%	10%	9%
CNS Conditions	4%	4%	4%
Pulmonary	11%	13%	11%
Gastrointestinal	8%	9%	9%
Diabetes, Type 2	7%	9%	9%
Skin Condition	7%	8%	8%
Renal	4%	5%	5%
Substance abuse	8%	9%	9%
Cancer	2%	2%	2%
Genital	3%	3%	3%
Metabolic	5%	6%	6%
Eye Disorder	5%	6%	5%
Cerebrovascular	1%	1%	1%
Infectious	3%	3%	2%
Hematological	1%	2%	2%

Analysis

To uncover groups within the Medicaid population based on members' history of chronic condition treatments and to examine changes in class membership over time, we employed Latent Class Analysis (LCA) and Latent Transition Analysis (LTA) methods. All LCA and LTA models were estimated using the maximum likelihood method with robust standard errors to account for any non-normality in the data. Model fit was assessed using established fit indices, including the Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), and the Lo-Mendell-Rubin Adjusted Likelihood Ratio Test (LMR-LRT). The optimal number of latent classes was determined based on these fit indices, conceptual interpretability, and the relative size of the classes. Statistical analyses were conducted using M*plus* (version 8.9).

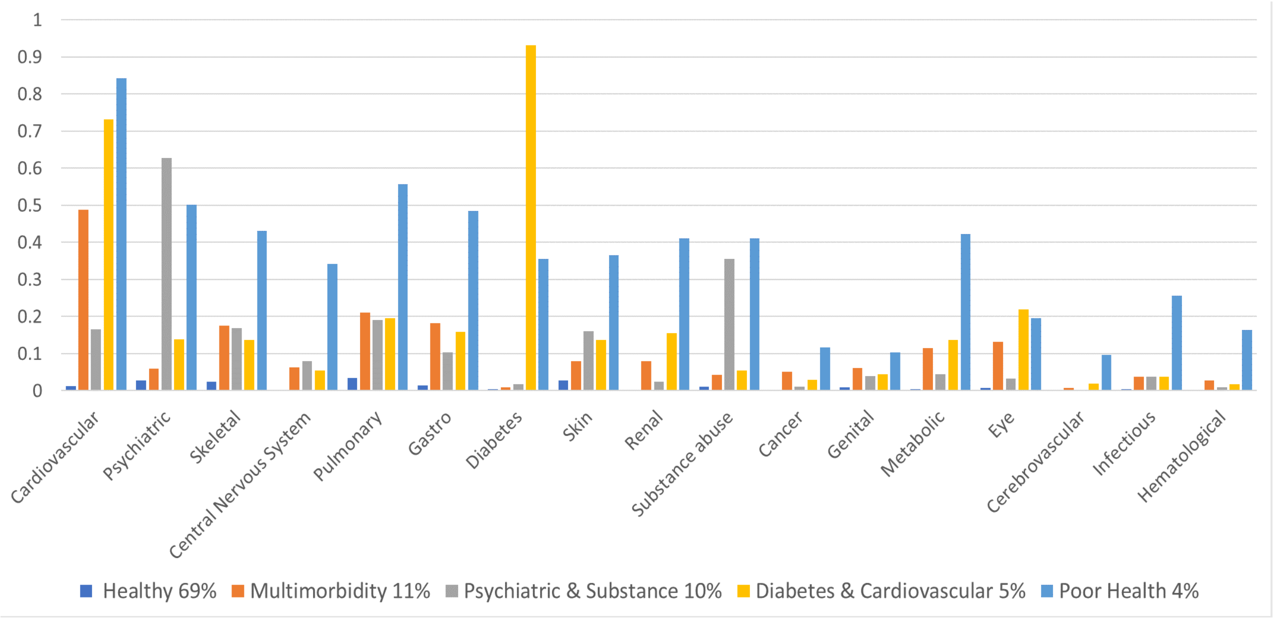
An initial LCA was conducted using 2017 data to identify the number of classes that best fit the data. Additional LCAs were then conducted to verify each year to determine whether the same class profiles could be replicated across years. This process confirmed that a 5-class model best fit the data, with an entropy value of .78. Subsequently, we performed LTA between the years 2017 and 2021 to measure the transition probabilities between these latent classes or health profiles. This analysis provided valuable insights into the dynamic nature of the population's health status, tracking the progression of chronic conditions treatment patterns over time.

Outputs

These latent classes represent underlying patterns of chronic conditions treatment within the population. The five-class model resulted in the following probabilities of class membership across the 17 chronic conditions (see Figure V.0.1). The classes represent groups of members who exhibited similar chronic condition profiles. Each of the five classes can be summarized as follows:

- The **Healthy Class (HC)** has relatively low utilization of healthcare for all conditions. This class represents the majority of members (69%).
- The **Multimorbidity Class (MCC)** has moderate healthcare utilization for many conditions, including cardiovascular, skeletal, pulmonary, and gastrointestinal, and eye disease, and accounts for 13% of the sample.
- The **Psychiatric & Substance Class (PSC)** members have a high probability of being treated for a psychiatric condition (63%) and a substance abuse condition (36%), and account for 10% of the overall sample.
- Members of the **Diabetes & Cardiovascular Class (DCC)** have a very high probability of being treated for type II diabetes (93%) and cardiovascular disease (73%), and account for 5% of the overall sample. They also have the highest rate of eye disease of any group (22%).
- The **Poor Health Class (PHC)** has the highest rates of almost all conditions (with the exceptions of type II diabetes, psychiatric, substance use and eye disease). Members of this class are in very poor health and accounted for 4% of the sample.

Figure V.0.1. Probabilities of Most Likely Class Membership by Condition, 2017



Examining demographic differences among members, the HC tended to be younger on average (mean age (M), M_{HC} = 34.69 in 2017) compared to all other classes (M_{MMC} = 47.59; M_{PSC} = 39.13; M_{DCC} = 51.77; M_{PHC} = 53.08). While some were statistically different, the HC, MCC, PSC, and DCC all had comparable percentages of males (ranging from 44.8%-46.9%) compared to the PHC (56.1% male). The PHC also had a much higher percentage of members identified as houseless (10.3%), compared to 5.8% for the PSC and .2%-1.0% for HC, MMC, and DCC. Not surprisingly, the PHC also had significantly higher actuarial risk scores (M_{PHC} = 4.57) compared to the HC (M_{HC} = 0.52), MMC (M_{MMC} = 1.47), PSC (M_{PSC} = 1.48), and DCC (M_{DCC} = 1.91).

Table V.0.3a. Between Class Differences, 2017

	Healthy (HC)	Multimorbidity (MMC)	Psychiatric & Substance (PSC)	Diabetes & Cardiovascular (DCC)	Poor Health (PHC)	Average
Age in 2017 (mean)	34.69 $_{a}$	47.59 $_{b}$	39.13 $_{c}$	51.77 $_{d}$	53.08 $_{e}$	38.25
Male (%)	45.8% $_{a}$	44.8% $_{b}$	46.9% $_{c}$	46.5% $_{a, c}$	56.1% $_{d}$	46.2%
Homeless Status (%)*	0.2% $_{a}$	0.6% $_{b}$	5.8% $_{c}$	1.0% $_{d}$	10.3% $_{e}$	1.2%
Risk Score (mean)	0.52 $_{a}$	1.47 $_{b}$	1.48 $_{b}$	1.91 $_{c}$	4.57 $_{d}$	0.96

Note: Values in the same row and not sharing the same subscript are significantly different at p< .05 in the two-sided test of equality for column means. *Homelessness is identified by the presence of specific homeless ICD-10 Z codes in their claim.

Comparing class membership by island (Table V.0.3b) revealed that in 2021:

- Oʻahu had a smaller proportion of its members in the PSC (56.7%) but a larger proportion in the DCC (70.7%) when compared to its members' overall proportion of all Medicaid members (60.7%).
- Kauaʻi had a larger proportion of its members in the HC (6.2%) and smaller proportion in the PHC (3.9%) and DCC (4.3%) compared to its overall proportion of all Medicaid members (5.9%).

- Hawaiʻi Island had a larger proportion of its members in the PSC (24.9%) and a smaller proportion of its members in the DCC (15.6%) and PHC (18.4%) compared to its members' proportion of all Medicaid members (20.9%).
- Maui had a larger proportion of its members in the HC (12%) and PSC (11.5%), and smaller proportion of its members in MMC (9.8%), DCC (8.2%), and PHC (8.8%) compared to its members' proportion of all Medicaid members (11.4%).
- Molokaʻi had a smaller proportion of its members in PSC (0.7%) and PHC (0.6%) compared to its members' proportion of all Medicaid members (1%).
- No significant differences were observed for Lānaʻi.

These findings suggest that Oʻahu has a disproportionate share of members with type II diabetes and cardiovascular disease, and Hawaiʻi has a disproportionate share of members with psychiatric and substance abuse conditions. On the other hand, Kauaʻi and Maui had a disproportionate share of members in the Healthy Class, with low healthcare utilization across conditions.

Table V.0.3b. Class Membership by Island, 2021

	Healthy Class (HC)		Multimorbidity Class (MMC)		Psychiatric & Substance Class (PSC)		Diabetes & Cardiovascular Class (DCC)		Poor Health Class (PHC)		Total	
Island	n	%	n	%	n	%	n	%	n	%	N	%
Oʻahu	90164_{a}	59.8	15276_{b}	62.2	12224_{c}	56.7	8365_{d}	70.7	5896_{e}	68.2	131925	60.7
Kauaʻi	9314_{a}	6.2	1402_{b}	5.7	$1318_{a,b}$	6.1	503_{c}	4.3	339_{c}	3.9	12876	5.9
Hawaiʻi	31412_{a}	20.8	5198_{a}	21.2	5362_{b}	24.9	1848_{c}	15.6	1588_{d}	18.4	45408	20.9
Maui	18098_{a}	12.0	2394_{b}	9.8	2471_{a}	11.5	964_{c}	8.2	$758_{b,c}$	8.8	24685	11.4
Molokaʻi	1521_{a}	1.0	241_{a}	1.0	155_{b}	0.7	120_{a}	1.0	56_{b}	0.6	2093	1.0
Lānaʻi	289_{a}	0.2	42_{a}	0.2	31_{a}	0.1	26_{a}	0.2	6_{a}	0.1	394	0.2

Note: Values in the same row not sharing the same subscript are significantly different at $p< .05$ in the two-sided test of equality for column proportions.

Notable differences were found across class membership by Health Plan (see Table V.0.3c). Significant differences included:

- Compared to its members' percentage of all Medicaid members (19.6%), **Health Plan 1** members were disproportionately likely to be in the HC (20.2%) and less likely to be in the PHC (17.9%).
- Compared to its members' percentage of all Medicaid members (46.7%), **Health Plan 2** members were disproportionately likely to be in the MMC (50.4%) and much less likely to be placed in the PHC (34%).
- Compared to its members' percentage of all Medicaid members (8.1%), **Health Plan 3** members were disproportionately more likely to be in the HC (8.9%) and much less likely to be in the PHC (4.4%).
- Compared to its members' percentage of all Medicaid members (12.1%), **Health Plan 4** members were disproportionately more likely to be in the PSC (15.4%) and *much more likely* to be in the PHC (24.4%).

- Compared to its members' percentage of all Medicaid members (13.4%), **Health Plan 5** members were disproportionately more likely to be in the DCC (15.2%) and *much more likely* to be in the PHC (19.2%).

These findings suggest that Health Plan 4 and Health Plan 5 disproportionately serve members who are in the Poor Health Class and have higher healthcare utilization across all conditions; these Health Plans also have the highest prevalence of ABD populations (Table V.0.1b). Health Plan 1 and Health Plan 3 disproportionately serve members in the Healthy Class and tend to have lower healthcare utilization across classes. While Health Plan 2 members are less likely to be in the Poor Health Class, they are disproportionately likely to receive treatment for multimorbidities and psychiatric/substance use disorders.

Table V.0.3c. Class Membership by Plan, 2021

Health Plan	Healthy Class (HC)		Multimorbidity Class (MMC)		Psychiatric & Substance Class (PSC)		Diabetes & Cardiovascular Class (DCC)		Poor Health Class (PHC)		Total	
	n	%	n	%	n	%	n	%	n	%	N	%
Health Plan 1	30528_a	20.2	4441_b	18.1	$3910_{b,c}$	18.1	$2286_{a,c,d}$	19.3	$1548_{b,d}$	17.9	42713	19.6
Health Plan 2	70446_a	46.7	12365_b	50.4	10649_b	49.4	5122_d	43.3	2942_d	34.0	101524	46.7
Health Plan 3	13479_a	8.9	1568_b	6.4	1146_c	5.3	1023_a	8.7	381_d	4.4	17597	8.1
Health Plan 4	16536_a	11.0	2845_b	11.6	3310_c	15.4	1592_d	13.5	2112_e	24.4	26395	12.1
Health Plan 5	19809_a	13.1	3334_a	13.6	2546_b	11.8	1803_d	15.2	1660_d	19.2	29152	13.4

Note: Values in the same row not sharing the same subscript are significantly different at $p< .05$ in the two-sided test of equality for column proportions.

Statistically significant differences were also found across classes for special population groups (Table V.0.3d). Regarding class differences among special population groups. Most notably:

- Aged, Blind, or Disabled (ABD) members were disproportionately likely to be in the PHC (47.5%) compared to their overall prevalence across the full sample (9%).
- Members associated with Medicaid Expansion were disproportionately less likely to be in the PHC (45.3%) compared to their overall prevalence across the full sample (65.3%).
- Members enrolled as Family & Children (limited to those 18 years and older) were disproportionately more likely to be in the HC (27.1%) and much less likely to be in the PHC (7.2%) compared to their overall prevalence across the full sample (24.1%).

These findings suggest that ABD members are disproportionately likely to have the highest healthcare utilization across all conditions, while members associated with Medicaid Expansion and QUEST were less likely to have high healthcare utilization.

Table V.0.3d. Class Membership by Program, 2021

Program	Healthy Class (HC)		Multimorbidity Class (MMC)		Psychiatric & Substance Class (PSC)		Diabetes & Cardiovascular Class (DCC)		Poor Health Class (PHC)		Total	
Plan	n	%	n	%	n	%	n	%	n	%	N	%
ABD	5792$_{a}$	3.8	3624$_{b}$	14.8	3502$_{c}$	16.2	2524$_{d}$	21.3	4108$_{e}$	47.5	19550	9.0
Expansion	101008$_{a}$	67.0	15823$_{b}$	64.4	13936$_{b}$	64.6	7301$_{c}$	61.7	3913$_{d}$	45.3	141981	65.3
Families and Children[1]	40818$_{a}$	27.1	4993$_{b}$	20.3	3874$_{c}$	18.0	1989$_{c}$	16.8	619$_{d}$	7.2	52293	24.1

Note: Values in the same row not sharing the same subscript are significantly different at p< .05 in the two-sided test of equality for column proportions. [1]Families and Children represent parents and caretakers of young children and/or pregnant woman; children were not included in these analyses.

Class Transitions

The evaluation team examined transitions from one class to another over time. Table V.0.4 below represents the probabilities of moving between classes, with each row representing class membership in 2017 and each column representing class membership in 2021. Examining latent transition probabilities between 2017–2021, we found that:

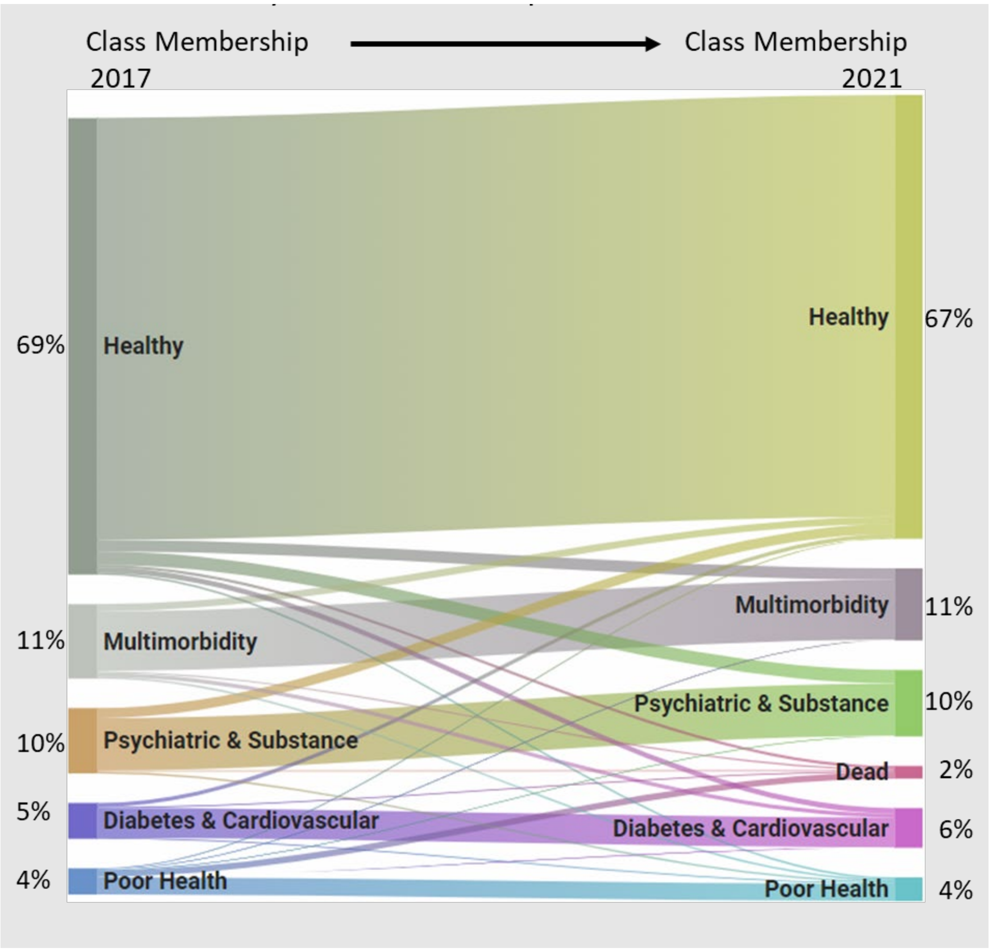
- Members of the HC had the highest probability of staying in their original class (84% remained in HC). However, 7% transitioned to the PSC and 6% to the MMC.
- Members of the MMC had a 12% probability of transitioning to the HC by 2021 and a 6% probability of transitioning to the DCC.
- Members of the PSC had a 21% probability of transitioning to the HC by 2021, which represents the highest probability of transitioning to a new class (excluding members in PHC who died prior to 2021).
- Members of the DCC had a 12% probability of transitioning to the HC but a 5% chance of transitioning to the PHC and a 3% probability of death.
- Members in the PHC in 2017 had a 60% probability of staying in PHC in 2021 and a 23% probability of dying over this period.

Table V.0.4. Probability of Staying or Transitioning into a New Class 2017–2021

		2021 Class					
		Healthy Class (HC)	Multimorbidity Class (MMC)	Psychiatric & Substance Class (PSC)	Diabetes & Cardiovascular Class (DCC)	Poor Health Class (PHC)	Death (as of 2021)
2017 Class	HC	0.84	0.06	0.07	0.02	0.01	0.01
	MMC	0.12	0.77	0.00	0.06	0.04	0.02
	PSC	0.21	0.00	0.74	0.00	0.04	0.01
	DCC	0.12	0.00	0.00	0.81	0.05	0.03
	PHC	0.06	0.05	0.04	0.04	0.60	0.23

These transitions are graphically presented in the following Sankey diagram (Figure V.0.2), which presents the extent of transitioning between classes between 2017 and 2021. Thicker lines represent a larger percentage of the overall sample.

Figure V.0.2. Most Likely Class Membership Transitions 2017–2021



These results suggest that overall, members were likely to remain in the same class in 2021 as they were in 2017. Members with low evidence of utilization (the Healthy Class) in 2017 were most likely to continue experiencing low healthcare utilization in 2021, suggesting that they maintained their health in subsequent years. Those members who received psychiatric and substance abuse treatments in 2017 were most likely to transition to a new class–the Healthy Class– in 2021. Notably, those members in the 2017 Poor Health Class had a high likelihood of having died by 2021.

Death Rates

Because of the number of deaths over the period, the evaluation team examined death rates across the classes. We conducted a Kaplan-Meier method survival analysis to assess the probability of death at each age up to age 65 for the five classes (see Figure V.0.3). The analysis was restricted to members under age 65 in order to focus on early death and limit the potential impact that transition to Medicare after age 65 and/or dual enrollment had on our conclusions. The analysis relied on 2017 classifications and member death status as of 2023.

Between 2017 and 2023, 5,804 members under age 65 died. Of those members who died, 1,476 were members in the HC (1.0% of the HC), 783 were members of the MMC (3.4% of the MMC), 663 were members of PSC (3.1% of the PSC), 547 were members of DCC (5.0% of the DCC), and 2,335 were members of the PHC (roughly 29.9% of the PHC). See Table V.0.5 for the unadjusted death rate by class based on members' classification in 2017. Analyses revealed that the rate of death among members of the PHC was very high for the full and restricted sample (those aged 18–65). These analyses also revealed that those in the MMC, PSC, DCC and PHC had significantly higher rates of death compared to the HC for the full and restricted sample starting in 2019.

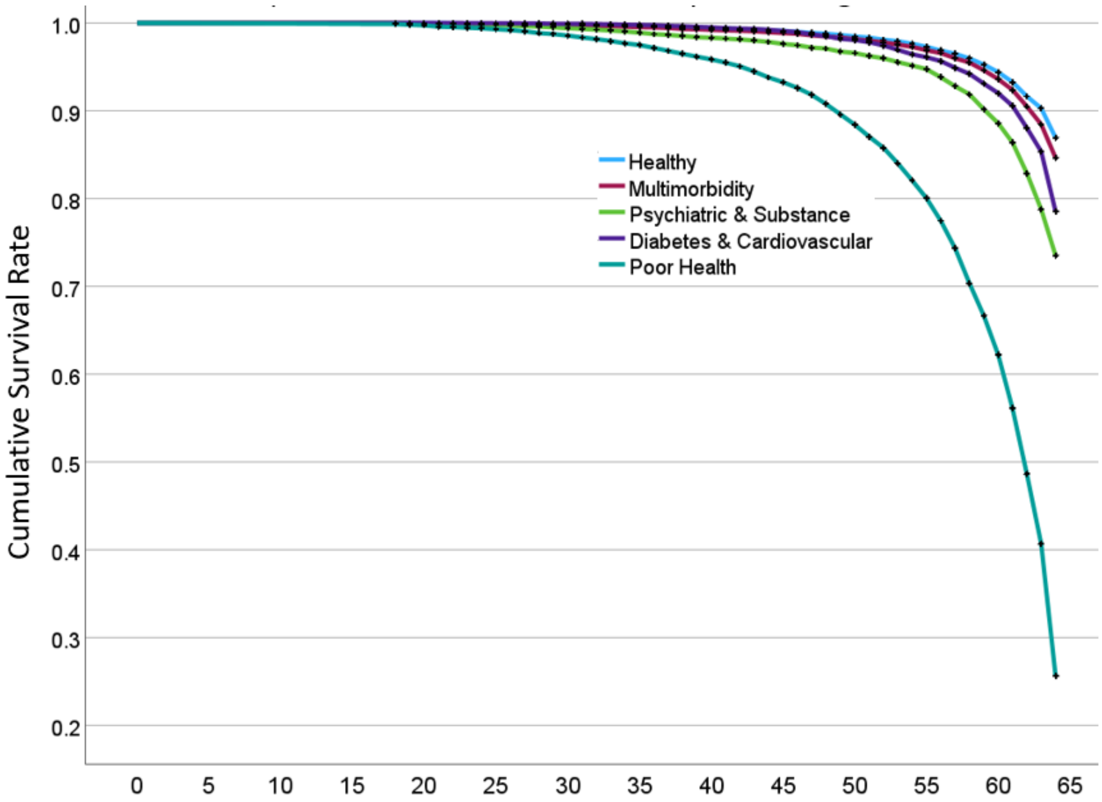
Table V.0.5. Unadjusted Rate of Death by Class between 2017 and 2023

All Members above age 18						
	Healthy Class	Multimorbidity Class	Psychiatric & Substance Class	Diabetes & Cardiovascular Class	Poor Health Class	Overall
Died by 2018	0.2% ^{a}	0.5% ^{b}	0.3% ^{c}	0.4% ^{b,c}	8.5% ^{d}	0.6%
Died by 2019	0.3% ^{a}	1.0% ^{b}	0.6% ^{c}	0.9% ^{b}	14.3% ^{d}	1.0%
Died by 2020	0.5% ^{a}	1.5% ^{b}	1.0% ^{c}	1.7% ^{b}	19.3% ^{d}	1.4%
Died by 2021	0.6% ^{a}	2.0% ^{b}	1.5% ^{c}	2.5% ^{d}	24.6% ^{e}	1.9%
Died by 2022	0.8% ^{a}	2.8% ^{b}	2.4% ^{c}	3.8% ^{d}	28.2% ^{e}	2.4%
Died by 2023	0.011 ^{a}	3.7% ^{b}	3.1% ^{c}	5.6% ^{d}	32.3% ^{d}	3.1%
	Members between the Ages of 18-65 Only					
Died by 2018	0.2% ^{a}	0.5% ^{b}	0.2% ^{a,c}	0.3% ^{b,c}	7.6% ^{d}	0.5%
Died by 2019	0.3% ^{a}	0.9% ^{b}	0.6% ^{c}	0.8% ^{b,c}	13.0% ^{d}	0.9%
Died by 2020	0.4% ^{a}	1.3% ^{b}	1.0% ^{c}	1.5% ^{b}	17.6% ^{d}	1.3%
Died by 2021	0.6% ^{a}	1.8% ^{b}	1.4% ^{c}	2.2% ^{b}	22.5% ^{d}	1.7%
Died by 2022	0.7% ^{a}	2.6% ^{b}	2.3% ^{b}	3.3% ^{c}	26.0% ^{d}	2.2%
Died by 2023	1.0% ^{a}	3.4% ^{b}	3.1% ^{b}	5.0% ^{c}	29.9% ^{d}	2.7%

Note: Values in the same row and not sharing the same subscript are significantly different at $p < .05$ in the two-sided test of equality for column means.

As presented in Figure V.0.3, the probability of early death among members of the PHC class is greater across all ages, with a gap that becomes considerably greater by age 50. This trend continues with growing gaps in probability of death between the PSC (second highest probability) and the DCC (third highest probability) by age 60.

Figure V.0.3. Kaplan-Meier Survival Functions by Class to Age 65



Predictors of Death

Finally, to further determine the extent that class membership in 2017 predicted death above and beyond demographic characteristics and actuarial risk scores, we conducted a logistic regression analysis, with demographic predictors entered in Step 1, class membership (HC as the reference group) in Step 2, and actuarial risk scores entered in Step 3 (Table V.0.7).

Table V.0.7. Logistic Regression Predicting Death by Year 2023

	Step 1 (Nagelkerke Pseudo R^2 = .15)							
	B	S.E.	Wald	df	Sig.	OR	95% C.I.for OR LL	 UL
Age in 2017	0.07	0.00	4866.56	1.00	<.001	1.07	1.07	1.08
Male in 2017	0.68	0.03	521.26	1.00	<.001	1.97	1.86	2.09
Homeless status in 2017	1.39	0.06	497.97	1.00	<.001	4.02	3.56	4.54
Constant	-7.40	0.06	15301.10	1.00	<.001	0.00		
	Step 2 (Nagelkerke Pseudo R^2 = .28)							
Age in 2017	0.05	0.00	1705.95	1.00	<.001	1.05	1.05	1.05
Male in 2017	0.64	0.03	419.77	1.00	<.001	1.89	1.78	2.01
Homeless status in 2017	0.18	0.07	6.90	1.00	0.009	1.20	1.05	1.37

Healthy Class			6639.96	4.00	<.001			
Multimorbidity Class	0.67	0.05	180.35	1.00	<.001	1.96	1.78	2.16
Psychiatric & Substance Class	0.90	0.05	278.05	1.00	<.001	2.46	2.21	2.73
Diabetes & Cardiovascular Class	0.82	0.06	199.63	1.00	<.001	2.28	2.04	2.56
Poor Health Class	3.07	0.04	5573.24	1.00	<.001	21.59	19.92	23.40
Constant	-7.14	0.06	12093.32	1.00	<.001	0.00		
	Step 3 (Nagelkerke Pseudo R^2 = .29)							
Age in 2017	0.05	0.00	1741.28	1.00	<.001	1.05	1.05	1.05
Male in 2017	0.65	0.03	427.29	1.00	<.001	1.92	1.81	2.05
Homeless status in 2017	0.05	0.07	0.57	1.00	0.451	1.05	0.92	1.21
Healthy Class			2247.04	4.00	<.001			
Multimorbidity Class	0.47	0.05	85.78	1.00	<.001	1.60	1.45	1.77
Psychiatric & Substance Class	0.72	0.05	173.41	1.00	<.001	2.05	1.84	2.28
Diabetes & Cardiovascular Class	0.53	0.06	77.34	1.00	<.001	1.69	1.51	1.91
Poor Health Class	2.30	0.05	1933.54	1.00	<.001	9.97	9.00	11.05
Risk Score in 2017	0.18	0.01	640.17	1.00	<.001	1.20	1.18	1.21

Results from this analysis determined that:

- Age in 2017, identifying as male, and being flagged as experiencing homelessness in 2017 were strong predictors of having died by 2022. Age, if exponentiated to represent a ten-year increase (versus 1 year [unit] increase), results in an odds ratio (OR) of 2.05 in step 1, 1.65 in step 2, and 1.67 in step three. This finding suggests that after accounting for class membership and actuarial risk scores, for every ten-year increase in age, the odds of dying increases by 67%.
- Membership in any class compared to the HC in 2017 was a very strong predictor of death by 2022. Being a member of the MMC, PSC, DCC, and PHC all resulted in OR at or over 2, with being a member of the PHC resulting in very high odds of death compared to the HC (OR = 21.59 in step 2 and 9.97 in step 3).
- The actuarial risk score (M = 0.96 ; SD = 1.25) was added in the final step to determine whether class membership was predictive of death, above and beyond age, identifying as male, and homelessness status, as well their risk score. The addition of the risk scores in the third step of the analysis resulted in negligible added effect (Δ = Nagelkerke Pseudo R^2 = .014).

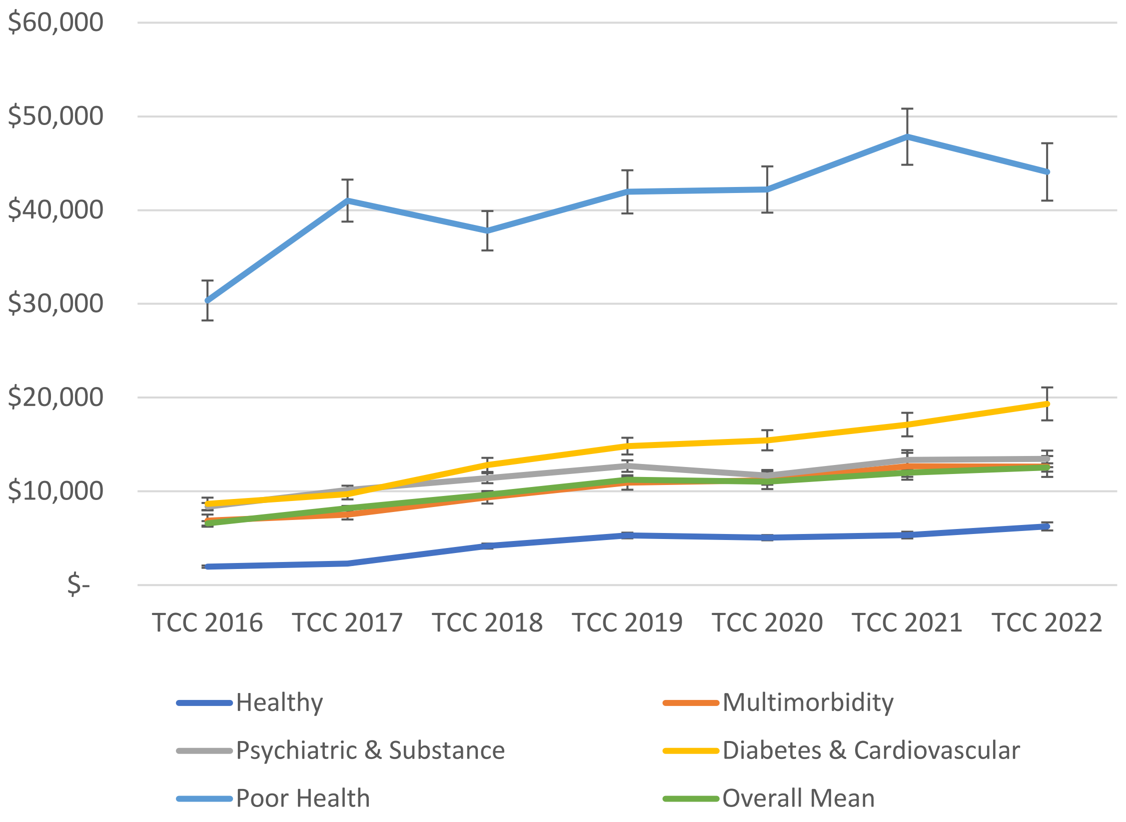
Thus, this final step in the analysis suggests that being placed in any class other than the healthy class in 2017 resulted in increased odds for death by 2022, with 2017 membership in the PSC (OR = 2.05) and the PHC (OR 9.97) being highly predictive of death.

Total Cost of Care

The evaluation team examined the total cost of care from 2016 to 2022 across classes. The mean total cost of care for an adult Medicaid member who received care in 2016 was $6,586. This amount rose to $12,548 by 2022. While a meaningful increase occurred overall, particularly sizable increases were observed among members in the PHC and the DCC (Figure V1.0.4). The PHC had the highest total cost of care across all years. Overall, the trend of costs increased fairly dramatically between 2016–2019 (overall increase by 70%). Increases between 2019–2022 were notably less (overall increase by 12%).

While this finding is promising, its interpretation is complicated by the onset of the COVID-19 pandemic, which may have limited access or led to deferred care in some cases, while increasing the need for care for others. When examined closely by class membership, it is clear that as a percentage, the HC class increased the most between 2016–2019 (a 169% increase) but exhibited fairly modest growth between 2019–2022. This can be contrasted to the DCC, which exhibited fairly high growth between 2016–2019 (70%), but still had notable growth between 2019–2022 (30%). Trends between 2016 to 2019 and 2019 to 2022 suggest that all classes reported slower growth in costs between 2019–2022 compared to 2016–2022. Changes in growth were within the margin of error in 2019–2022 for the PHC and PSC, and increased only modestly for the HC and MCC. One could speculate that those in the Healthy Class were more likely to defer non-urgent care, while those in the DCC were more susceptible to complications associated with acquiring COVID-19 and/or had medical treatments that could not be deferred.

Figure V.0.4. Total Cost of Care by Class 2016–2022



Note: Total Cost of Care = TCC

Conclusions

The PHC had the highest probability of death and the highest cost of care compared to all groups. They also experienced an increase in the cost of care between 2016 and 2022. Members in this class in 2017 tended to stay in this class in 2021. Notably, membership in the PHC predicted early death above and beyond age, risk scores, and other characteristics. PSC membership was also highly predictive of death; however, membership in this class in 2017 had the highest probability of transitioning to the Healthy Class by 2021. This finding suggests an opportunity for reducing costs and increasing health outcomes for members in this class through robust substance use prevention and treatment programs. Moreover, programs that prevent individuals from falling into or remaining in this class could be particularly beneficial, with previous data demonstrating that it is possible. Related, it also appears that members of the DCC were associated with a steep incline in total cost of care compared to the MMC, PSC, as well as the overall mean. This suggests that the treatment costs for members of this class are outpacing treatment costs in other areas. This finding offers opportunities to closely examine the costs of care for these individuals and emphasizes the need to prioritize prevention services to limit the number of people who fall into this class and tertiary services to limit the probability that they transition to the PHC Finally, the rate of expenditure growth slowed when comparing the prior demonstration period (2016–2019) to the current demonstration period (2019–2022) for most groups; however, these findings may have been confounded by the COVID-19 pandemic and thus need to be interpreted with caution.

Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes

Introduction and Background

The hypothesis explored in this chapter is: “Increasing utilization for primary care, preventive services, and health promotion will reduce prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.”

The two primary research questions explored in this chapter include:

> RQ 1A.1: What are time trends in utilization, spending (as a percentage of total spending), and quality of primary care for demonstration populations?
>
> RQ 1A.2: Are changes in primary care utilization associated with plausibly relevant health outcomes?

Primary care has many definitions and component concepts. During its 1979 meeting, the World Health Assembly defined primary health care as services that promote a level of health that permits citizens to lead a socially and economically productive life (Starfield, 1998). This definition of primary care included “essential health care…at a cost that the community and the country [could] afford to maintain at every stage of their development in a spirit of self-reliance and self-determination” (Starfield, 1998). Primary care can also be described in the context of four pillars of primary care practice including: first-contact care, continuity of care over time, comprehensiveness or concern for the entire patient rather than one system, and coordination with other parts of the health system (Bodenheimer & Pham, 2010). Primary care centers on a patient-centered culture that places the needs of patients above all else, and care that is regularly measured to ensure high quality (Bodenheimer & Pham, 2010). These definitions speak to a vision of primary care as a service area critical to the well-being of a society and its constituents.

In the U.S., primary care responsibilities are shared by many categories of practitioners, including family physicians, geriatricians, general pediatricians, nurse practitioners, and physician assistants (Bodenheimer & Pham, 2010). The prevailing approach to healthcare stresses a sustained relationship between patients and their clinicians, and its definitions generally encompass the need for accessibility, continuity, integration, and a whole-person orientation of care (Safran, 2003). Primary care generally includes a focus on health promotion, health maintenance, disease prevention, counseling, patient education and literacy, and diagnosis and treatment of chronic and acute illnesses (Stanborough, 2020).

Investments in primary care result in improvements to equity and access, health care performance, health outcomes, accountability of health systems, and are seen as the most equitable, inclusive, and cost-effective approach to enhance the health of people (WHO, 2021; Starfield et al., 2005). Research indicates that continued availability of Primary Care Providers (PCP) is associated with improved overall health outcomes, observable in results including reduced low birth weight, reduced mortality rates, decreased hospitalizations, and increased self-rated health status (Shi, 2012).

Primary care Measurement Across other States

While substantial research has documented the benefits of primary care, and the importance of investing in primary care, the conceptualization of primary care in the US is best characterized as an emerging discourse.

The Patient-Centered Primary Care Collaborative (PCPCC) authored a report titled *Investing in Primary Care: A State-Level Analysis* to aid state-level and national policy leaders by providing quantitative data and analysis of primary care spending at the state level. This report also describes the association between primary care and patient outcomes in order to measure and increase the investment in primary care. In it, primary care is measured using two definitions. A narrow definition of primary care includes spending related to PCPs in offices and outpatient settings, while a broad definition also covers spending upon other members of the primary care clinical team, including nurses, nurse practitioners (NPs), physician assistants (PAs), OB/GYNs, and behavioral health professionals (i.e., psychiatrists, psychologists, and social workers) (PCPCC, 2019). Healthcare expenditures included outpatient, office-based, hospitalizations, emergency department, prescription medications, vision care, dental care, home health care, and other medical categories.

The Primary Care Collaborative found that in 2019, primary care spending across commercial payers was only 4.67% of total national commercial healthcare spending, a fall from 4.88% in 2017. From 2017–2019, primary care spending under the narrow definition of PCPs and primary care services varied from as low as 3.14% in Kentucky to as high as 9.48% in Michigan; using the broad definition, from a low of 5.57% in Pennsylvania to a high of 16.64% in Mississippi (Kempski & Greiner, 2020). Within this report, Hawaiʻi ranked 31st in the nation with 4.34% on primary care utilizing the narrow definition and 36th with 7.58% of total primary care spend utilizing the broad definition (Kempski & Greiner, 2020). Additionally, Hawaiʻi ranked 49th (-1.26) on percent change in primary care spending using the narrow definition and 47th (-1.29) on percent change in primary care spending using the broad definition (Kempski & Greiner, 2020). A negative association was found between the measure of primary care spending percentage and measures of utilization including ED visits and hospitalizations, thus indicating targeted strategies to invest in primary care capacity can improve patient outcomes and the appropriate use of health system resources (Kempski & Greiner, 2020).

Both definitions of primary care in the PCPCC report measured primary care spend in terms of the quantity of clinician-patient interactions; neither attempted to assess the quality or richness of preventative care received by patients as a result of their engagement with their primary care providers.

Primary Care Measurement in Hawaiʻi

As Hawaiʻi embarked upon its own 1115 waiver demonstration, its first task was to define primary care investment. Similar to the PCPCC report, a review of definitions applied by other states principally leaned towards methodologies that emphasized primary care visits and overall engagement with primary care providers. Despite parallels in some definitions of primary care spend (e.g., costs of vaccinations, screenings), no comprehensive definition of primary care services was found in use by any state. Hawaiʻi also recognized that for members with more complex health conditions (e.g., comorbid behavioral health conditions) the provision of primary care alone may not be adequate to prevent avoidable service utilization. These patients likely need additional outpatient supports in conjunction with primary care, such as care coordination, psychotherapy, and other services, to be sufficiently supported in the outpatient setting and avoid a deterioration in their health outcomes. Finally, Hawaiʻi also recognized that even in the primary care setting, certain services are well-documented to provide no perceptible positive impact on health outcomes, making them unnecessary and wasteful services that ought not to be promoted. Given these considerations, Hawaiʻi came up with a more comprehensive definition of primary care services and spend for its 1115 waiver demonstration including four distinct metrics: spend on primary care visits, spend on beneficial primary care services, spend on primary care supports, and spend on low-value care. The first three metrics were mutually exclusive in definitions and in combination, added up to Hawaiʻi's total primary care spend, while the individual definitions would allow separate evaluation of each of the distinct domains of primary care.

Based on the definitions, Hawaiʻi created a new managed care report during the current 1115 waiver demonstration period, the *Primary Care Report*. The purpose of this report was to track progress towards a Health Plan's investments in primary care using each definition of primary care spend. Its purpose was to establish baseline spending on primary care based on each definition; then, a Health Plan could set a series of achievable targets to iteratively decrease its spending on low-value care and increase spending on beneficial services, with proven patient and monetary benefits. The report was created in 2020, and introduced to Hawaiʻi's Health Plans in 2021. The state provided substantial technical assistance and support to its Health Plans to promote accurate reporting on the metrics contained within the report. The first accurate reports of primary care spend for calendar years 2020 and 2021 were submitted by Health Plans at the beginning of 2023. At the time of authorship of this evaluation report, Med-QUEST Division has not set targets for primary care spending across any of the definitions.

The definitions of primary care spend included in the *Primary Care Report* are:

1. Primary care visits, which are the setting for preventive care provided by PCPs, often serving as the first point of care for an individual. An office consult of a specified duration (e.g. 30 minutes) is a characteristic service under this definition. Increasing spend on primary care visits can indicate greater utilization of primary care providers, and/or higher rates of reimbursement for primary care visits; both result in an increase in access to primary care.
2. Beneficial primary care services concern services provided, or, in some cases, recommended in the outpatient primary care setting. This definition emphasizes the preventative services provided during and as a result of an outpatient visit. Beneficial primary care services are defined as preventive care with a focus on high value care services such as screenings, assessments, and immunizations provided or referred in the primary care setting.
3. Primary care supports, defined broadly as the set of care services that engage, support, stabilize, and improve management of the member in the outpatient setting, so as to reduce excessive and inappropriate inpatient utilization. Examples include care coordination and behavioral health supports.
4. Low-value primary care services, defined as services that are typically provided in primary care settings but considered unnecessary and known to result in wasteful spending.

The 2019–2023 1115 waiver evaluation design hypothesized that the activities conducted during the MQD 1115 waiver, would increase utilization of, spending upon, and quality of primary care services, preventive services, and health promotion services, which in turn would improve measures of relevant health outcomes.

Anticipated Relationships Between Cost, Utilization, and Outcomes

Hawaiʻi has consistently maintained a PCP-Enhancement (PCP-E) program during the period from 2013-present, through which primary care providers have been paid at levels equivalent to Medicare rates for primary care practice. Therefore, increases in Medicare rates have been closely mirrored by increases in rates for Hawaiʻi's PCPs (following some lag). This program, administrated as a directed payment arrangement, is most likely to impact the first definition, primary care visits, as it is focused on expenditures connected directly to provider visits. To account for potential confounding due to PCP-E, this evaluation looks at both spend and utilization to assess whether an increase in spend led to corresponding increases in utilization.

In normal times, a theory of prevention benefits of primary care would have predicted that an increase in utilization would lead to improved quality outcomes over time because of the preventative benefits of primary care and the capacities of primary care to provide anticipatory care. The mechanism by which primary care works is through anticipating care and preventing problems before they occur (Watt, O'Donnell and Sridharan, 2011). Given the disruptions caused by the COVID-19 pandemic, the relationship between utilization and quality outcomes may not be strong for multiple reasons:

- Shutdowns caused by the pandemic made for unusually sporadic access to primary care and reduced utilization of primary care services.
- The pandemic also resulted in the changes in the modalities of care. There was an increased focus on contactless modalities like telehealth. It is unclear whether these alternate modalities are as effective as in-person services.
- Individuals delayed care during the COVID-19 pandemic (Findling et al., 2020; Gertz et al., 2022).

For these reasons, the evaluation team adjusted expectations to anticipate a weakened relationship between utilization and outcomes in primary care.

Evaluation Approach

Various methods were used to explore the two primary research questions. Changes in spending were explored using descriptive statistical approaches and multivariate statistical methods were implemented to explore the relationship between utilization and outcomes.

RQ 1A.1: What are time trends in utilization, spending (as a percentage of total spending), and quality of primary care for Demonstration populations?

Due to Hawaiʻi's unique approach to defining primary care spending as high- and low-value care, it is expected that proportional spending on (high-value) primary care per member per month will increase over time as waste is reduced and more expensive specialist care is prevented.

Spending on Primary Care Services

We operationalized spending in three ways: total spend on primary care for the full Medicaid population, proportional spend (as a percentage of total spend), and spend per member per month. Spend and utilization metrics were calculated for the various definitions of primary care: 1) primary care visits; 2) beneficial primary care services; 3) primary care supports; and 4) low-value primary care services. Historic encounter data was used to calculate all metrics besides low-value primary care services, which was evaluated based on Health Plan reported data.

- Total spend for the Medicaid population
    - Presented for the years 2016–2022 for 1) primary care visits; 2) beneficial primary care services; and 3) primary care supports (Source: MQD Encounter Data)
    - Presented for the years 2020–2021 for 4) low-value primary care services (Source: MQD Health Plan Reports)
- Average spend per member per month (PMPM)
    - Presented for the years 2016–2022-for 1) primary care visits; 2) beneficial primary care services; and 3) primary care supports (Source: MQD Encounter Data)
    - Presented for the years 2020–2021 for 4) low-value primary care services (Source: MQD Health Plan Reports)
    - Spend was adjusted for inflation using the Consumer Price Index (CPI) to represent 2022 dollars. An inflation adjustment is standard for any cost comparison over time. Any changes in inflation need to be accounted to look at differences in 'real costs' between years. From 2016–2022, inflation was around 20%.
- Proportional spend (primary care spend as a proportion of total spend)
    - Presented for the years 2020–2021 for 1) primary care visits; 2) beneficial primary care services; 3) primary care supports; 4) primary care low-value services; (Source: Med-QUEST Health Plan Reports)

To provide information on differences between ABD, Family & Children, and expansion populations, we additionally derived information from Health Plan reports on costs per eligibility group in 2020 and 2021.

Utilization of primary care services

We operationalized utilization as total number of primary care claims for the Medicaid population and average number of claims PMPM.

Comparison between utilization and spend

Additionally, we evaluated the relationship between spend and utilization to assess for trends in spend that were not explained by trends in utilization. For this purpose, we calculated the mean spend per claim for the first three primary care definitions.

Analyses of RQ1

Changes to primary care spending and utilization over time were provided from 2016–2022 to represent changes over time from 3 years prior to the demonstration (2016–2018), and 4 years within the current demonstration period (2019–2022).

Differences in spend between the start of the demonstration period (2019), and the latest available complete year of data during the demonstration period (2022) were calculated using t-statistics.

RQ 1A.2: Are changes in primary care utilization associated with plausibly relevant health outcomes?

For the purpose of investigating if primary care utilization is associated with plausibly relevant health outcomes, we tested whether any use of 1) primary care visits, 2) beneficial primary care services, and 3) primary care supports in 2021 was associated with multiple health care outcomes in 2021.

Association between primary care utilization and health outcomes

Data Sources

This section of evaluation obtained data from three sources, including the encounter data from MQD's HPMMIS system, the Healthcare Effectiveness Data and Information Set (HEDIS) Patient-Level Data (PLD) from 2021, and the Chronic Illness and Disability Payment System (CDPS) risk score data from 2021 provided by MQD's actuaries.

Measures

Independent variable

Primary care utilization was analyzed as a binary variable and obtained from the encounter data from MQD's HPMMIS system for each primary care definition: primary care visits (1), beneficial primary care services (2) and primary care supports (3). Members were categorized into groups, "no primary care claim in 2021" and "had at least one primary care claim in 2021".

Outcome variables

All outcome variables were obtained from the encounter data extracted from MQD's HPMMIS system and quality measures from the HEDIS PLD 2021. Outcome variables included the counts PMPM of ED visits, outpatient visits, inpatient visits, and inpatient length of stay in 2021 for members. In addition, to explore the relationship between primary care utilization and outcomes among sub-populations, several outcomes for multiple sub-populations were also tested:

a. Adults' Access to Preventive/Ambulatory Health Services (AAP)
   Subpopulation: members who are adults older than 20 years old meeting qualifying criteria for AAP
b. Well Child Visits (WCV)
   Subpopulation: members ages 3–21 meeting qualifying criteria for WCV
c. Comprehensive Diabetes Care (CDC), including:
   - Eye exam performed
   - HbA1c Testing
   - HbA1c Control (<8.0%)
   - HbA1c Poor Control (>9.0%)
   - Blood Pressure Control (<140/90 mm Hg)

   Subpopulation: members with diagnosed diabetes meeting qualifying criteria for CDC

Covariates

Covariates included age, sex, race/ethnicity, island, and risk score in 2021:

- Age was categorized into five groups: under 18 years old, 19–44 years old, 45–64 years old, 65–84 years old, 85 years and older.
- Sex (0=male, 1=female) was analyzed as a binary variable.
- Race/ethnicity was categorized into six groups: non-Hispanic White American, non-Hispanic Black, Hawaiian (including part Hawaiian), Asian or Pacific Islander, American Indian/Alaska Native, and other or unknown or unspecified.
- Six groups for island of residence were identified: Oʻahu, Kauaʻi, Hawaiʻi, Maui, Molokaʻi, and Lānaʻi.
- Actuarial risk scores (prospective CDPS risk scores) calculated based on measurement year 2021 were included as an indicator of health status in 2021.

Analyses of RQ2

Multivariate linear regression was conducted to detect any significant differences between primary care utilization and health outcomes. Members with missing data in any of the independent or dependent variables and covariates were excluded from analyses.

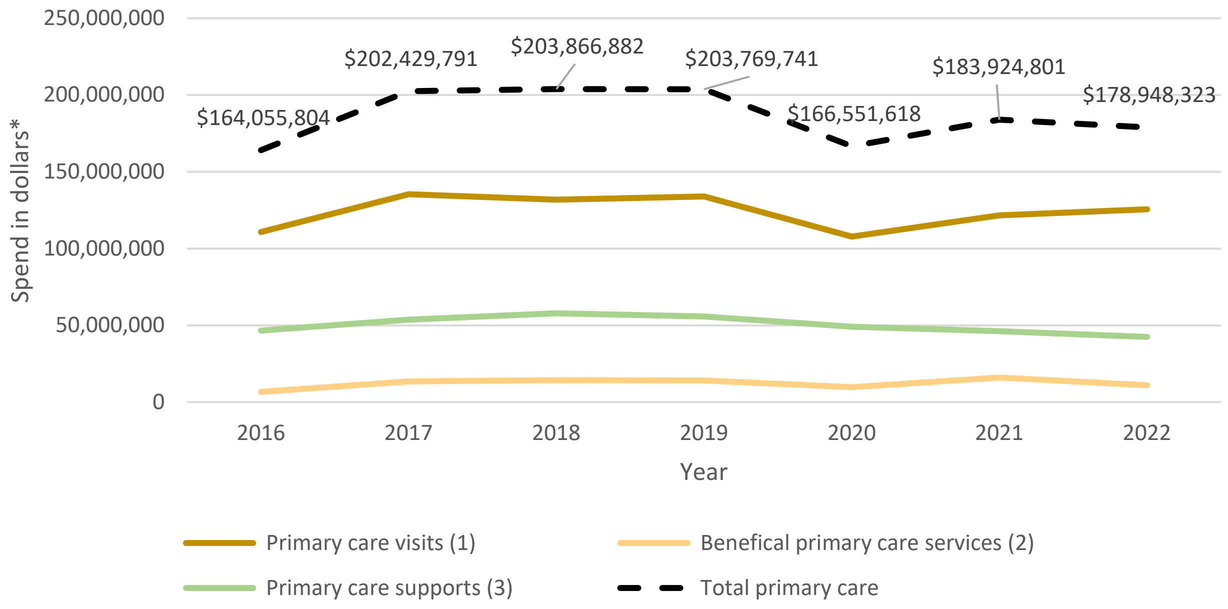
Results

Spending on primary care

Figure V.1A.1 demonstrates changes over time for spending on primary care and subdivided to the primary healthcare definitions 1) primary care visits, 2) beneficial primary care services, and 3) primary care supports. As indicated by the graph, an overall increase in primary care spending on all definitions is shown between 2016 and 2018. A dip in overall primary care spending (in line with a dip in spending on primary care visits) is noticeable in 2020, specifically for spending on primary care visits, with a slight recovery in 2021.

The graph indicates spending has not recovered to 2018 levels; overall primary care spending reached $178,948,323 for 2022, which is less than the inflation-adjusted spending of $203,866,882 in 2018, the highest observed yearly total.

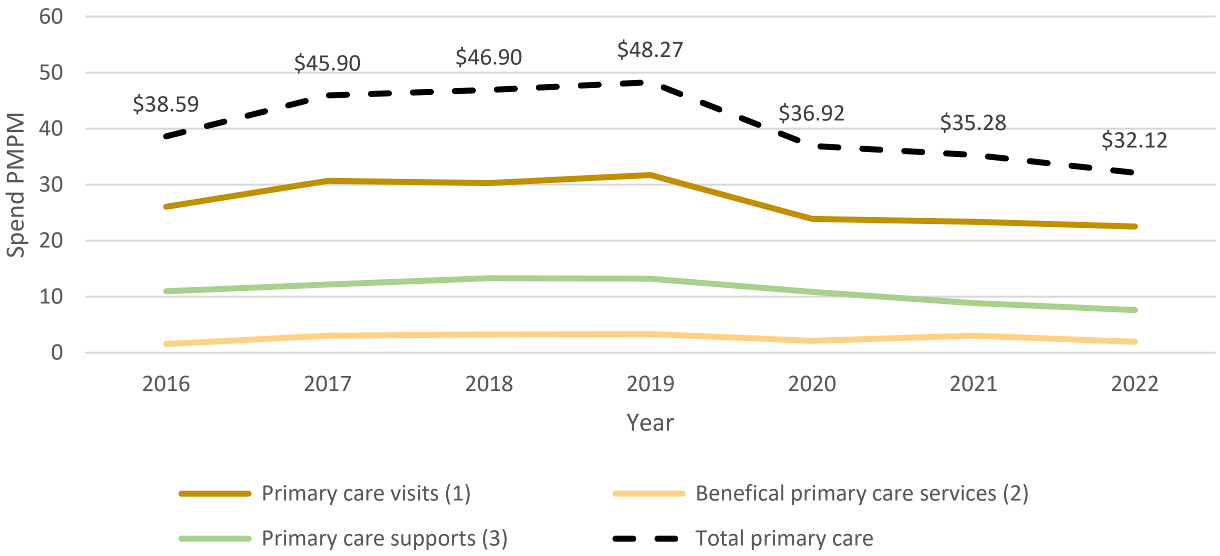
Figure V.1A.1. Total Amounts of Primary Care Spend in Dollars, by Primary Care Procedure Definition 2016–2022



Note: Costs were inflation adjusted to represent 2022 dollars

Figure V.1A.2 demonstrates spend per member per month for the Medicaid population upon primary care. The graph demonstrates a decline in total primary care spend PMPM since 2019. A decrease in Primary care visits (definition 1) is visible in line with the decrease in overall spending. Beneficial primary care services (definition 2) show an initial light rise in spending until 2021, reaching $3.06 PMPM in 2021, to then decrease to $1.97 in 2022. Primary care supports (definition 3) has declined since 2018 from $13.30 PMPM to $7.62 PMPM in 2022.

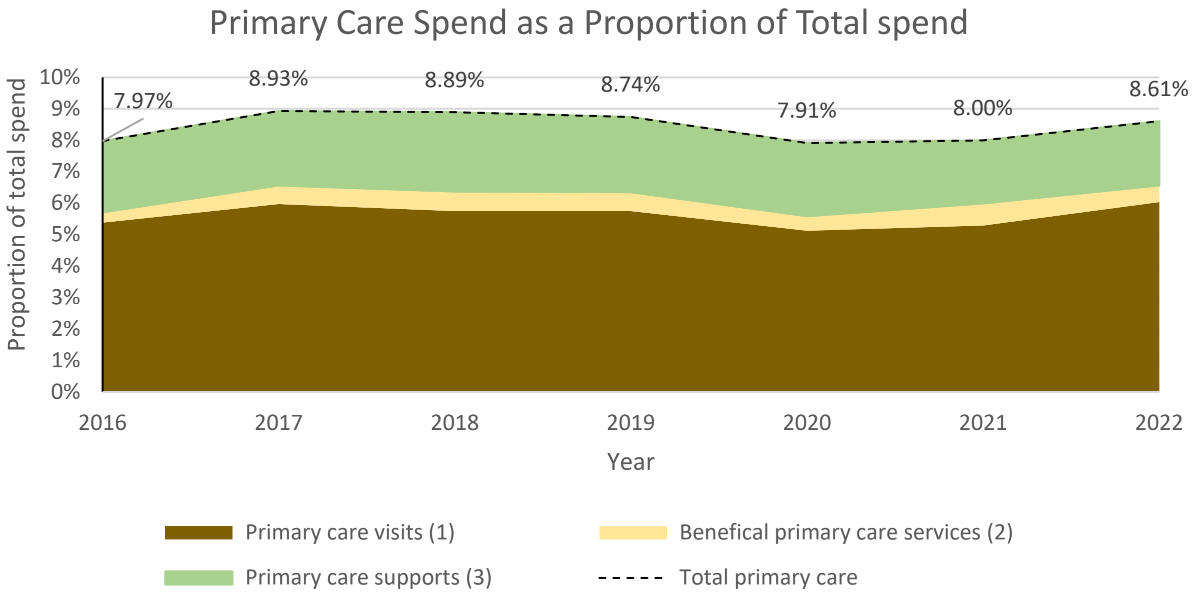
Figure V.1A.2. Primary Care spend PMPM, by Primary Care Procedure Definition 2016–2022



Note: Costs were inflation adjusted to represent 2022 dollars

Figure V.1A.3 demonstrates proportional spend (primary care spend as a proportion of total spend) for the three definitions. The graph indicates that proportional spend on primary care has remained relatively stable from 2016–2022, with primary care spend consisting of 8.93% of the total spend in 2018 and 8.61% of the total spend in 2022. Proportional spend on primary care dipped in 2020 to 7.91% of total spend.

Figure V.1A.3. Primary Care Spend as a Proportion of Total Spend 2016–2022



Analyses of mean differences in spending

Since the start of the demonstration period, total spend on primary care decreased from *$*48.30 PMPM in 2019 to *$*32.10 PMPM in 2022. Total spend on primary care has decreased significantly from 2019 to 2022: spend on primary care visits has decreased by 29%, beneficial primary care services by 41%, and primary care supports by 42%. Table V.1A.1a displays the differences in mean PMPM spend.

Table V.1A.1a. Difference in Mean PMPM Spending on Primary Care, 2019–2022

	2019			2022			Trend		
	Number of eligible member-months	Spend	Mean PMPM*	Number of eligible member-months	Spend	Mean PMPM	Difference in mean PMPM 2019/2022	p-value	CI
Definition 1 (Primary Care Visits)	4,221,153	$ 133,897,779	$31.70	5,571,323	$ 125,517,947	$22.50	-29.0%	<.001	8.93 - 9.45
Definition 2 (Beneficial Primary Care Services)	4,221,153	$ 14,122,278	$3.30	5,571,323	$ 10,989,761	$2.00	-41.0%	<.001	1.31 - 1.43
Definition 3 (Primary Care Supports)	4,221,153	$ 55,749,683	$13.20	5,571,323	$ 42,440,615	$7.60	-42.3%	<.001	5.29 - 5.89
Primary Care (Total)	4,221,153	$ 203,769,741	$48.30	5,571,323	$ 178,948,323	$32.10	-33.5%	<.001	15.71 - 16.60

Note: Costs were inflation adjusted to represent 2022 dollars.

Based on reports submitted by Health Plans, spend on low-value primary care services reportedly fell from $3.11 PMPM in 2020 to $2.09 PMPM in 2021. This equals a reduction of 32.7% in the year 2020–2021. Spending on low-value care services was $14,008,558 in 2020, and $10,890,093 in 2021. Differences between eligibility groups exist in the change between 2020 and 2021, with the ABD Non-Dual eligibility group demonstrating a strong increase in spending by 146% on low-value services specifically (Table V.1a.1b).

Table V.1A.1b. Difference in Mean PMPM Spending on Low-Value Primary Care, 2020–2021

	2020			2021			Trend
	Number of eligible member-months	Spend	Mean PMPM*	Number of eligible member-months	Spend	Mean PMPM	Difference in mean PMPM 2020/2021
Family & Children	2,291,683	$7,472,810.59	$3.26	2,436,938	$ 4,141,853.27	$ 1.70	-47.9%
Expansion	1,616,887	$4,882,442.08	$3.02	1,979,784	$ 3,373,939.52	$ 1.70	-43.6%
ABD Non Dual	256,798	$1,237,257.94	$4.82	244,491	$ 2,898,966.90	$ 11.86	146.1%
ABD Dual	454,005	$416,046.98	$0.92	483,955	$ 475,333.36	$ 0.98	7.2%
Low-value services (Total)	4,510,557	$14,008,558	$3.11	5,213,340	$10,890,093	$2.09	-32.74%

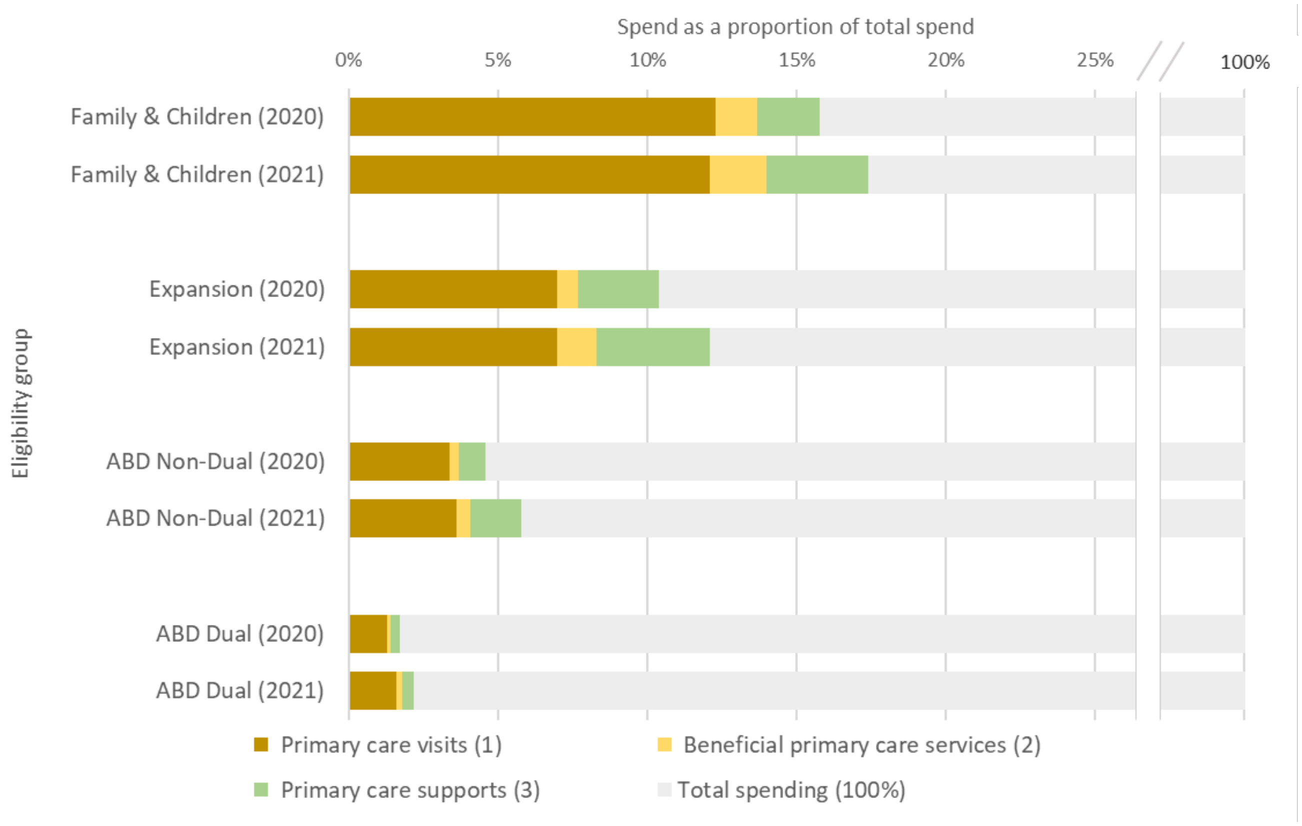
Note: Costs were inflation-adjusted to represent 2022 dollars. No statistical significance was calculated as Health Plans provided aggregated data;
Total eligible number of members months for each eligibility group does not match with total number of eligible member months due to rounding error in the attribution of member months per group.

Figure V.1A.4. shows primary care spending as a proportion of total expenditure for the first three primary care definitions, parsed by eligibility subgroups. Data were derived from Health Plan reports to MQD.

Spending on primary care as a proportion of total spend increased for all eligibility populations from 2020 to 2021. Specifically, from 2020 to 2021, proportional spend on primary care visits (definition 1) decreased from 12.3% to 12.1% for Family & Children, remained stable at 7% for the Expansion population, and increased from 3.4% to 3.6% for ABD non-Dual and 1.3% to 1.6% for ABD-Dual populations.
Beneficial primary care services (definition 2) increased for all eligibility groups. Proportional spend on Family & Children increased from 1.4% to 1.9%, Expansion population proportional spend increased from 0.7% to 1.3%, ABD-non-Dual spend increased from 0.3% to 0.5%, and ABD Dual increased from 0.1% to 0.2% from 2020 to 2021.

Additionally, proportional spend on primary care supports (definition 3) increased for all eligibility groups. From 2020 to 2021, Family & Children increased from 2.1% to 3.4%, Expansion from 2.7% to 3.8%, ABD Non-Dual from 0.9% to 1.7%, and ABD Dual from 0.3 to 0.4%.
Lastly, percent spend as a proportion of total spend on Low-value services in 2020 for the demonstration populations demonstrated a range of 0.1% (ABD Dual) to -0.8% (Family and Children), with an overall average percentage of 0.5%. In 2021, Low-value services for the demonstration populations saw a range of 0.1%-0.7% (ABD Dual, Non-ABD & Non-Expansion), with an overall percentage of 0.5% (the same overall percentage as 2020).

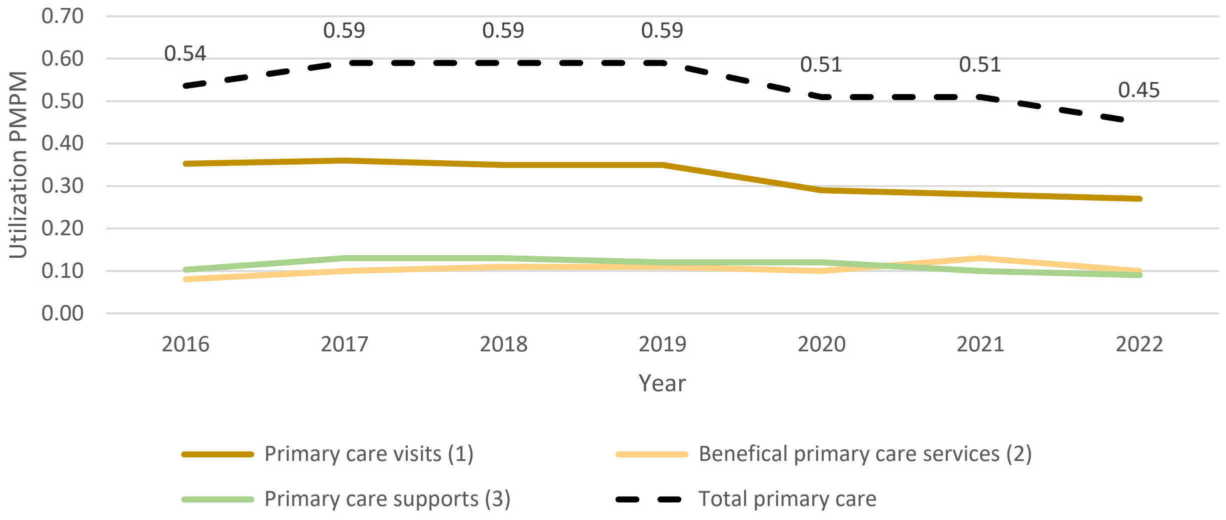
Figure V.1A.4. Primary Care Spend as a Proportion of Total Spend in 2020–2021 by Population Group (as Reported by Health Plans)



Utilization of primary care services

Figure V.1A.5 demonstrates the utilization per member per month from 2017 to 2022 for the primary healthcare definitions 1) primary care visits, 2) beneficial primary care services, and 3) primary care supports. The graph indicates a decrease in utilization from the year 2019 at 0.59 claims PMPM to 0.45 claims PMPM in 2022. As indicated by the graph, utilization remained around 0.59 claims PMPM until 2019, after which a visible decrease in utilization rates occurred.

Figure V.1A.5. Utilization PMPM, by Primary Care Definition



Since the start of the demonstration period, utilization PMPM for primary care decreased significantly from 0.59 claims PMPM in 2019 to 0.45 claims PMPM in 2022. This is a decrease of 23.4% in utilization. Utilization for primary care visits, beneficial primary care services and primary care supports decreased respectively by 24.9%, 14.8% and 27.1%. Table V.1A.2 displays the differences in utilization on these definitions of primary care.

Table V.1A.2. Difference in Mean Utilization PMPM on Primary Care, 2019–2022

	2019			2022			Trend		
	Number of eligible months	Incurred claims	Mean PMPM*	Number of eligible months	Incurred claims	Mean PMPM	Difference in mean PMPM 2019/2022	p-value	CI
Definition 1 (Primary Care Visits)	4221153	1497545	0.3530	5571323	1477407	0.2652	-24.9%	<.001	8.93 - 9.45
Definition 2 (Beneficial Primary Care Services)	4221153	483721	0.1140	5571323	541094	0.0971	-14.8%	<.001	1.31 - 1.43
Definition 3 (Primary Care Supports)	4221153	521861	0.1230	5571323	499809	0.0897	-27.1%	<.001	5.29 - 5.89
Primary Care Services (Total)	4221153	2503127	0.5900	5571323	2518310	0.4520	-23.4%	<.001	15.71 - 16.60

Comparison between utilization and spend

Both primary care expenditure and utilization decreased from 2019–2022. Spending decreased to a larger extent, with decreases in primary care visits (Definition 1, -29.0%), beneficial primary care services (Definition 2, -41.0%), and primary care supports (Definition 3, -42.3%), resulting in a total decrease in ‘valuable’ primary care expenditure of -33.5%. Utilization decreased over the same period with primary care visits (Definition 1, -24.9%) beneficial primary care services (Definition 2, -14.8%), and primary care supports (Definition 3, -27.1%), resulting in a total decrease in ‘valuable’ primary care utilization of -23.4%.

Figure V.1A.6. demonstrates the trend in average spend per claim from 2016 to 2022. The graph indicates an increase in average spend per primary care claim from 2016 to 2019 with a peak annual average of $81.41 per claim, after which the spend per claim decreased to $71.06 in 2022.

Figure V.1A.6. Mean Spend Per Claim, by Primary Care Definition, 2016–2022

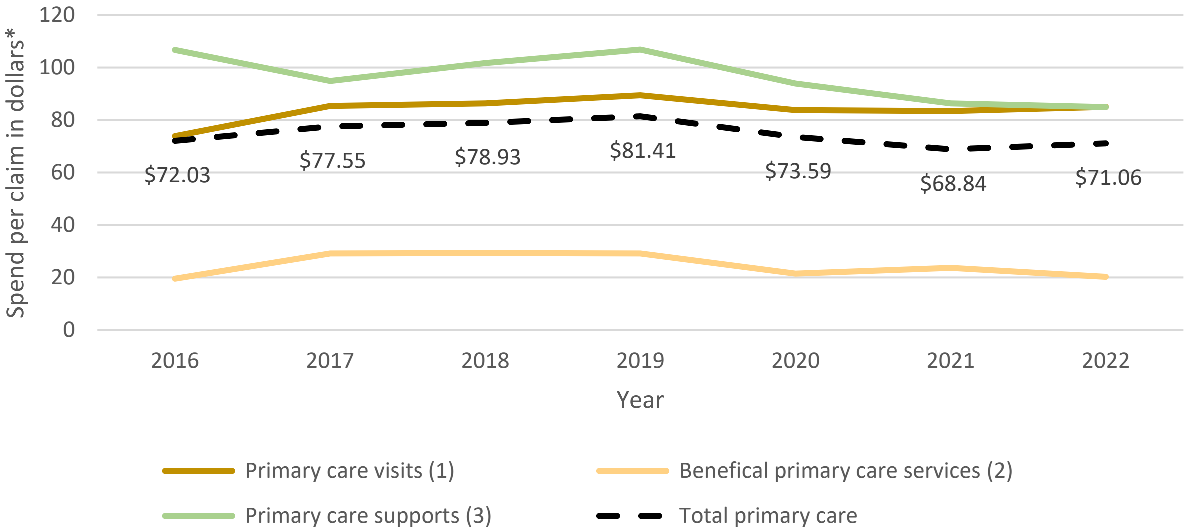


Table V.1A.3. compares the differences in mean spend per claim between 2019 and 2022. Since 2019, mean spend per claim has reduced by 5.0% for primary care visits, 30.4% for beneficial primary care services, and 20.5% for primary care supports.

Table V.1A.3. Difference in Mean Spend Per Claim on Primary Care, 2019–2022

	% Reduction Claims	% Reduction Spend	Mean spend / claim 2019	Mean spend / claim 2022	Trend 2019/2022
Definition 1 (Primary Care Visits)	-24.9%	-29.0%	$89.41	$84.96	-5.0%
Definition 2 (Beneficial Primary Care Services)	-14.8%	-41.0%	$29.20	$20.31	-30.4%
Definition 3 (Primary Care Supports)	-27.1%	-42.3%	$106.83	$84.91	-20.5%
Primary Care Services (Total)	-23.4%	-33.5%	$81.41	$71.06	-12.7%

Relationship Between Utilization and Outcomes

The sample size of members that were included in the regression analysis was 114,226. As detailed in Table V.1A.4, around seventy percent of members had at least one primary care visit (72.67%) and received at least one beneficial primary care service (69.97%), and the majority of members had at least one claim for primary care supports in 2021 (85.86%). Bivariate analyses showed that age, sex, race/ethnicity, island, and CDPS risk score were correlated with primary care utilization ($p<0.001$).

Table V.1A.5. demonstrates the relationship between primary care utilization and health outcomes. Use of primary care visits was positively associated with ED visits, indicating those members who had at least one primary care visit were also marginally more likely to have ED visits, IP visits, and IP length of stay ($p<0.001$), but the effect sizes were very small. On the other hand, the use of primary care visits is also significantly related to higher OP visits (Coefficient=0.25, $p<0.001$), and better performance on all the HEDIS measures evaluated: better adults' access to preventive services (Coefficient=0.57, $p<0.001$), increased well-child visits (Coefficient=0.48, $p<0.001$), and better diabetes care across several measures (receiving timely eye exams, receiving regular HbA1c testing, and having both HbA1c and blood pressure under control).

Use of one or more beneficial primary care services is negatively associated with ED visits and positively related to OP visits and IP visits ($p<0.001$), with a very small effect size. Adults with more beneficial services also performed better on all HEDIS measures evaluated. In other words, they performed better on adults' access to preventive services (Coefficient=0.05, $p<0.001$), although the effect size is small. Members between 3 and 21 years old with more beneficial primary care service had higher well-child visits (Coefficient=0.29, $p<0.001$). Improved diabetes care (specifically receiving regular HbA1c testing and having HbA1c under control) also appeared to be associated with receiving beneficial primary care services among members with diabetes ($p<0.001$).

Use of primary care supports was negatively associated with ED visits, OP visits, and adults' access to preventive services, and positively associated with IP length of stay ($p<0.001$), although the effect sizes are small.

Table V.1A.4 Characteristics and primary care utilization in 2021 of the sample (N=114226)

			Definition 1 (Primary care visits) At least one claim in 2021			Definition 2 (Beneficial primary care services) At least one claim in 2021			Definition 3 (Primary care supports) At least one claim in 2021		
	%	n	%	n	*p*-Value	%	n	*p*- Value	%	n	*p*-Value
Total			72.67	83032	N/A	69.97	79926	N/A	85.86	98075	N/A
Age											
Newborn after December 2021	1.64	1873	94.02	112	0.000	79.71	1493	0.000	99.63	1866	0.000
1-18 years old	38.89	44419	72.16	12368		69.17	30725		91.38	40588	
19-44 years old	36.11	41242	68.92	12820		68.77	28364		81.66	33680	
45-64 years old	21.26	24284	78.24	5285		72.98	17723		81.68	19835	
65-84 years old	2.00	2279	74.20	588		67.88	1547		81.32	1990	
85 years and older	0.11	129	68.22	41		57.36	74		89.92	116	
Sex											
Male	48.38	55260	70.90	39177	0.000	71.06	39267	0.000	86.34	47714	0.000
Female	51.62	58966	74.34	43835		68.95	40659		85.41	50361	
Race/Ethnicity											
Non-Hispanic White American	16.17	18468	73.82	13634	0.000	70.32	12986	0.000	79.77	14732	0.000
Non-Hispanic Black	1.90	2175	70.71	1538		69.15	1504		82.71	1799	
Hawaiian (include part Hawaiian)	16.08	18363	71.08	13052		65.10	11955		80.73	14825	
Asian or Pacific islander	35.24	40258	70.35	28320		69.72	28069		87.47	35215	
American Indian/Alaska native	1.89	2160	73.38	1585		69.77	1507		80.56	1740	
Other or unknown or unspecified	28.72	32802	75.86	24883		72.88	23905		90.74	29764	
Island											
O‘ahu	61.81	70605	73.49	51888	0.000	70.91	50065	0.000	86.39	60995	0.000
Kaua‘i	4.83	5513	75.28	4150		69.42	3827		85.87	4734	
Hawai‘i	11.42	13041	70.64	9212		66.61	8686		82.73	10789	
Maui	20.13	22988	71.18	16364		70.31	16164		86.52	19890	
Moloka‘i	1.53	1747	67.26	1175		57.81	1010		78.31	1368	

Lānaʻi	0.29	332	67.17	223		52.41	174		90.06	299	
	Mean	SD		Correlation			Correlation			Correlation	
CDPS risk score in 2021	1.11	2.41	N/A	0.16	0.000	N/A	0.00	0.35	N/A	-0.10	0.000

Table V.1A.5. Relationship between Primary Care Utilization and Health Outcomes

		Primary care visits (1)			Beneficial primary care services (2)			Primary care supports (3)		
Outcomes	N	Standardized Coefficient	Standardized Error	*p*-Value	Standardized Coefficient	Standardized Error	*p*-Value	Standardized Coefficient	Standardized Error	*p*-Value
ED visits	65539[i]	0.04	0.002	0.000	-0.004	0.002	0.000	-0.015	0.002	0.000
OP visits	114226	0.25	0.004	0.000	0.08	0.004	0.000	-0.04	0.006	0.000
IP visits	114226	0.03	0.000	0.000	0.009	0.000	0.000	0.004	0.000	0.18
IP length of stay	114226	0.007	0.001	0.000	0.000	0.004	0.940	0.008	0.005	0.008
Adults' Access to Preventive Services	54241	0.57	0.003	0.000	0.05	0.004	0.000	-0.03	0.005	0.000
Well Child Visits	42641	0.48	0.004	0.000	0.29	0.005	0.000	-0.008	0.008	0.109
Comprehensive Diabetes Care—Eye exam performed	849	0.20	0.05	0.000	0.05	0.04	0.12	0.04	0.04	0.246
Comprehensive Diabetes Care—HbA1c Testing	2244	0.34	0.02	0.000	0.14	0.02	0.000	0.008	0.02	0.719
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	2244	0.12	0.03	0.000	0.08	0.02	0.000	0.03	0.03	0.105
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	2244	-0.17	0.03	0.000	-0.09	0.02	0.000	-0.04	0.03	0.104
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	849	0.22	0.05	0.000	0.05	0.04	0.13	0.06	0.04	0.11

§Note: i. N for ED visits was lower due to additional missing data on associated member months

Conclusions and Recommendations

During the 2019–2023 1115 waiver demonstration period, Med-QUEST introduced the HOPE initiative, and a desire to advance primary care and prevention through an increased investment in primary care. The initiative was introduced within the Health Plans' managed care contract in 2021, and baseline data on primary care spend was successfully collected for calendar years 2020–2021 by early 2023. MQD has not yet set primary care spend targets for its Health Plans.

Our analyses are presented in their current form for the first time because primary care spend is decomposed into several meaningful categories, worth evaluating separately (primary care visits, beneficial primary care services, primary care supports, and primary care low-value services). Evaluating spend, utilization, and outcomes in these categories will allow MQD to consider targeted goals such as decreasing wasteful spending and increasing spending on beneficial and preventative primary care services in areas with the largest impact on health care outcomes.

Spending and Utilization

Our results indicate that no increase in primary care spending occurred during the demonstration period; rather the period showed a decline in both spending as well as (to a lesser extent) utilization of primary care visits, beneficial primary care services, and primary care supports. The year-over-year change was not uniform across primary care categories. For example, when evaluating spend, the decline in spend from 2019 to 2022 was larger for beneficial primary care services than for primary care visits; the difference may be explained in part by the PCP-E program, which allowed for rate increases for providers of primary care services to match Medicare rates over the time period in question and partially mitigated the total decline that may have otherwise occurred in spend on primary care visits. This is further supported by the relatively limited reduction in average spend per claim (-5%) for primary care visits as compared to beneficial services and supports.

On the other hand, the decline in utilization during the same period (2019–2022) was larger for primary care visits rather than beneficial primary care services, indicating that people continued to receive preventative care despite delaying visits to their primary care providers during the COVID-19 pandemic. The COVID-19 vaccine may have substantially contributed to the total spend on beneficial primary care services in addition to strongly decreasing spend per claim on beneficial services (by 30%). For instance, relatively high-cost beneficial services such as mammograms and colonoscopies may have reduced, while spending and utilization of low-cost services such as COVID-19 vaccines may have increased, resulting in a decreased spend per beneficial service claim. The UH evaluation team did not explore differences in sub-categories of spend within each overall category of primary care spend but may do so in the future to understand the root causes underlying the patterns observed. The evaluation team did not explore differences in sub-categories of spend within each overall category of primary care spend but may do so in the future to understand the root causes underlying the patterns observed. The dip in utilization in 2020 was not noticeable for primary care supports (definition 3). This may be because behavioral health, which is included in the definition for primary care supports, was still heavily used during the pandemic through telehealth (McBain et al., 2023). The continued utilization of behavioral health might have offset a stronger decreasing trend.

Similarly, we were able to observe a decrease in spend on low-value services from 2020 to 2021 by 20.5%. This is a steeper decrease than expected in a single year, and might be partially attributed to the increased awareness by Health Plans due to the new reporting requirements on this definition.

Further, differences in (proportional) primary care spending also exist between different eligibility groups. Family & Children members have a higher proportional spending on primary care in the MQD system, while ABD and Expansion populations have a much lower proportional spending on care. These differences in spending are explained by the more complex and long-term care needed for these populations. Any changes in the composition of the Medicaid population may thus have a strong impact on overall spending.

The decrease in spending and utilization of these primary care services might be further explained by several factors that outweigh the investments made in primary care development. First, the COVID-19 pandemic occurred shortly after the start of the demonstration period. This coincides with a strong dip in spending in 2020, with a slight recovery in 2021. A freeze in disenrollment from Medicaid during the pandemic years greatly increased the size of the Medicaid population, and a large percentage of the population was not seeking care during this period, therefore reducing utilization per member. Hawaiʻi additionally implemented very strong quarantine laws in response to the pandemic resulting in a longer recovery to normal operations for the state (Bond-Smith & Fuleky, 2022). As such, the COVID-19 pandemic may continue to have a long-lasting impact on the on the provision of care and availability of primary care services in the state.

Second, Hawaiʻi is facing a long-term challenge with provider shortages in the state. In 2022, Hawaiʻi faced an unmet need of 776 physicians, including a shortage of 162 primary care providers (UH System, 2022). Moreover, workforce shortages have reportedly increased by 80% from 2019 to 2022 (AMA, 2023). It is possible that the effects of provider shortages impacted the accessibility of care for members and consequently the utilization of primary care over time.

While spending and utilization on primary care decreased, it is encouraging that proportional spending on primary care saw increases from 2020 to 2022, indicating a recovery after the COVID-19 pandemic, with potential to sustain the upward trend in the coming years. Reasons for the overall decline in spending and utilization of primary care requires further research by Medicaid sub-populations as well as an in-depth investigation on the shifts in costs and utilization of care. Further research is needed to understand the drivers of primary care spending and utilization, as well as how providers, Health Plans and MQD can collaborate to increase utilization of beneficial primary care services. Initiatives started by MQD during the current demonstration period instigated a change in focus on primary care; nevertheless, initiatives that seek to increase investment in primary care are generally longer-term initiatives. At the time this evaluation was conducted, the two-year window that had elapsed since the managed care contract was revised to include the Advancing Primary Care initiative was as yet too short to move health plans towards increasing primary care investments. A continued emphasis on primary care investments is needed to achieve the long-term goals of increased utilization of primary care and consequently, its expected positive effect on health outcomes.

Relationship Between Utilization and Outcomes

Across three definitions of primary care, we found a weak positive relationship between primary care utilization and ED/IP visits. While it is hypothesized that increasing investment in primary care might lead to decreasing ED and IP utilization, the impact of primary care utilization on ED and IP visits might be hard to see within only a single year of observation due to the delayed effects of seeking and receiving primary care services. Earlier studies showed that results of primary care utilization on outcomes such as ED visits or hospitalizations might take longer to be realized: studies show that it takes two to three years to show effects on ED visits, whereas it might take six years before hospitalizations reduce (Fu et al., 2021).

More significantly, our findings indicated a stronger relationship between primary care visits and the selected short-term health outcomes (various HEDIS metrics). Primary care visits are the setting for preventive care provided by PCPs, often serving as the first point of care for an individual. Our outputs showed an increase in several preventive care services among members who had primary care visits, including increased adults' access to preventive services, well-child visits, and various indicators of optimal and comprehensive diabetes care. These results strongly support MQD's and Health Plans' investment in primary care visits to improve health outcomes.

While a similar positive relationship was also found between beneficial primary care services and health outcomes, the relationship tended to be less robust. Beneficial primary care services are defined as preventive care with a focus on high value care services such as screenings, assessments, and immunizations provided or referred in the primary care setting. These services are likely to result in strong improvements of specific healthcare outcomes over a longer period of time. For instance, increased investments in cervical cancer screening will be more likely to show outcomes for cervical cancer mortality over an extended period of time, rather than the health outcomes evaluated in the current analysis.

Compared to primary care visits and beneficial primary care services, primary care supports are defined more broadly. The definition includes the set of care services that engage, support, stabilize, and improve the management of the member in the outpatient setting, so as to reduce excessive and inappropriate inpatient utilization. Rather than showing short-term consequences on the health of members receiving these services, improved health outcomes might be expected after engagement with these services over a longer period of time. Therefore, a relationship may not be directly visible within a single year of observation.

Lessons Learned and Future Recommendations

While spending and utilization on primary care have not increased over time for the Medicaid population, our results indicate that the use of primary care is associated with improved short-term health outcomes. Moreover, the division of all primary care into the complementary primary care definitions allows us to identify areas where investment in primary care can be further supported, and provides the groundwork for further investigations into health care outcomes tied to each of these definitions of primary care investments. These results further emphasize the importance of investment in primary care to support the health of the Medicaid population, especially considering the visible effects of the COVID-19 pandemic on utilization and spending on primary care in Hawaiʻi's Medicaid population.

Of particular interest to future research and evaluation will be whether the trends from the years immediately following the COVID-19 pandemic reflect a permanent shift in spending and utilization, or are a temporary adjustment to the disruptive effects of the pandemic and the healthcare system's response.

Given some of the dynamic and cumulative impacts of COVID-19 on health care, a systems evaluation approach to primary care is needed. Watt, O'Donnell and Sridharan (2011, p. 4) have argued for focusing on coverage, continuity, coordination, balance and sustainability in evaluating primary health care. COVID has impacted each of these dimensions of primary health care. A systemic perspective in future evaluations will need to incorporate a dynamic perspective on the impacts of the pandemic over time due to delayed care.

Project 1B: Care Coordination for Beneficiaries with Complex Conditions

Introduction and Background

The U.S. healthcare system is highly complex and fragmented, which creates substantial barriers to both preventative and crisis-focused healthcare for Medicaid members with multiple, complex health needs (Assefa et al., 2022). Some barriers to care include undiagnosed health conditions, confusion about which services are needed and available, where and how to access services after referral, and lack of clarity on how much health services will cost (Miller et al., 2009). Transportation and other economic and social factors can also be a barrier to care, as well as language, lack of childcare, low health and digital literacy, and inability to take time off work, among others (Bellerose et al., 2022).

Providers also face many challenges in their efforts to deliver integrated health care services that can help bridge these gaps and improve health outcomes for their patients (Dean et al., 2019). Providers are frequently pressured to limit their time with patients, even those with complex health needs, and face multiple, competing demands such as extensive documentation requirements (particularly for services that require pre-authorization), high caseloads, understaffing, burnout, and pressures to provide services reimbursable at a higher rate (Dyrbye & Shanafelt, 2011; Zeng, 2016). Further, electronic health records from multiple sources are often disconnected, limiting both patient and providers' ability to understand and integrate vital health information, including diagnoses, allergies, prescriptions, medical test results, clinical summaries and case notes, and social risk factors (such as housing status, employment status, food security and isolation) (Cantor & Thorpe, 2018; Gottlieb et al., 2015). These barriers and others may negatively impact Medicaid members' health, leading to poorer individual outcomes, worse quality of life, low confidence in the medical system, and greater cost of care.

Care Coordination

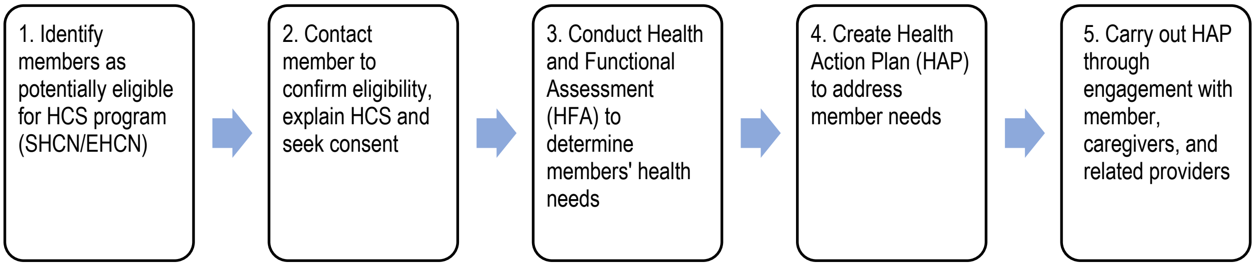
In order to address these barriers, MQD has implemented a care coordination program for individuals with complex care needs to receive Health Coordination Services (HCS). The purpose of HCS is to support individuals with complex health needs to navigate the complexities of our health care system, access high quality preventative care, manage chronic conditions, and address social risk factors. The 1115 waiver demonstration hypothesized that providing these services to individuals with special care needs in Hawaiʻi's Medicaid population would simultaneously improve health outcomes and lower costs for the participating individuals.

Specifically, MQD hypothesized: "Improving care coordination (e.g., by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e., high-needs, high-cost individuals)."

Beneficiaries with Complex Conditions

Within the Care Coordination program implemented by MQD, beneficiaries with complex conditions are identified as having Special Health Care Needs (SHCN) or Enhanced Health Care Needs (EHCN). Figure 1 provides an overview of the HCS Delivery process.

Figure V.1B.1 Overview of Healthcare Coordination Services (HCS) Delivery Process



Special Health Care Needs (SHCN)

SHCN beneficiaries are identified by MQD as members with “chronic physical, behavioral, developmental, or emotional conditions that require health-related services of a type or amount that is beyond what is required of someone their general age" (Health Plan Manual, 2020. Ch.6).

Additionally, members who are at risk for serious health challenges may be identified for SHCN services as well. SHCN services go beyond the standard level of care typically provided to individuals within their general age group. These services are intended to ensure SHCN members receive the necessary support, treatments, and interventions to manage their conditions effectively. Health care needs for each SHCN member are identified and a Health Action Plan (HAP) is created to best support their individual needs.

Enhanced Health Care Needs (EHCN)

EHCN population are SHCN individuals who have complex and costly health care needs, or who are at a high risk of developing such conditions in the near future. These individuals are considered highly impactable, meaning their health outcomes can be significantly improved with appropriate care and coordination. EHCN services are focused on providing comprehensive and coordinated care to address the complex needs of these individuals. This involves a proactive and collaborative approach among healthcare providers, specialists, and other stakeholders to ensure that all aspects of the individual's health are effectively managed. The goal is to improve health outcomes, enhance quality of care, and reduce overall healthcare costs by preventing or minimizing the impact of serious health conditions. These services aim to ensure seamless communication and collaboration among various healthcare providers involved in the individual's care. By coordinating care and sharing information, EHCN services help to prevent fragmentation and ensure that all healthcare professionals involved are well-informed and working together to provide the best possible care.

Research Questions

The purpose of this evaluation is to assess the impact of healthcare coordination services to support individuals with complex health needs (SHCN and EHCN population). Specifically, this evaluation aims to answer two research questions: 1) Will care coordination for individuals identified as having complex health needs result in improved health outcomes? 2) Will care coordination for individuals identified as having complex health needs result in lowered utilization of the healthcare system, and a slower rate of expenditure growth?

Evaluation Approach

Evaluation Activities

The introduction of the HOPE Strategy and the approval of the current 1115 waiver demonstration had far-reaching impacts on the strategic approach that MQD implemented to reorient its managed care program towards the triple aim of better healthcare and better health outcomes at a lower cost. As such, the onset of this 1115 waiver evaluation coincided with a substantial change in the overall managed care contract, and in tandem, the data and evaluation culture as well as data reporting package within MQD and thus with the Health Plans. This waiver demonstration period marked the first time that Health Plans in Hawaiʻi were required to provide such a high volume of detailed, individual-level metrics necessary for the evaluation and to incorporate those data and metrics into their quarterly reports; this required substantial collaboration between the evaluation team, Health Plans, and MQD. Additionally, operational definitions of care coordination, and data sources to match them, are fundamentally necessary to answer the overall research questions.

While the proposed evaluation design was exclusively outcome oriented, the evaluation team carried out extensive relationship building, capacity building, technical assistance, and process evaluation over the demonstration period through consistent contact with MQD and Health Plans.

Due to the developmental stage of the data collection methods and the active efforts carried out to improve the program, the evaluation team adjusted our analytical approach to align its feasibility with the available information. First, we created an overview of the available data and variables. Second, we selected data for the analyses; and third, we selected relevant measures and an appropriate statistical approach.

Selection of Data Sources for Evaluation

The evaluation team requested raw data extracts from Health Plans for all of their SHCN/EHCN members from since 2020.

In order to answer the research questions, the evaluation team extracted variables which allowed us to identify enrolled SHCN/EHCN members, length of enrollment in the program, reasons for exiting the program, and HCS interactions/contacts. Table V.1B.1 shows the availability of each variable from each Health Plan.

Enrollment

For our analysis, we included members who were enrolled in the program continuously for at least one year before the evaluation period. Participation in SHCN/EHCN HCS program relies on a rolling enrollment process. Data extracts from all five Health Plans contained variables that allow the evaluation team to identify SHCN/EHCN members and how long they were enrolled in the program. To obtain an adequate sample size of members who were enrolled in the program continuously for at least one year before the evaluation period, the evaluation team analyzed the following variables from each Health Plan: SHCN/EHCN enrollment start date, active SHCN/EHCN members until data extract date (March, 2023), and sample size of SHCN/EHCN members enrolled continuously for at least one year.

Member health status

The HCS data obtained from Health Plans was merged with Chronic Illness and Disability Payment System (CDPS) risk score data available from MQD actuaries. Only members who had attributed risk scores were included in the analyses. We investigated the availability of risk scores calculated by Health Plans as well as MQD's actuarial risk scores. The inclusion of risk scores allowed the evaluation team to stratify members by health acuity; however, the data had some limitations. For example, MQD does not calculate risk scores on dually-enrolled members (members with both Medicare and Medicaid) since it does not have a comprehensive understanding of the health and costs of these members. To understand the impact of this limitation, the evaluation team investigated the percentage of dual members among continuously enrolled members in each Health Plan.

Inclusion of Health Plan data

We included data from Health Plan 2 (Health Plan 2) for the evaluation of SCHN/EHCN. Data from the other four health plans were omitted due to various reasons, a) Data from Health Plan 4 only includes members who enrolled in SHCN/EHCN starting from 2023; b) Health Plan 3 had a too-small sample size (n=177); c) Health Plan risk score data could not be determined for Health Plan 4; and for Health Plan 1 and Health Plan 5, the final sample size with CDPS risk score data was too small and we were not able to determine the date when Health Plans risk scores were measured.

Table V.1B.1. Description of Healthcare Coordination Data Extract from Health Plans

MGOs	Health Plan 1	Health Plan 2	Health Plan 3	Health Plan 4	Health Plan 5
Enrollment in SHCN/EHCN Program	✓ Variable name: care management plan	✓ Variable name: care coordination program description (i.e., LTSS, SHCN, at risk, EHCN)	✓ Variable name: program (i.e., HCBS, SHCN, EHCN, LTSS, CIS, GHP, LOC)	✓ Variable name: profile cohort name (i.e., DDD, Deleted CM, EHCN, HI-At Risk, HI-LTSS, etc.)	✓ Variable name: SHCN status code
Member months in SHCN/EHCN program (start and end date)	✓	✓	✓	Not reported	✓
SHCN/EHCN disenrollment reason	Not reported	✓	✓	Not reported	✓
HCS contact (interaction) data	✓	Only available for members in the LTSS program	✓	✓	✓
Risk score calculated internally by Health Plans	✓ Continuous (Repeated measure without date of measurement)	✓ Continuous	Not reported	✓ Ordinal (low, moderate, high)	✓ Continuous (Repeated measure without date of measurement)
Earliest SHCN/EHCN	✓ 04/04/2021	✓ 12/18/2014			✓ 05/02/2018

enrollments start date			Excluded from further investigation	Excluded from further investigation	
Active SHCN/EHCN members until data extract date (March 2023)	n=767	n=2887			n=2331
SCHN/EHCN member enrolled continuously for at least one year	✓ 2022q1-2022q4 n=495	✓ 2020q3-2022q4 n=2538			✓ 2022q1-2022q4 n=1556
Sample size of continuously enrolled SHCN/EHCN members with CDPS risk score data	n=319	n=2489			n=623

Data Description

This section of evaluation uses data extracts from Health Plan 2. The sample consists of members who were continuously enrolled in the SHCN/EHCN healthcare coordination program from July 1st, 2020 (2020 Quarter 3) through December 31st, 2022 (2022 Quarter 4). Other than data extract from Health Plan 2, this section of evaluation also relied on encounter data for key variables like total expenditure, health utilization, and health outcomes.

Measures

Independent Variable—Receiving Healthcare Coordination Service

The independent variable of this evaluation was 'receiving healthcare coordination service' as defined by data that indicated that individuals were 'engaged' or 'non-engaged' in HCS. Engaged included members who were both enrolled as well as had any interaction with the program. Non-engaged included members who were enrolled but did not interact with the program.

Table V.1B.2 displays the how the determination of engaged and non-engaged members was made by the evaluation team based on available data on enrollment status and reason for disenrollment.

Members who were enrolled in SHCN/EHCN program continuously from 2020 Quarter 3 to 2021 Quarter 4 were included in the analysis.

Table V.1B.2 Description of Enrollment Program Status and Discontinuation Reason for Health Plan 2

Enrollment program status	Discontinuation reason if closed	Defined engaged vs. non-engaged
Engaged		Engaged
Unengaged		Non-engaged
Closed	Enrolled in CCS	Engaged
	Goals Met	Engaged
	Institutionalized	Engaged
	Member transferred to LTSS	Engaged
	Outside Referral	Engaged
	Plan Termination	Engaged
	Referred to another program	Engaged
	Transitioned to Hospice Care	Engaged
	Unable to Locate	Non-engaged
	Declined	Non-engaged
	Denied for Services	Non-engaged

Outcome Measures

Outcome measures evaluated included total expenditures, healthcare utilization, and health outcomes in calendar year 2022, when members had been enrolled in the program for at least a year and half (from 2020 Q3 to 2021 Q4). All measures used encounter data from MQD's HPMMIS system.

Total expenditures included payment for healthcare costs from all coverage sources (Medicaid, Medicare, and other coverage). Besides total expenditure for all healthcare services member received, total expenditures for primary care, emergency department (ED) services, inpatient services, and home health services were also separately investigated.

Healthcare utilization was measured as the count of primary care visits, beneficial primary care services, and primary care supports (as defined in this evaluation report in section V.1A, Primary Care), home health visits, ED visits, and inpatient visits.

Health outcomes evaluated included counts of ED visits and inpatient visits.

Covariates

The analyses include age as of March 2023, sex, English as primary language, race/ethnicity, island of residence, and actuarial risk score as covariates:

- Age was categorized into five groups: under 18 years old, 19–44 years old, 45–64 years old, 65–84 years old, 85 years and older.
- Sex (0=male, 1=female) and English as primary language (0=no, 1=yes) were analyzed as binary variables.
- Race/ethnicity was categorized into seven groups: non-Hispanic White American Indian/Alaska native, Asian or Pacific islander, non-Hispanic Black, Hawaiian (include part Hawaiian), other, or unknown or unspecified.
- Members residing on Molokaʻi and Lānaʻi islands were grouped together due to small sample size, resulting in six groups for island of residence: Oʻahu, Hawaiʻi Island-East, Hawaiʻi island-West, Kauaʻi, Molokaʻi/Lānaʻi, and Maui.

- Actuarial risk scores (prospective CDPS risk scores) calculated based on measurement 2019 were included as a prospective indicator of health status in 2020 prior to being engaged in HCS in 2020.

Statistical Analysis

We first conducted a descriptive analysis to describe the overall characteristics of the sample, as well investigate the unadjusted difference between the non-engaged and engaged groups. We then conducted propensity score matching analysis to investigate the average treatment effect of HCS engagement in 2022 (after members were enrolled in the program for one and half year). Lastly, we used kernel-based propensity score matching difference-in-difference analyses to examine differences in outcome measures between the two groups from 2019 (pre-intervention period) to 2022 (when members had been enrolled in the program for one and half years).

Results

Characteristics of Sample and Unadjusted Differences between Non-Engaged Group and Engaged Group

The final sample included 2,538 unique individuals. As detailed in Table V.1B.3, the unadjusted difference in characteristics between engaged members and non-engaged members underscored the need for matching. Compared to members that were not engaged with HCS, engaged members were more likely to be older ($p<0.01$), to be of unspecified race/ethnicity, Asian or Pacific Islander, or non-Hispanic White ($p<0.001$), to be an English speaker ($p<0.001$), to live on the island of Kauaʻi, Lānaʻi, or Molokaʻi ($p<0.001$), and to have higher CDPS risk score ($p<0.001$). The effectiveness of matching at balancing these characteristics between engaged members and non-engaged members was assessed using standardized differences after matching and variance ratios before and after matching. Post-estimation shows that matching improved covariate balance.

Table V.1B.3. Characteristics of sample and unadjusted difference between two groups (N=2,538)

	Total		Non-engaged		Engaged		*p*-Value
	%	N	%	N	%	N	
All			84.71	2150	15.29	388	
Enrolled before 2019q2 (including 2019q2)	11.15%	283	34.98	99	65.02	184	<0.001
Enrolled after 2019q2	88.85%	2255	90.95	2051	9.05	204	
Age							
0-18	37.16	943	90.77	856	9.23	87	<0.001
19-44	39.20	995	89.95	895	10.05	100	
45-64	19.15	486	68.72	334	31.28	152	
65-84	4.41	112	58.04	65	41.96	47	
85 and over	NR	NR	NR	NR	NR	NR	
Sex							
Male	53.31	1353	85.51	1157	14.49	196	0.23

Female	46.69	1185	83.80	993	16.20	192	
Race/ethnicity							
Non-Hispanic White	19.94	506	83.79	424	16.21	82	<0.001
American Indian/Alaska Native	1.50	38	97.37	37	NR	NR	
Asian or Pacific Islander	31.32	795	82.77	658	17.23	137	
Non-Hispanic Black	2.13	54	88.89	48	NR	NR	
Hawaiian (include part Hawaiian)	21.99	558	89.43	499	10.57	59	
Other	6.15	156	76.28	119	23.72	37	
Not provided	16.96	431	84.69	365	15.31	66	
English Primary Language							
No	42.20	1071	88.89	952	11.11	119	<0.001
Yes	57.80	1467	81.66	1198	18.34	269	
Island							
O‘ahu	57.39	1456	82.49	1201	17.51	255	<0.001
Hawai‘i-E	22.23	564	91.13	514	8.87	50	
Hawai‘i-W	8.63	219	85.84	188	14.16	31	
Kaua‘i	4.93	125	81.60	102	18.40	23	
Lāna‘i/Moloka‘i	NR	NR	NR	NR	NR	NR	
Maui	6.46	164	83.54	137	16.46	27	
	Mean	SD	Mean	SD	Mean	SD	*p*-Value
CDPS Risk Score 2019	1.63	2.22	1.43	1.93	2.81	3.28	<0.001

Outputs from Propensity Score Matching

Table V.1B.4 presents outputs of treatment effects of HCS engagement after matching. Being engaged with HCS was associated with higher total expenditures in 2022 (coefficient=9847.57, *p*<0.001). Members engaged in HCS have higher total expenditures for home health services (coefficient=1100.27, *p*<0.01) as well as higher home health utilization (coefficient=4.20, *p*<0.01) in 2022.

There was no significant effect of HCS engagement on total Medicaid expenditures on inpatient services, home health services, or primary care services. We also did not find any significant effect of HCS engagement on primary care utilization, inpatient services utilization, or home health services utilization.

Table V.1B.4. Effect of HCS engagement on healthcare expenditure and system utilization

	Total			
Samples in non-engaged vs engaged after matching	1801			
Non-engaged	1547			
Engaged	254			
	Coefficient	**SE**	**p-Value**	**%95 CI**
Total expenditure				
Total expenditure in 2022	9847.57	2613.51	<0.001	(4725.18, 14970.00)
Total expenditure of primary care visits in 2022	893.16	2089.28	0.67	(-3201.749, 4988.07)

Total expenditure of beneficial primary care services in 2022	72.90	166.85	0.66	(-254.11, 399.92)
Total expenditure of primary care supports in 2022	149472.10	143773.30	0.30	(-132318.3, 431262.6)
Total expenditure of ED services in 2022	4.26	19.44	0.83	(-33.85, 42.37)
Total expenditure of inpatient services from 2020q3 in 2022	38.92	42.97	0.37	(-45.30, 123.14)
Total expenditure of home health services in 2022	1100.27	350.60	<0.01	(413.12, 1787.43)
Health utilization				
Primary care visit counts in 2022	-1.24	4.99	0.80	(-11.02, 8.54)
Beneficial primary care service counts in 2022	1.13	2.81	0.69	(-4.38, 6.64)
Primary care support counts in 2022	6.45	3.94	0.10	(-1.29, 14.19)
Home health visit counts in 2022	4.20	1.31	<0.01	(1.63, 6.77)
Health outcomes (utilization of ER and inpatient services)				
ED visit counts in 2022	0.17	0.34	0.63	(-0.51, 0.84)
Inpatient visit counts in 2022	0.24	0.41	0.55	(-0.56, 1.04)

Notes: *Post estimation after matching shows that members who are in two groups have no significant difference on all covariates.
*Analysis dropped members older than 85 years old and who are American Indian/Alaska Native due to small sample size.
*Total expenditure of primary care, ED services, inpatient services, and home health services only include amount paid by Med-QUEST.

Outputs from Kernel-based Propensity Score Matching Difference-In-Difference Analysis

Table V.1B.6 presents outputs of outcome measures change from 2019 to 2022 between two groups. First, expenditures on primary care supports increased from 2019 to 2022 in the engaged population relative to the non-engaged population (*p*<0.10). Second, expenditures on home health services also increased from 2019 to 2022 in the engaged population relative to the non-engaged population (*p*<0.05). Third, ED expenditures, and concomitant ED visits declined in the engaged population relative to the non-engaged population (*p*<0.01). Forth, inpatient utilization also slightly declined in the engaged population relative to the non-engaged population (*p*<0.10). Lastly, the utilization of beneficial primary care services declined in the engaged population compared to the unengaged population (*p*<0.01).

Table V.1B.5. Difference in difference of outcome measures between the groups that were Unengaged and Engaged in HCS, comparing the baseline (2019) and evaluation (2022) years

	Coefficient	SE	p-Value
Total expenditure			
Total expenditure	2128.81	1704.09	0.21
Total expenditure of primary care visits	1052.08	855.88	0.22
Total expenditure of beneficial primary care services	-133.99	92.20	0.15
Total expenditure of primary care supports	12000.00	6400.00	<0.10
Total expenditure of ED services	-36.40	13.19	<0.01
Total expenditure of inpatient services	-61.26	55.28	0.27
Total expenditure of home health services	787.26	375.45	<0.05
Healthcare utilization			

Count of primary care visits	-0.06	2.30	0.98
Count of beneficial primary care services received	-0.54	2.04	<0.01
Count of primary care supports received	1.53	2.32	0.51
Count of home health visits	1.85	1.19	0.12
Health outcomes (utilization of ED and inpatient services)			
Count of ED Visits	-0.93	0.31	<0.01
Count of Inpatient Visits	-1.14	0.60	<0.10

Notes: *Analysis dropped members older than 85 years old and who are American Indian/Alaska Native due to small sample size.
*Total expenditure of primary care, ED services, inpatient services, and home health services only include Medicaid paid amounts.

Conclusions and Recommendations

While outputs need to be interpreted with caution, this section of the 1115 waiver evaluation has several conclusions that can provide implications for future policy and practice regarding HCS among SHCN/EHCN population.

First, although 2,538 members in Health Plan 2 were continuously enrolled in SHCN/EHCN program from 2020 Quarter 3 to 2022 Quarter 4, only 15% were engaged with HCS. Bivariate analysis revealed factors that may be associated with the high non-engagement rate. For example, members who do not speak English as primary language were less likely to be engaged, which implicates language barriers as a potential factor that predicts a lack of participation. Moreover, members who live on Kauaʻi, Lāna'i, or Moloka'i were more engaged as well, which might imply closer ties with local HCS on Hawaiʻi's neighbor islands. In order to increase the HCS engagement rate for the full SHCN/EHCN population, more investigation is needed to explore why SHCN/EHCN engagement is low for certain groups and what can be done to increase engagement and follow up.

Second, our outputs suggest that: 1) engagement in HCS predicts higher utilization on home health services and, 2) HCS engagement also relates to higher expenditure on primary care services and home health services, as well as lower expenditure on ED services, utilization of ED services and inpatient services. The purpose of HCS is to support SHCN/EHCN population to navigate the complexities of the health care system, access high quality preventative care, manage chronic conditions, and address social risk factors. The increased expenditure and utilization in home health services and primary care supports among members who are engaged with HCS indicate a significant step to achieve this purpose.

Home health services include direct or indirect skilled nursing services and other therapeutic services (physical, occupational, and/or speech therapy; social services; etc.) under a physician's direction to homebound patients. Home health services provided for SHCN/EHCN included skilled nursing care, physical and occupational therapies, behavioral health services, medication management, preventive care services, homemaker services, and home delivered meals. Most previous research of the effectiveness of home health services were conducted for members receiving home health services under Medicare. Previous research has demonstrated the effectiveness of home health utilization on reducing readmission death, and health cost and improving chronic conditional knowledge, self-care confidence, and quality of life (Siclovan et al., 2021; Xiao et al, 2018; Leavitt et al., 2020). Given these potential benefits of home health services, higher expenditure and utilization of home health services among SHCN/EHCN members engaged with HCS is likely to lead to lower total cost of care and improved health outcomes in the long run.

The outputs showed a significant increase of primary care supports among SHCN/EHCN members engaged with HCS. Primary care supports are defined as a set of care services that engage, support, stabilize, and improve management of the member in the outpatient setting so as to reduce excessive and inappropriate inpatient utilization (e.g., care coordination and behavioral health supports). Given the inclusion of care coordination service codes in the definition of primary care supports, it is unsurprising that higher expenditures in this category were found for members engaged in HCS compared to those who remained unengaged. Greater access to primary care supports in general, and care coordination in particular, is inversely associated with the utilization of avoidable hospitalizations (Rosano et al., 2013) and ED services (Lowe et al., 2005). On the other hand, the results also showed a decline in the receipt of beneficial primary care services among SHCN/EHCN members engaged with HCS compared to unengaged members. This finding highlights the need to reiterate the continued value of secondary prevention even for members with complex healthcare needs, and the steadfast intent with which these members must continue to be supported in receiving screenings and other beneficial primary care services while receiving care for their complex health needs.

The major positive finding of this analysis was the decrease in utilization of ED and inpatient services for members engaged in HCS compared to those who remained unengaged; the decreased ED utilization was additionally associated with a significant reduction in ED expenditures. In other words, over the evaluation period (2019–2022), members who were actively engaged in receiving Health Coordination Services had a relatively greater reduction in ED and inpatient utilization as well as ED costs compared to members who remained disengaged from HCS. The finding demonstrates that members who engage in HCS in fact reap the intended health and cost benefits hypothesized in Hawaiʻi's 1115 waiver. However, the finding also underscores the importance of identifying and eliminating the root causes of current high levels of non-engagement in HCS to improve population-level outcomes. Therefore, more work is needed to understand why the majority of qualifying SHCN/EHCN members remain unengaged in HCS, and how to remove the barriers identified so that more qualifying members are able to achieve the intended benefits of these services. Further work and investment in HCS will allow Hawaiʻi to achieve and demonstrate a population-level impact of HCS on the health outcomes and cost of care for its SHCN/EHCN population.

Limitations

The results of this evaluation must be interpreted with caution due to several limitations. First, only one Health Plan was included in the evaluation, which limits the generalizability to the Medicaid population statewide. Second, for the purpose of analysis, only members enrolled continuously from 2020 Quarter 3 to 2022 Quarter 4 were included in the evaluation. Assignment of engagement or non-engagement depended entirely on the engagement status during this evaluation period, which makes a strong assumption that engagement status remained the same before 2020 Quarter 3. This assumption introduces potential bias to the treatment dose between the two groups. Lastly, with a single variable to determine whether members were or were not engaged in HCS, we were unable to evaluate the components of HCS more thoroughly, for example, by exploring how and what type of HCS are provided and at what dose.

Lessons Learned and Future Recommendations

The past two years represent the first time that Health Plans in Hawaiʻi have been required by MQD to provide detailed individual-level metrics necessary for the evaluation and to incorporate those data and metrics into their quarterly reports. The evaluation team undertook a detailed analysis of the types of data collected by Health Plans and found significant variation in the quality, completeness, and types of data currently collected, significantly limiting the possibility for a more comprehensive analysis. Further work is necessary to increase the consistency of data collection and reporting of HCS across Health Plans, an effort that this evaluation team and MQD are enthusiastic to engage in during the next 1115 waiver period. Despite the limitations of the data, a successful collaboration between MQD, Health Plans, and the evaluation team resulted in our ability to develop practical measurement of care coordination and identify data sources that could be used to evaluate the impact of these services. However, given the innovation of the waiver demonstration, the evaluation process was full of unavoidable surprises and challenges that limited the generalizability of the analysis. Below we list the challenges we encountered during the evaluation process and provide recommendations.

Recommendation 1: More clarity is needed on the conceptualization and operationalization of care coordination. For example, what care coordination services are offered, which are most needed, and how members view the impact of care coordination on their own lives is limited.

- Conduct a thorough process evaluation to identify what care coordination services are consistently needed and offered. This should engage members, providers, and Health Plans.
- Conduct regular randomized quality assurance calls with care coordination members to identify what needs are or are not being met.
- Establish a care-coordination patient advisory group that represents member perspectives and needs and invites provider input.

Recommendation 2: Standardized data collection and reporting system for care coordination is necessary.

- Develop parsimonious metrics to capture the delivery and dose of care coordination services on individual, provider-to-provider, and organizational levels.
- Work with Health Plans to integrate the fewest, most impactful metrics within their systems and require high-fidelity reporting linked to payment.

Project 1C: Home- and Community-Based Services (HCBS)

Introduction and Background

Home- and community-based service (HCBS) programs are designed to enable individuals who need long-term services and supports (LTSS) to receive care and assistance in their homes and communities. Their objective is to empower members, to enhance quality of life and to maintain their functional abilities and independence by avoiding placement into institutional settings (Neary, 1993). However, the literature on the efficacy of HCBS on health and wellbeing shows mixed results (Wysocki et al. 2015). While some studies underscore the vital role of HCBS in promoting individual autonomy and enhancing patient satisfaction (Kane, Kane, & Ladd, 1998; Weissert et al., 2005), others demonstrate no significant differences for most health outcomes by setting (Sloane et al., 2005; Frytak et al., 2001). A lack of consideration of additional factors which may impact these outcomes, such as within-setting variation and subgroup differences, may contribute to these conflicting results.

HCBS in Hawaiʻi are particularly crucial for the state's diverse population, which includes a significant elderly demographic and population of individuals with disabilities. The state's unique geographical and cultural context adds complexity to the delivery of HCBS. Efforts to strengthen and expand HCBS in Hawaiʻi aim to enhance person-centered care, improve care coordination and member well-being, reduce healthcare costs, and increase community inclusion.

Project 1B described the need for providing health coordination services to the SHCN/ECHN populations. This project (Project 1C) addresses health coordination services provided to individuals who are eligible for LTSS. Generally speaking, these programs (SHCN/EHCN and LTSS) are mutually exclusive.

LTSS focuses on individuals that have high health needs, and individual eligibility is determined through a level of care (LOC) assessment. The LOC assessment is performed by a physician, RN or APRN within a Health Plans or via delegated authority using a functional assessment form called Form 1147. These functional assessments should be repeated at least every twelve months, if there is a significant change in the member's condition, or by member request. As such, when repeated with fidelity, the LOC data provides a consistent, longitudinal measurement of functional status for LTSS members.

MQD provides HCBS services to two LTSS populations: 1) individuals who meet nursing facility (NF) LOC requirements, and 2) individuals who are assessed to be "at risk" of deteriorating to a NF LOC. Members who are considered NF LOC are expected to have the choice between receiving care in an institutional setting (such as a skilled nursing facility) or receiving care in a home- or community-based setting (such as a personal residence or a community care foster family home (CCFFH)). Those who receive services in a community setting receive HCBS.

The designation of NF LOC versus At-Risk determines the amount and type of services eligible for a given member. The At-Risk population has access to a subset of HCBS that are intended to improve health and prevent deterioration to NF LOC. This includes access to home delivered meals, personal assistance, adult day health, and adult day care, among others. Table V.1C.1 below outlines the services available to LTSS members considered At-Risk or Institutional levels of care.

Table V.1C.1. HCBS Benefits for At Risk and Institutional (NF) LOC

Service	Available for individuals "At Risk" of deteriorating to institutional level of care	Available for individuals who meet institutional level of care
Adult day care	X	X
Adult day health	X	X
Assisted living facility		X
Community care foster family homes		X
Counseling and training		X
Environmental accessibility adaptations		X
Home delivered meals	X	X
Home maintenance		X
Moving assistance		X
Non-medical transportation		X
Personal assistance	X	X
Personal emergency response system	X	X
Residential care		X
Respite care		X
Private duty nursing	X	X
Specialized case management		X
Specialized medical equipment and supplies		X

Evaluation Approach

RQ 1C.1: Does HCBS slow the deterioration of health as reflected in the level of care among individuals meeting NF LOC criteria?

This research question was answered using Form 1147 LOC assessment data. Form 1147 includes LOC assessments for activities of daily living (ADLs) such as mobility, alertness and orientation, and continence among other things. The form includes a separate section to addresses instrumental activities of daily living (IADLs), which is only completed for the At-Risk population. ADL and IADL sections of the LOC assessment are scored, and the cumulative points assigned to ADLs (or IADLs) constitute the individual's LOC score. Form 1147 also includes information about demographic characteristics (e.g., age and sex), availability of social support, and necessity of skilled procedures.

After completion, Form 1147 is usually reviewed by a Health Plan and then by MQD. Based on the assessment, a requested LOC (e.g., NF or At-Risk LOC) is approved, deferred, or denied. Upon an approval, approval begin and end dates are specified. The data is maintained in a database called Hawaiʻi Level of Care (HILOC).

We analyzed HILOC data from May 2014 to November 2021. The approval begin date on Form 1147 was used as the anchor date for this analysis. We quantified disability using the LOC score, with a higher score indicating a higher severity of functional limitations.

The original research question was broken down into the following questions:

1. How do members who meet NF LOC, and who are living at home, in foster homes, and in nursing homes differ in their LOC score?
2. Does the receipt of HCBS result in a slower deterioration of LOC score compared to receiving care in nursing homes?

The table below summarizes the methodology for addressing these questions.

Table V.1C.2. Summary of Methodology

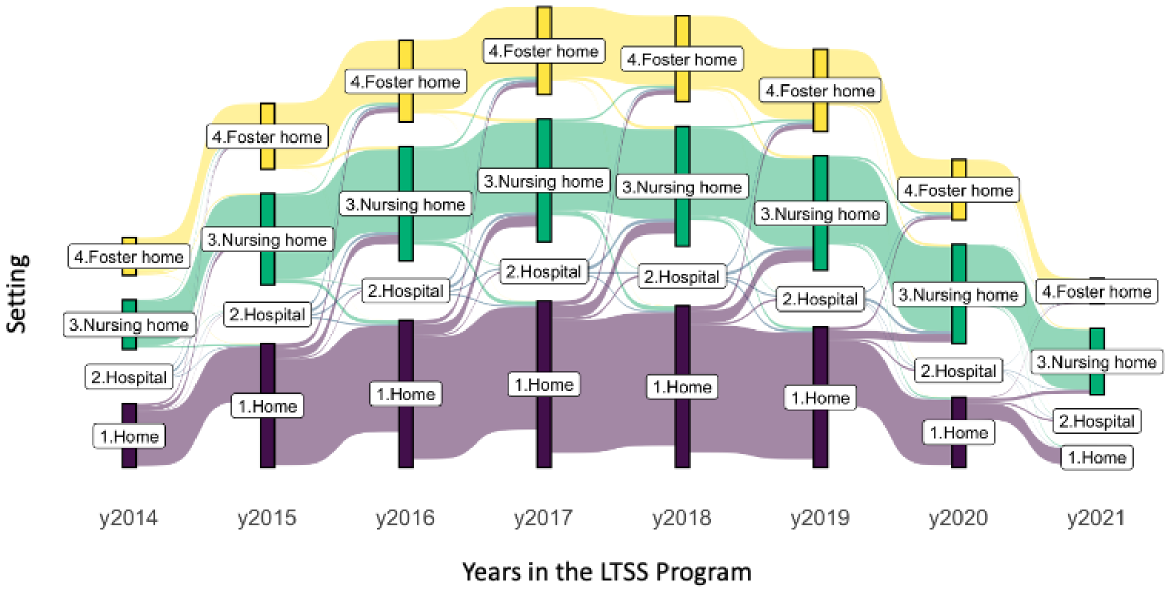
	How do members who meet NF LOC, and who are living at home, in foster homes, and in nursing homes differ in their LOC score?	Does the receipt of HCBS result in a slower deterioration of LOC score compared to receiving care in nursing homes?
Data source	2014-2021 HILOC	2014-2021 HILOC
Sample selection	Those in LTSS for at least two continuous years	Those in LTSS for at least two continuous years with high severity of functional limitations (LOC score >15 points)
Outcome measure	LOC score	LOC score
Analytical approach	Descriptively compare three groups of LTSS members based on where they live (home, community foster home, and nursing home) over time, by LOC score, age, and sex	Longitudinal analysis comparing members who reside at home, nursing home, and community foster home after matching members based on age, sex, and LOC score at baseline
Comparison group	N/A	Matched individuals living in nursing homes

We used longitudinal HILOC data from May 2014 to November 2021 because there were no significant changes to the content of Form 1147 during this period. Data from May 2014 to November 2021 initially included 35,582 members. This initial data set included children and youth populations as well as adults. However, we decided to focus on older adults (age 65 and above) because our comparison group was members living in nursing homes who tend to be older adults. The 2017 national data show that over 80% of nursing home residents are age 65 or older (Laws et al., 2022). The sample was reduced to 22,026 members after excluding children (Form 1147E) and reassessments that did not include LOC scores (Form 1147A) (1,405 members excluded), a small number of members reporting residence in Care Homes, External Adult Residential Care Homes, or indicating "other" for present address (460 members excluded), and individuals under 65 (11,691 members excluded).

Because we intended to track the change in LOC scores over time and members are expected to receive reassessments annually or when significant changes happen after their initial assessment, we further excluded those without follow-up assessments or with follow-up for less than two years. This left a final sample of 8,532 members.

Figure V.1C.1 shows the flow of these members in each setting (i.e., home, hospital, nursing home, and foster home) and the movement between settings between 2014 and 2021. It illustrates that most members stay within the same setting from year to year although movement does occur between all settings. Note that, compared to year 2015–2019, year 2014 has a smaller sample because it started from May 2014, and years 2020–2021 have smaller samples due to the inclusion criteria of members having at least two continuous years in the program.

Figure V.1C.1. Flow of Members Aged 65+ with At Least Two Years in the LTSS Program by Setting



Specifically, we found that between 2014 and 2021, 64% (n=5,426) of LTSS members stayed in the same setting, while 36% (n=3,106) switched between settings. Among members who stayed in the same setting, 28% were in home settings, 14% in CCFHs, and 21% in nursing homes. Once the final sample was determined, we descriptively analyzed their demographic characteristics (e.g., age and sex), LOC score, whether their caregiving support system was willing to provide/continue care if they have a home, and whether the member had a primary or secondary diagnosis of mental illness or dementia, by setting (i.e., home, CCFFH, or nursing homes) at baseline. We also described their change in LOC scores over time by setting.

We then focused on members with high LOC scores (>15 points[1]) and matched members by age, sex, and LOC score at baseline. The matched sample includes a total 1,077 members with 359 members in each of the three settings. For this high acuity group, we compared changes in LOC score by setting over time.

We also examined subgroup differences by diagnosis. Of particular interest was individuals who had dementia or mental illness as their primary or secondary diagnosis, as indicated on the Form 1147. Dementia is one of the most expensive health conditions among older adults and the most time-consuming for caregivers (Mather & Scommegna, 2020), with increasing prevalence among the older population (Alzheimer's Disease International, 2015). Psychological conditions, especially severe mental illnesses (e.g., schizophrenia and bipolar illness), are associated with early mortality and higher risk of comorbidity (The National Association of State Mental Health Directors Council, 2006). Additionally, across the U.S., states have challenges placing Medicaid members with mental illness or dementia, both of which may lead to behavioral health issues that are challenging in various settings. HILOC data include the primary and secondary significant, current diagnosis reported on Form 1147; these data are captured in text fields. We used the roots of keywords,

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[1] LOC score of 15 points was chosen as the cutoff point because it is the 75 percentile of LOC score for those living at home.

including “schiz”, “bipol”, “depres”, and “psycho” to identify members with mental illness and used “dementia” and “alzheim”' to identify members with dementia as their primary or secondary diagnosis. Although this does not include all LTSS members who have a diagnosis of mental illness or dementia, it identifies those who have mental illness or dementia listed as their primary diagnosis at the time of the LOC assessment.

RQ 1C.2: Does length of time to enter a nursing home, patient-reported health outcomes (PROs), and total cost of care vary depending on a variety of client characteristics among individuals meeting NF LOC criteria and receiving HCBS services?

The second evaluation question addresses subgroup differences within three relevant outcomes for the LTSS population—length of time to enter a nursing home, patient reported outcomes (PROs), and cost of care—with a focus on the population meeting NF LOC. We address each outcome in the following section.

Length of time to enter a nursing home

For the length of time to enter a nursing home, we analyzed 2014–2021 HILOC and focused on those older adults (aged 65 or older) who were in the LTSS program for at least two years from 2014–2021 and entered a nursing facility. During this period 421 members switched from home to nursing homes and were approved to receive services at a nursing facility (comprising approvals for care delivered in an Intermediate Care Facility; Skilled Nursing Facility; waitlist services, meaning that the member is receiving ICF or SNF level of care while awaiting a permanent placement to become available; hospice facility; or in a subacute facility including both subacute level I and level II facilities). We counted the days from the date of the first assessment after the member was placed at home with HCBS services to the date of the first assessment after the member was placed in a nursing home and used it as our outcome measure. We estimated the average days by member characteristics such as sex and county and tested the extent to which the days to enter a nursing home varied by member characteristics.

Patient-reported outcomes (PROs)

For PROs, we analyzed the data extract from one Health Plan. We were not able to use data extracts from all Health Plans because of inconsistent data fields and data quality issues across Health Plans. Data extracts from each Health Plan varied in terms of content, available variables, format, and completeness. This made it impossible to analyze data extracts from all five Health Plans to address this particular research question. We chose the Health Plan data extract that provided the most complete information on goal attainment. This included goals set by members in the Health Action Plan and dates of goal attainment from 2021–2022 after goals were initiated. We counted the number of goals for each member and calculated the average percentage of completed goals by each member. Only 3,408 members had both demographic and goal attainment information. Among the 3,127 members who stayed in the same care coordination program (LTSS, SHCN, EHCN, or At Risk) in 2021–2022, 382 were LTSS members. Within this sample, we descriptively analyzed goal attainment by member characteristics such as age, sex, and county.

Cost of care

We used cost of care information from HPMMIS Claims and Encounter data from 2016 to 2022 to examine cost distribution. We also linked the cost data with HILOC data. Specifically, we first calculated the total cost of care for each individual for each calendar year, identified the approved LOC (i.e., whether one meets NF or At-Risk LOC) for each individual in each calendar year, and then merged records by individual identifier and calendar year. The merged data included 11,937 individuals and 44,644 records. We excluded 2,569 records of individuals meeting NF LOC or at risk for part of a calendar year (e.g., an individual with functional decline changed from At-Risk to NF LOC in a calendar year) from the analysis. Among these 44,644 records, 51% were for those meeting NF LOC and 49% were for those in the at-risk population during the calendar year.

We created three cost variables: the amount paid by Medicaid (including the amount paid by managed care and fee-for-service programs), total spending (including the amount paid by Medicaid, Medicare, and from other coverage) and percentage of total spending paid by Medicaid. We then described the overall trend in cost of care and trend by age and sex between 2016 and 2022.

RQ 1C.3: Does length of time to enter a nursing home, PROs, and total cost of care vary depending on a variety of client characteristics among the At-Risk population?

This evaluation question addresses the same set of outcomes as RQ 1C.2 but focuses on the At-Risk population.

Length of time to enter a nursing home

For the length of time to enter a nursing home, we analyzed 2014–2021 HILOC and focused on those who were in the program for at least two years in 2014–2021. Among the 722 members switching from home to nursing homes during this period, 301 members were approved at an At-Risk LOC status in their first assessment when they were at home. We estimated the average days to enter a nursing home by member characteristics such as sex and county and tested the extent to which the days to enter a nursing home varied by member characteristics. We also compared the length of time to enter a nursing home of At-Risk versus LTSS members who met NF LOC.

Patient-reported outcomes (PROs)

For PROs, we analyzed the goal attainment status from one Health Plan data extract. Among 3,127 members who stayed in the same program with both demographic and goal attainment information in 2021-2022, 479 were At-Risk members. We described goals that were completed by member characteristics such as age, sex, and county and compared the goal completion of At-Risk versus LTSS members who met NF LOC.

Cost of care

We used the same data for the At-Risk population as that used for individuals meeting NF LOC in RQ 1C.2. We described the overall trend of cost and trends by age and sex between 2016 and 2022 in comparison to the trends of individuals meeting NF LOC.

Results

RQ 1C.1: Does the receipt of HCBS result in a slower deterioration of LOC score compared to receiving care in nursing homes?

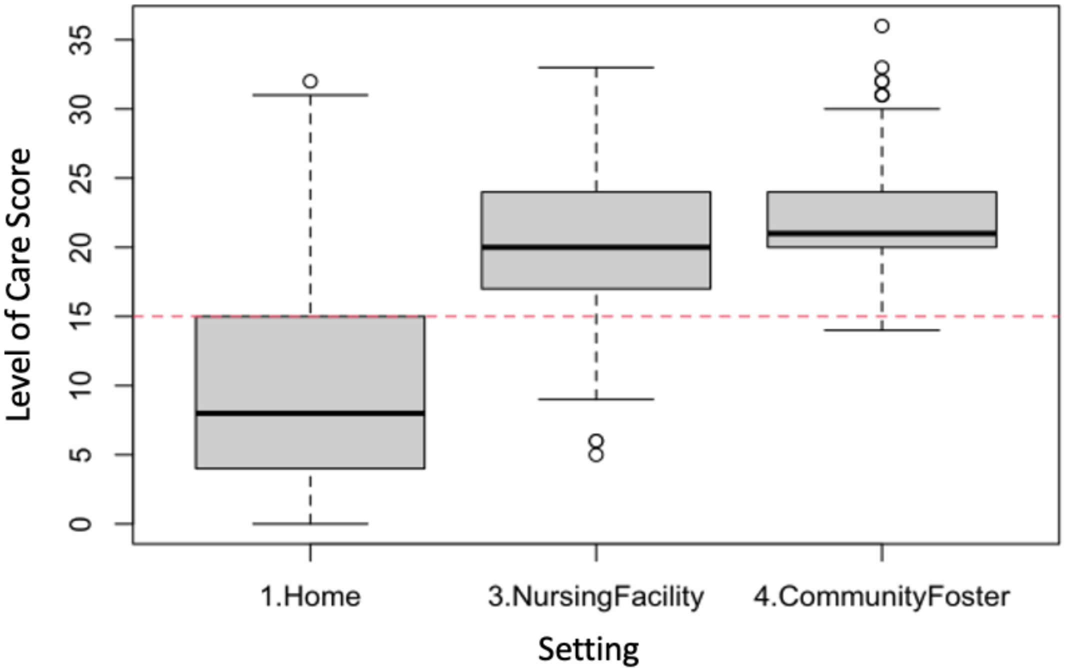
LTSS members in different settings (homes, community foster homes, and nursing homes) had different characteristics. For example, members at home and foster homes tend to be younger, have a caregiver who is willing to provide/continue care, and have a lower percentage of mental illness as the primary or secondary diagnosis at the time of assessment compared to those in nursing homes. In terms of LOC scores of functional limitations in engaging in ADLs, members in nursing homes and foster homes had higher LOC scores compared to members living at home. This difference is also illustrated in the figure following Table V.1C.3 (Figure V.1C.2).

Table V.1C.3. Baseline Characteristics of Longitudinal LTSS Data with 2 or More Years of Follow-up (Age 65 or Older)

	All Sample	**Home**	**Nursing Facility**	**Community Foster Home**	**p-value**
Total Sample	5,426	2,419 (44.6%)	1,798 (33.1%)	1,209 (22.3%)	
Sex					
Female	3,886 (71.6%)	1,756 (72.6%)	1,308 (72.7%)	822 (68.0%)	0.006
Male	1,540 (28.4%)	663 (27.4%)	490 (27.3%)	387 (32.0%)	
Age (years)					
Mean±SD	80.7±9.7	77.4±8.8	84.1±9.4	82.1±9.8	<0.001
Age Group					
65-74	1,753 (32.3%)	1,074 (44.4%)	354 (19.7%)	325 (26.9%)	<0.001
75-84	1,610 (29.7%)	804 (33.2%)	471 (26.2%)	335 (27.7%)	
85+	2,063 (38.0%)	541 (22.4%)	973 (54.1%)	549 (45.4%)	
LOC scores (ADL)					
Mean±SD	16.2±8.0	9.7±6.8	21.0±4.5	21.9±3.4	<0.001
LOC score categories					
0-15	2,071 (38.2%)	1,876 (77.6%)	169 (9.4%)	26 (2.2%)	<0.001
16+	3,355 (61.8%)	543 (22.4%)	1,629 (90.6%)	1,183 (97.8%)	
Social Support					
No Support	2,113 (38.9%)	497 (20.5%)	743 (41.3%)	873 (72.2%)	<0.001
Have Support	1,883 (34.7%)	1,694 (70.0%)	21 (1.2%)	168 (13.9%)	

Missing	1,430 (26.4%)	228 (9.4%)	1,034 (57.5%)	168 (13.9%)	
Mental Illness as Primary or Secondary Diagnosis					
No	5,389 (99.3%)	2,404 (99.4%)	1,779 (98.9%)	1,206 (99.8%)	0.027
Yes	37 (0.7%)	15 (0.6%)	19 (1.1%)	3 (0.2%)	
Dementia as Primary or Secondary Diagnosis					
No	5,342 (98.5%)	2,395 (99.0%)	1,743 (96.9%)	1,204 (99.6%)	<0.001
Yes	84 (1.5%)	24 (1.0%)	55 (3.1%)	5 (0.4%)	

Figure V.1C.2. Level of Care Score Distribution by Setting before Matching

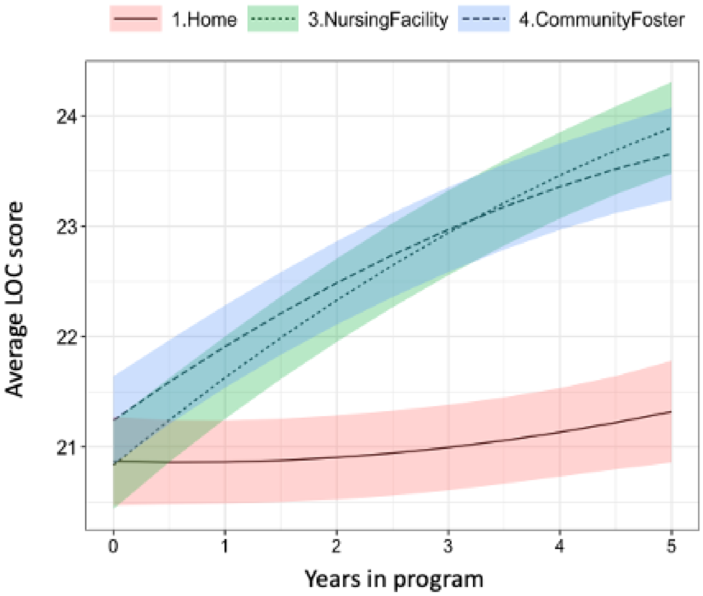


As we examined members with different levels of functional limitations by dividing the sample by LOC scores at baseline, we identified higher average LOC scores for older adults living in nursing homes and foster homes compared to those living at home. Since the 75th percentile of the LOC score for members living at home is 15, we chose 15 points as the cutoff and separately examined members with LOC scores of 15 or lower (low acuity) and members with LOC scores higher than 15 (high acuity) by setting over time. Trends in functional decline over time differed by setting as well as baseline acuity. LOC scores increased gradually over time for members with low acuity in all settings, meaning they all experienced functional decline over time. However, there were differences in the extent to which they declined based on setting. The scores of individuals in nursing homes and foster homes were notably higher at baseline when compared to those of individuals living at home and exhibited a comparable trend over time. For members with high acuity LOC, the differences in LOC scores over time were smaller based on setting.

Since the differences between settings in the baseline LOC scores of members with high acuity LOC were smaller, we focused on this sub-group to identify the extent to which provision of HCBS slows the deterioration of health (measured by LOC score) compared to those in nursing homes. Specifically, we examined three groups—individuals living at home or in a community foster home (both HCBS recipients) and those in in a nursing home. We exclusively focused on members with NF LOC, not the At-Risk population. The matched sample includes 1,077 members with 359 members in each setting. The LOC scores of members by setting after matching were similar.

We found that, among members meeting NF LOC with high LOC scores (>15 points), the LOC scores for those in the home setting were stable over the years they were in the program, whereas the LOC scores for those in the nursing home or CCFFH deteriorated over the years they stayed in the program (see Figure V.1C.3). The difference in functional decline over time by setting is illustrated below in Figure V.1C.3. Over time, functional decline for members in nursing facilities and foster homes increases steadily, while members in home settings experience functional decline at a much slower rate.

Figure V.1C.3. Average LOC score by years in program and setting adjusted for age and sex



Both home and foster home settings are considered community-based (HCBS settings). However, the functional decline outcomes in CCFH were similar to nursing homes, while home settings resulted in substantially reduced functional decline over time. These trends in functional decline by setting did not differ by age group. For all older adults (i.e., 65–74, 75–84, and 85+) home settings were associated with less functional decline over time than nursing facilities or CCFHs. The trend persisted when we explored subgroup differences by primary or secondary diagnosis of dementia or mental illness. That is, members with these primary diagnoses living in nursing facilities or CCFFH deteriorated faster compared to those staying at home, and they were also less likely to be in homes settings. This suggests that there may be unique supports or protective factors within home settings that slow functional decline that are not reflected equally in a HCBS settings.

RQ 1C.2: Does length of time to enter a nursing home, patient-reported health outcomes (PROs), and total cost of care vary depending on a variety of client characteristics among individuals meeting NF LOC criteria and receiving HCBS services?

The second evaluation question addresses the subgroup differences of three outcomes—length of time to enter a nursing home, PROs, and total cost of care—with a focus on the population meeting NF LOC and receiving HCBS. We address each outcome in the following section.

Length of time to enter a nursing home

For the population with approved NF LOC at baseline, the average age was 84 years with over half being 85 or older. The majority of this population were females (72%). The average LOC score at the baseline was 19 points, indicating high acuity of functional impairments. Over half had a caregiving support system that was willing to provide/continue care. Approximately 14% had some type of mental illness as a primary or secondary diagnosis and 32% had dementia as a primary or secondary diagnosis. The average length of time before entering a nursing home was 722 days.

Table V.1C.4. NF LOC Population Demographics at Baseline

	N	Mean / %	SD
Age (all)	421	83.95	8.97
Age groups			
[65, 75)	82	0.20	0.40
[75, 85)	118	0.28	0.45
85+	221	0.53	0.50
Sex			
Male	116	0.28	0.45
Female	305	0.72	0.45
LOC score (ADL, [0,38])	421	18.78	3.68
Social support			
Yes	242	0.58	0.50
No	129	0.31	0.46
Unknown	50	0.12	0.32
Primary or Secondary Diagnosis			
Mental illness	59	0.14	0.35
Dementia	133	0.32	0.47

When we examined the number of days before entering a nursing home by demographic characteristics, we found that members aged between 65 and 75 (vs. those 85 or older), female members, and those with a caregiving support system that was willing to provide/continue care tended to have a longer time in the community setting before entering a nursing home. Members with higher LOC scores at baseline tended to have a shorter time in the community setting before they entered a nursing home.

Table V.1C.5. Average Number of Days before Entering a Nursing Home by Demographics of NF LOC Population at Baseline

	Mean	SD	T	P>t
All	722.51	535.75		
Age groups				
[65, 75)	824.85	621.45	reference	
[75, 85)	706.24	554.33	-1.54	0.12
85+	693.22	487.27	-1.90	0.06
Sex				
Male	627.59	474.43	reference	
Female	758.61	553.77	2.25	0.03
LOC score (ADL)			-2.94	0.00
Social support				
Yes	883.32	567.05	reference	
No	505.34	390.55	-6.89	0.00
Unknown	504.46	424.16	-4.85	0.00
Primary or Secondary Diagnosis				
Mental illness	656.68	571.50	-1.02	0.31
Dementia	687.14	508.22	-0.92	0.36

Patient-reported outcomes (PROs)

LTSS members had two goals on average in 2021–2022, and only a small percentage (2.9%) of goals were documented as completed by the end of the observation period. As this program has an explicit emphasis on person-centered care, efforts should be directed towards enhancing the achievement of goals set by the LTSS member.

In terms of subgroup differences, we found only geographic differences in goal completion. Members in Maui County and Hawaiʻi County had higher percentages of goals that were completed compared to those in Honolulu County.

Cost of care

For individuals meeting NF LOC, the results illustrated in Figures VI.1C.4 and VI.1C.5 show that 1) Medicaid spending (in dollar amount) increased from 2016 to 2022 but the percentage of total spending paid by Medicaid was relatively stable during this period, and 2) Medicaid is the largest payer for this population. Specifically, the nominal average Medicaid spent on care increased from $65,137 per person in 2016 to $76,081 in 2022. The increase could be partly due to inflation. The percentage of total cost paid by Medicaid first increased from 80% in 2016 to 84% in 2017, and then decreased to 82% in 2022.

Figure V.1C.4. Amount paid by Medicaid for individuals meeting NF LOC by calendar year

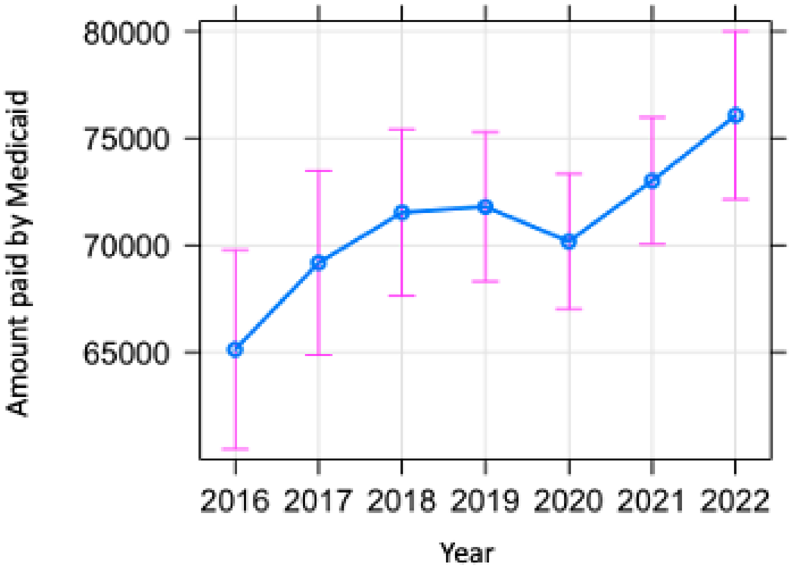
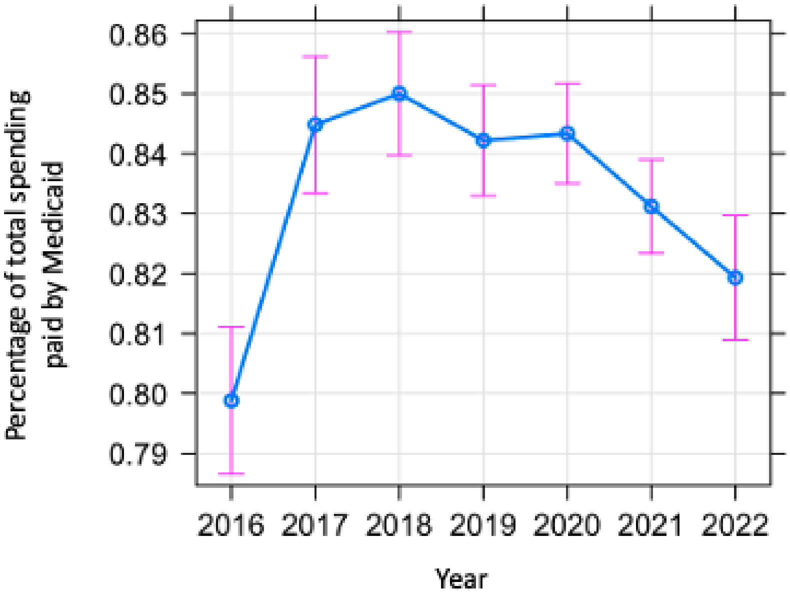


Figure V.1C.5. Percentage of total spending paid by Medicaid for individuals meeting NF LOC by calendar year



In terms of subgroup differences, Medicaid paid more for individuals younger than 65 years old, especially those under 55, likely due to a lower prevalence of Medicare coverage for this group. There is an increasing trend in the Medicaid spending on younger members meeting NF LOC between 2016 and 2022 (see Figure V.1C.6). However, we did not find age differences with regard to the percentage of total spending paid by Medicaid. For sex, males had a higher average cost paid by Medicaid (see Figure V.IC.7) but we did not observe sex difference for the percentage of total spending paid by Medicaid.

Figure V.1C.6. Amount paid by Medicaid for individuals meeting NF LOC by calendar year and age group

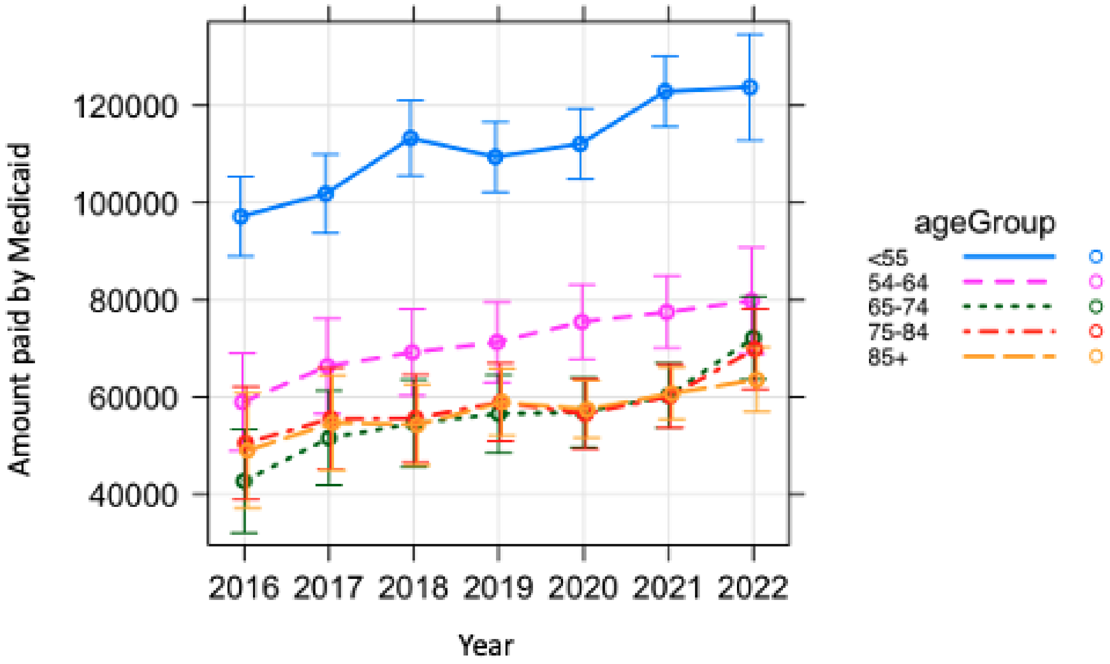
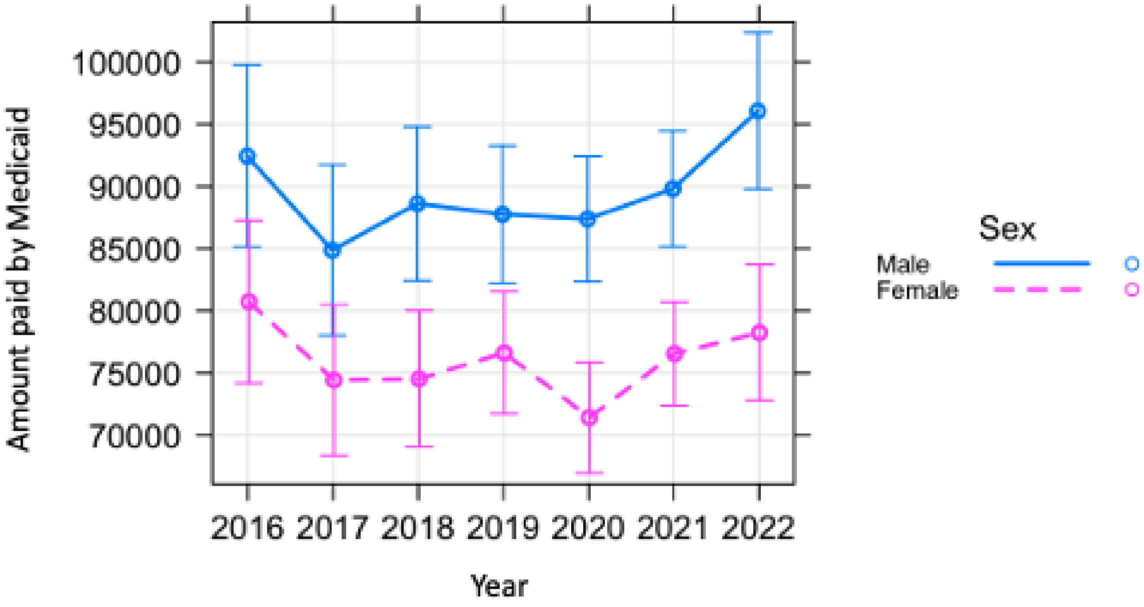


Figure V.1C.7. Amount paid by Medicaid for individuals meeting NF LOC by calendar year and sex



RQ 1C.3: Does length of time to enter a nursing home, PROs, and total cost of care vary depending on a variety of client characteristics among the At-Risk population?

This analysis addressed the same research question and set of outcomes as RQ 1C.2 but focused on the At-Risk population. We addressed this question by outcome as follows.

Length of time to enter a nursing home

The average age of the At-Risk population was 82 years with a majority of females (70%). The average LOC score for IADL was 7.4, which indicates much lower acuity than NF LOC, as expected. Over 60% of members had a caregiving support system that was willing to provide/continue care. Approximately 10% had a primary or secondary diagnosis of mental illness and 22% had a primary or secondary diagnosis of dementia. On average, the length of time before entering a nursing home was 1,090 days.

Table V.1C.6. At-Risk Population Demographics at Baseline

	N	Mean	SD
Age (all)	301	81.50	8.08
Age groups			
[65, 75)	72	0.24	0.43
[75, 85)	105	0.35	0.48
85+	124	0.41	0.49
Sex			
Male	89	0.30	0.46
Female	212	0.70	0.46
LOC score			
ADL [0,38]		6.78	3.46
IADL [0,10]		7.40	1.93
Social support			
Yes	191	0.64	0.48
No	71	0.24	0.43
Unknown	39	0.13	0.34
Primary or Secondary Diagnosis			
Mental illness	29	0.10	0.30
Dementia	66	0.22	0.41

When we examined the length of time to enter a nursing home by member characteristics, we found that members aged 85 or older (vs. 65–75) tend to have a shorter length of time before they entered a nursing home.

Table V.1C.7. Average Number of Days before Entering a Nursing Home by Demographics of At-Risk Population at Baseline

	Mean	SD	t	P>t
All	1,089.53	561.45		
Age groups				
[65, 75)	1,210.35	549.15	reference	
[75, 85)	1,089.91	587.50	-1.41	0.16
85+	1,022.13	538.39	-2.27	0.02
Sex				
Male	1,051.52	579.05	reference	
Female	1,107.29	554.49	0.79	0.43
LOC score				
ADL			-2.11	0.04
IADL			-1.50	0.14
Social support				
Yes	1,054.02	569.10	reference	
No	1,194.51	556.08	1.8	0.07
Unknown	1,082.13	522.30	0.29	0.78
Primary or Secondary Diagnosis				
Mental illness	1,005.97	616.90	-0.86	0.39
Dementia	1,009.96	576.39	-1.33	0.19

At-Risk individuals tended to have a longer length of time before they entered a nursing home compared to NF LOC population, who were also receiving HCBS, and are eligible for a broader array of services, but who have substantially higher acuity. At-Risk individuals, however, tended to be younger, less likely to have dementia, and have a lower percentage of members without a caregiving support system willing to provide/continue care. These two groups are not directly comparable. While the descriptive analysis cannot conclude the effectiveness of HCBS on mitigating health deterioration to NF LOC, it establishes a baseline for Hawaiʻi's At-Risk population. Continued research is needed to conclusively demonstrate the value of providing at risk services to Medicaid members.[2]

Patient-reported outcomes (PROs)

For PROs, we analyzed the data extract of the goal attainment status from one Health Plan. Among 3,127 members who stayed in the same program, with both demographic and goal attainment information in 2021–2022, 479 were At-Risk members. On average, each At-Risk member had two goals, and a small percentage (3.5%) of members had goals that were completed. Given the emphasis on person-centered care, it is essential to enhance the achievement of goals.

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[2] The statistical tests were conducted with all p-values under 0.05.

While there were no differences in goal completion by age, sex, and language use, we found geographic differences. Members in Maui County had a higher percentage of goals that were completed compared to Honolulu County.

Compared to LTSS members, At-Risk members in Honolulu County had a higher percentage of goals completed.

Total Cost of care

The total average spending (in dollar amount) for individuals with approved at-risk LOC was stable between 2016 and 2022. In contrast, the total spending (in dollar amount) on individuals who met NF LOC continued to rise during the same time period.

The percentage of total spending paid by Medicaid for the at-risk population increased from 56% in 2016 to 61–65% in 2017-2022, whereas the percentage for those meeting NF LOC was around 80–85% in 2016–2022.

Figure V.1C.8. Amount paid by Medicaid by approved LOC status and calendar year

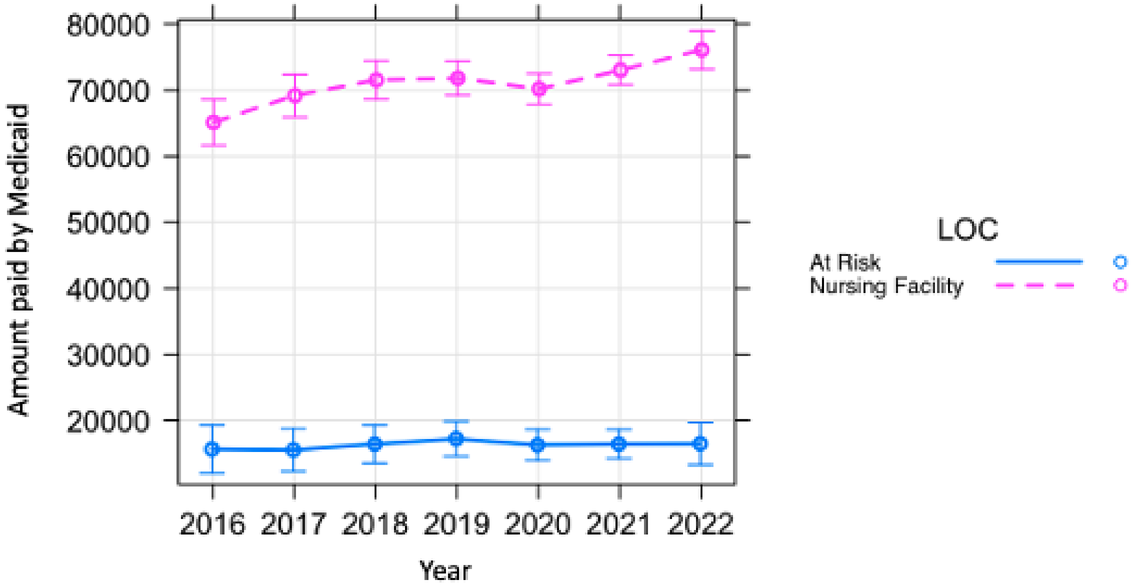
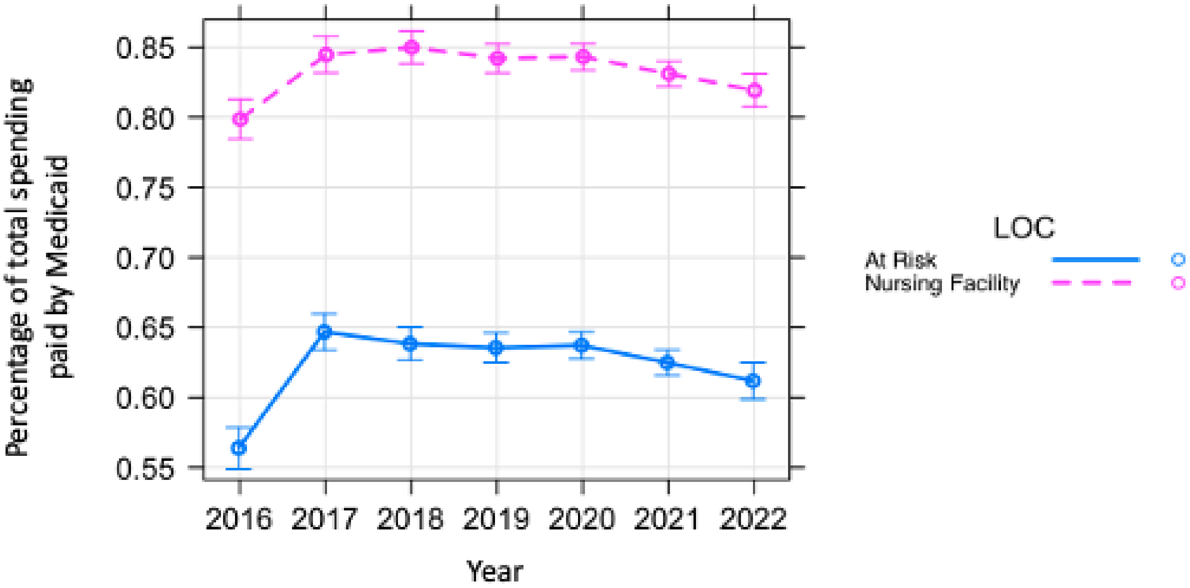


Figure V.1C.9. Percentage of total spending paid by Medicaid by approved LOC status and calendar year



The above two figures consistently show that At-Risk population had lower costs compared to those meeting NF LOC. This finding is expected, as those in the latter group tend to have more LOC needs.

In terms of subgroup differences for the At-Risk population, we found that the age group under 65 years had a higher cost paid by Medicaid compared to older age groups. For example, over 70% of the total spending were paid by Medicaid for those under 65 years old, whereas the rates for those over 65 years were 40–57%. This finding is not surprising as Medicare generally covers adults aged 65 years and older, with Medicaid being the payer of last resort. We observed sex difference with higher costs paid by Medicaid for males.

Limitations

The analysis has a few limitations. For the first evaluation question, we focused on older adults who stayed in the same setting for at least two years and excluded those who switched between settings (e.g., from home to nursing home) from our analysis. Such exclusion may lead to bias, as individuals who stayed in the same setting may tend to have a more stable health status compared to those who changed settings (e.g., due to functional declines). Further exploration of the population experiencing changes in setting are necessary to understand the factors contributing to transitions in setting, particularly given our findings that distinct settings are associated with different outcomes. In addition, using primary or secondary diagnoses of mental illness or dementia on the LOC assessment does not capture the entire LTSS population with these conditions; an LTSS member may have mental illness or dementia which is not recorded as “primary” or indicated as such on the LOC assessment. Nevertheless, this is the diagnosis that the person scoring the assessment decides is most salient at the time of the assessment. Lastly, while the matching based on age, sex, and LOC score at baseline made the treatment and comparison groups more comparable, some characteristics of matched groups are still different. We will consider other matching variables from other data sources to expand the analysis in the future. For the second and third questions, we used goal attainment as the patient-reported outcome (PRO) with data from one Health Plan but we will consider other PRO measures and include all Health Plans as data quality and consistency are actively being improved through work by MQD and Health Plans.

Conclusions and Recommendations

The above findings highlight several important points about care options and outcomes for individuals with varying levels of need.

The analysis showed that receiving care at home slows functional impairment over time when compared to receiving care in foster homes or nursing homes, although both foster homes and personal homes are considered HCBS settings. This suggests that staying in a familiar environment with family, friends and known surroundings might have a positive impact on health. Our findings provide support for the effectiveness of home care and indicate that policy solutions such as support for family caregivers, training and certification of more home care providers, and personalized care plan may help optimize healthcare delivery and promote member health.

Furthermore, we found that individuals who were placed at home tended to have much lower average acuity than those in foster homes or nursing homes. This, paired with the finding that home settings can be protective even for individuals with high acuity, suggests that greater efforts should be taken to support in-home care whenever possible. This may include increasing supports for family caregivers and providing more in-home caregiving support, even for high acuity members. Future research should examine reasons for the difference in placement patterns in home versus foster home settings, and potential strategies to enhance supports for in-home care for higher acuity members.

Next, while foster home residents receive care in the community, they experienced a similar pattern of functional decline as those in nursing homes. As funding shifts from institutional care to home- and community-based care, this finding calls attention to the variations in quality of care and functional status within HCBS settings; certain settings within HCBS may require targeted interventions that recognize the unique challenges and advantages associated with each type of care. For instance, when planning and implementing healthcare interventions, it becomes crucial to tailor strategies based on the specific characteristics of home-based care and foster home care. By taking into account the differences in these environments, healthcare professionals can provide more effective and personalized care that aligns with the distinct needs and preferences of the individuals receiving support.

Despite being in a community-based setting, foster home residents seem to face challenges similar to those in more traditional nursing home settings. Further research is warranted to discern the factors contributing to patient wellbeing, such as the level of personalized attention, medical expertise, or the specific types of care and activities provided in these settings, to inform targeted policy interventions.

One unique aspect of the Hawaiʻi's 1115 waiver demonstration is the provision of a limited set of HCBS to the population that is "at risk" of deteriorating to a nursing facility level of care. Compared to individuals who meet the Nursing Facility Level of Care (NF LOC), the At-Risk population spent longer in the community before entering a nursing home, had higher goal attainment, and lower total cost of care. These findings are consistent with, though not by themselves adequate to reach, the conclusion that the provision of "At-Risk services" is a cost-effective strategy to mitigating the deterioration of functional status to the nursing facility level of care.

This evaluation establishes a baseline for Hawaiʻi's At-Risk population; it highlights the need to explore factors contributing to the decline in functional status among populations receiving care in community foster homes. It paves the way for future monitoring of health and cost outcomes, focused on continuing to improve the quality of care and decreasing healthcare spending on Hawaiʻi's LTSS population.

Projects 2A & 2B: Value-based purchasing (VBP) reimbursed at the Health Plan and Provider Levels; Alternative Payment Models (APM) at the Provider level

Introduction and Background

Within the U.S. healthcare system, there is a current movement away from fee-for-service (FFS) payments towards a more person-centered approach with value-based purchasing (VBP). VBP aims to incentivize higher quality service, better health outcomes, and increased value of care over volume. The Centers for Medicare and Medicaid Services (CMS) has sought to transform U.S. health care from a system that rewards value and quality of services rather than incentivizes volume (Werner et al., 2021). A key part of this strategy has been shifting from FFS payments to pay structures that link provider reimbursement to improved quality and reduced costs, or in other words, VBP (Werner et al., 2021). However, adding bonuses and penalties to FFS payments is not enough to transform the health care system with historically high prices and inefficient processes. Therefore, CMS has also developed advanced alternative payment models (APMs) that hold providers financially accountable for the cost of care delivered to patients, as well as the quality of this care. These APMs include accountable care organizations (ACOs), episode-based payment models, Comprehensive Primary Care models, and other arrangements (Werner et al., 2021).

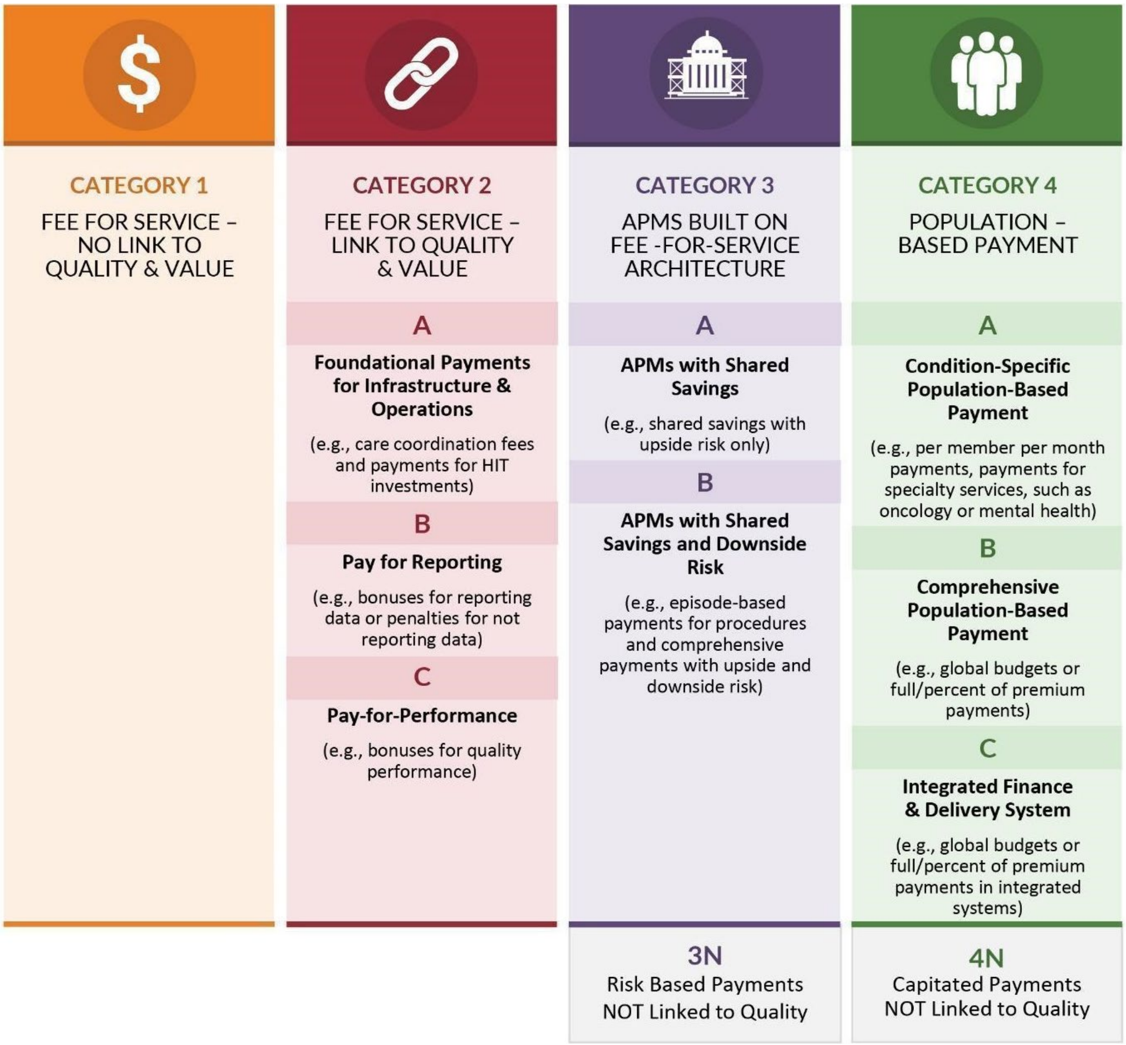
MQD aims to implement VBP strategies that incentivize quality and whole-person care through VBP-centered transformation models of payments. A VBP framework demonstrates an arrangement that holds a provider, or a managed care organization, accountable for both the costs paid and the quality of care provided (MQD, 2017). MQD supplied a VBP roadmap within the HOPE initiative that is expected to transform how healthcare is provided by implementing new models of care that strive for and drive population-based healthcare value (MQD, 2017). MQD's plans for advancing VBP in Hawaiʻi includes steps to:

- Evolve current Health Plan VBP requirements to reflect the Health Care Payment Learning and Action Network (HCP-LAN) APM Framework (Figure V.2.1), and require the Health Plans to move toward more sophisticated VBP purchasing over the life of the contract with PCPs, hospitals, specialists, LTSS providers, and other provider types;
- Evolve pay-for-performance models to reward Health Plans for providing high quality care and access to services and move them towards more outcome-based performance and population metrics;
- Research other managed care VBP models such as accountable care organizations, global payments, and other health models and consider the inclusion of these models within Hawaiʻi's healthcare delivery system.

Alternative Payment Model (APM) Framework

The Alternative Payment Models (APM) Framework (Figure V.2.1) is a payment model classification system developed by CMS and later modified and refined by the Health Care Payment Learning & Action Network (HCP-LAN). The classification framework allows for monitoring of progress towards person-centered care and health payment reform and away from FFS payments. This framework represents payments from public and private payers to provider organizations, which includes payments between the payment and delivery arms of health systems. It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in APM models across different categories involving shared financial risk and population-based payments (*Updated APM Framework*, 2017). The APM Framework establishes a common pathway for measuring and sharing successful payment models. The Framework includes the categories identified in Figure V.2.1.

Figure V.2.1. Alternative Payment Model (APM) Framework



CATEGORY 1

FEE FOR SERVICE – NO LINK TO QUALITY & VALUE

CATEGORY 2

FEE FOR SERVICE – LINK TO QUALITY & VALUE

A

Foundational Payments for Infrastructure & Operations

(e.g., care coordination fees and payments for HIT investments)

B

Pay for Reporting

(e.g., bonuses for reporting data or penalties for not reporting data)

C

Pay-for-Performance

(e.g., bonuses for quality performance)

CATEGORY 3

APMS BUILT ON FEE -FOR-SERVICE ARCHITECTURE

A

APMs with Shared Savings

(e.g., shared savings with upside risk only)

B

APMs with Shared Savings and Downside Risk

(e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)

3N

Risk Based Payments NOT Linked to Quality

CATEGORY 4

POPULATION – BASED PAYMENT

A

Condition-Specific Population-Based Payment

(e.g., per member per month payments, payments for specialty services, such as oncology or mental health)

B

Comprehensive Population-Based Payment

(e.g., global budgets or full/percent of premium payments)

C

Integrated Finance & Delivery System

(e.g., global budgets or full/percent of premium payments in integrated systems)

4N

Capitated Payments NOT Linked to Quality

Source: *APM FRAMEWORK. (2017). Health Care Payment Learning & Action Network. Retrieved June 20, 2023, from https://hcp-lan.org/apm-framework/*

This report aims to gather information on payment models used by MQD at the Health Plan level, and by Health Plans at the provider level, in the state of Hawaiʻi during 2020 and 2021 as reported by MQD and Health Plans respectively. MQD hypothesized that the adoption and use of VBP arrangements will align Health Plans and their providers with health system transformation objectives and lead to overall improvements in quality, outcomes, and lowered expenditures (MQD, 2017).

This evaluation serves as an initial overview of the current state of VBP arrangements and the progress made towards VBP-focused APM categories for Health Plans and healthcare providers in Hawaiʻi. For this evaluation, a demonstration objective, hypothesis, key evaluation projects, and two VBP project-based research questions were developed. Existing arrangements were measured at both the healthcare provider and managed care organization levels for VBP, and APMs were evaluated at the provider level.

- Hypothesis: Implementing APM at the provider level and VBP reimbursement methodologies at the Health Plan level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.
    - Project 2A: VBP reimbursed at the Health Plan and Provider levels.
    - Project 2B: APM at the Provider level.

The VBP hypothesis serves the "triple aim" of better health, better care, and sustainable costs – the primary focus of the 1115 waiver demonstration renewal, as well as a core tenet of the HOPE Initiative.

Table V.2.1. VBP Original Research Questions

VBP Original Research Questions
RQ 2A.1: Will implementing VBP reimbursements at the Health Plan level result in improved health outcomes? RQ 2A.2: Will implementing VBP reimbursements at the Health Plan level result in lowered utilization of the healthcare system and slower rate of expenditure growth? RQ 2B.1: Will implementing one or more APMs at the provider-level result in improved health outcomes? RQ 2B.2: Will implementing one or more APMs at the provider-level result in lowered utilization of the healthcare system and slower rate of expenditure growth?

Evaluation Approach

The HOPE initiative has increased attention to VBP in Hawaiʻi's Medicaid program. Across states, vanishingly few examples demonstrate methods to monitor and evaluate VBP in alignment with the APM framework. MQD implemented a new VBP report for its Health Plans as part of the new managed care contract and released it in 2021. Therefore, the development of the data collection tool and work with Health Plans to collect this data is novel and continues to be strengthened iteratively. The developmental stage of the collaboration between Health Plans and MQD caused some methodological and logistical limitations in assessing the effectiveness of individual arrangements reported by the Health Plans. This limited our ability to fully assess the originally posed research questions (Table V.2.1.) but allowed us to gain valuable descriptive insights reported within this evaluation. As such, description, commentary and narrative information was provided by Health Plans on the implemented VBP arrangements in 2020, as 2021 Health Plan reporting was not completed in time for this evaluation report.

The primary goal of the evaluation was to demonstrate the extent to which VBP and APM arrangements are implemented across Hawaiʻi's Medicaid program, as well as show the progress of these programs towards reaching a higher category of value-based care in the APM framework. Future research efforts will include assessment of health outcomes for members included in VBP arrangements.

First, this evaluation report provides descriptive information on how MQD implemented VBP methodologies at the Health Plan level, including: 1) descriptive information on the VBP approaches employed by MQD with its managed care Health Plans; and 2) evaluation of how Health Plans perform in accordance with these set approaches.

MQD provided information on the implemented methodology, and the calculations that form the base for its pay-for-performance (P4P) program. Additional information was derived from memos released by MQD on MQD's P4P plan and Auto-assign program to Health Plans (MQD memoranda CCS-2309, QI-2307, QI-2220A; and QI-2207).

Next, this evaluation report provides descriptive information on VBP arrangements with providers reported by the Health Plans for CY2020, including: 1) an overview of where the various arrangements are classified within the APM framework; and 2) a report of bonus payments made to providers that were involved with implemented arrangements to supply an indication of the extent and successes of value-based arrangements in Hawaiʻi.

Health Plans reported on their implemented alternative payment methods in CY2020, which are summarized descriptively in the section below. The descriptions of these initiatives were provided directly by the Health Plans; thus, some inconsistencies exist in the reporting on the arrangements and how providers attributed to each individual arrangement were determined.

To gain some insight into possible differences in health outcomes of members who were attributed to a provider we posed the following question:

What is the difference in ED visits between members who are attributed to a provider participating in a VBP arrangement and those who are not?

The count of ED visits was selected as an outcome measure as it is closely related to improved primary care and timely care, and the majority of VBP agreements reported were tied to primary care in some way.

Data sources

Health Plans reported on members who were attributed to one or more VBP arrangements in 2020. Using the unique member Medicaid IDs provided, we merged this data with measurement year 2020 encounter data extracted from MQD's HPMMIS system.

One health plan additionally included members who were attributed exclusively to FFS arrangements. Members from one health plan were excluded from the analyses as no data on their member attribution was provided. After matching members across data sets, we were able to derive a final dataset consisting of 287,976 unique members; this dataset was further limited to adults over the age of 19 years with continuous enrollment in Medicaid in 2020 to arrive at the final dataset for analysis.

Independent variable

The independent variable used was attribution to any primary care VBP program. From the description of VBP programs provided through Health Plan report, we identified VBP programs aimed at primary care as indicated in Table V.2.7. We operationalized the independent variable as a dichotomous indicator (0= no attribution to a primary care provider participating in a VBP program, 1= attribution to a primary care provider participating in a VBP program).

Dependent variable

The outcome variable was the number of ED visits.

Analyses

We conducted a multivariate Poisson Regression analysis to identify differences between the two groups with regard to ED visits as outcome variable. We included sex, race/ethnicity, and age as covariates. Age was included as a continuous variable.

Results

MQD implemented three strategies to incentivize Health Plans to focus on improving quality and maintaining costs for their Medicaid members 1) health plan capitation; 2) The Health Plan Pay for Performance Program (P4P program); and 3) the member auto-assignment program with a quality component.

Health Plan capitation payments

Contracts between MQD and the Health Plans are based on a capitated arrangement. Health Plans are paid a PMPM rate based on patient eligibility characteristics. As Health Plans are paid a set dollar amount per member, Health Plans benefit from reducing costs incurred per member. As such, capitated payments incentivize Health Plans to lower volume of care and reduce high costs services. In theory, Health Plans may achieve this by investing in primary care and prevention to reduce future high-cost treatments for their members. The base PMPM payment does not include quality performance measures but does include efficiency adjustments focused on quality such as assumptions that Health Plans will proactively address and reduce polypharmacy.

Health Plan P4P program

MQD has employed a P4P program for its Health Plans since 2015. A withhold arrangement is implemented by MQD whereby a percent of the Health Plans' capitation payment is withheld by MQD. Upon meeting performance targets on selected outcome measures, Health Plans are able to earn back a portion or all of their withheld payment.

The amount that is withheld is based upon the distribution of members across major capitation groups (Family and Children, Expansion, ABD Dually Eligible, ABD – Medicaid Only) within each Health Plan. In 2020, $20,477,801 was withheld and available for Health Plans to earn back based on their performance on specific quality measures.

MQD worked with a national consultant to develop the P4P methodology. The methodology used to evaluate performance and calculate Health Plan earnings has evolved since 2015, but generally focused on meeting National Committee for Quality Assurance (NCQA) Quality Compass national Medicaid targets and rewarding Health Plans for closing gaps in performance even when targets have not been met. The most recent significant revision to methodology occurred in 2021. HEDIS measures used in the P4P program are announced to Health Plans prior to the beginning of the measurement year, and weights are assigned to measures varying by Health Plan, depending on the Health Plan's membership composition. As an example, measures may be weighted differently for a Health Plan with more children and young adults compared to one with a greater prevalence of ABD members. All HEDIS data used in P4P calculations are audited by MQD's External Quality Review Organization (EQRO). The calculation of the payout is based on the Health Plan's performance relative to NCQA Quality Compass benchmarks for the same measure. NCQA Medicaid Quality Compass benchmark are set nationally for HEDIS Measures. Levels are determined based on the Medicaid Population specifically.

Health Plans are eligible to earn a portion of their withhold for a given measure if they meet at least the 25th percentile for the measure. The gap between performance on the measure between the 25th and 50th percentile is divided into thirds; and the gap between performance on the measure between the 50th and 75th percentile is divided into sixths. Taken together, the range from the 25th to 75th percentile includes ten benchmarks, and meeting each progressive benchmark earns the Health Plan another 10% of the withhold. Health Plans that exceed the 75th percentile are eligible for bonus payments up to the maximum withheld amount. In 2023, MQD introduced a new, bonus-based P4P program for its CCS Health Plan based on a similar method. No performance data exists yet on the new program.

Box V.2.1. ***Selected 10 performance measures in 2023***

1. Childhood Immunization Status (CIS-CH)
2. Child and Adolescent Well-Care Visits (WCV)
3. Well-Child Visits in the first thirty months of life (W30)
4. Prenatal and Postpartum Care (2017 PIP): Timeliness of Prenatal Care (PPC-AD)
5. Prenatal and Postpartum Care (2017 PIP): Postpartum Care (PPC-AD)
6. Asthma Medication Ratio (AMR)
7. Comprehensive Diabetes Care (CDC): HbA1c Control (<8%)
8. Plan All-Cause Re-Admissions (PCR-AD)
9. Follow-Up After Hospitalization for Mental Illness (FUH-AD)
10. LTSS 2 - Comprehensive Care Plan and Update

Health Plan P4P achievements

Table V.2.2. shows Health Plan P4P earnings between 2016 and 2020. In summary, Health Plans vary widely regarding meeting quality targets. For instance, in 2016, Health Plan 1 achieved 30.0% of total P4P awards, while Health Plan 3 achieved 100% of the P4P awards. In 2020, differences between health plans were markedly smaller, with Health Plan 1 achieving 53.5% of P4P rewards, while Health Plan 3 achieved 93.5% of P4P awards. On average, P4P awards increased from 46.3% in 2016, to 67.7% in 2020.

To note, over the years, some performance measures were changed, and minor methodological changes were made. Table V.2.2. indicates withhold earnings based on performance against national benchmarks which are adjusted and updated every year.

Table V.2.2. P4P Awards Achieved by Health Plans 2016–2020

	2016	2017	2018	2019	2020
	P4P award Achieved %	P4P award Achieved %	P4P award Achieved %	P4P award Achieved %	P4P award Achieved %
Health Plan 1	30.0%	28.4%	33.8%	49.1%	53.5%
Health Plan 2	46.9%	44.7%	51.3%	46.3%	72.3%
Health Plan 3	100.0%	87.5%	100.0%	100.0%	93.5%
Health Plan 4	2.6%	33.3%	39.4%	37.6%	59.7%
Health Plan 5	72.6%	61.7%	55.1%	62.6%	69.3%
Total	46.3%	46.0%	51.1%	52.2%	67.7%

Note: the data in this table are derived from calculations made by MQD

New member auto-assignment program with a quality component

Every month, MQD enrolls a number of new members into Medicaid, and these new members are assigned to a Health Plan following a distribution algorithm. Generally, members are assigned to the Health Plan of their choice, their prior Health Plan if they were previously enrolled in Medicaid or enrolled into the same plan as their family members. New members who don’t meet these criteria are subject to MQD’s auto assignment algorithm; in 2020, MQD auto-assigned approximately 93,000 members.

Quality component

To incentivize health plans to improve their quality, MQD rewards health plans with a larger proportion of auto-assigned new members if they achieve higher quality metrics than the other plans.

Health plans are ranked on their performance on four selected health outcome measures. Table V.2.3 shows the measures used to evaluate auto-assignment for 2023 and the changes that will be applied for the years 2024–2026. The plan that has the highest total ranking for all measures will receive the highest overall ranking. The overall ranking is used to determine the percentage of the total quality portion of the auto-assign allocation that will be attributed to the Health Plan. Auto-assignment allocates 30% of new enrollees equally amongst Health Plans. The quality component determines 70% of the auto-assignment. Of that 70%, 40% is assigned to the first ranked plan, 30% to the second and 15% to the third, 10% to the fourth and 5% to the fifth. Adjustments are made as needed for geographic regions with fewer than five Health Plans operating.

Table V.2.3. Measures used to determine quality ranking among Health Plans

Measures used in 2023	Measures to be used in 2024-2026
1. Prenatal and Postpartum Care (PPC), Timeliness of Prenatal Care 2. Follow-Up After Hospitalization for Mental Illness (FUM), within seven (7) days of discharge 3. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Getting Needed Care 4. Early and Periodic Screening Diagnosis and Treatment (EPSDT) Participant Ratio	1. Child & Adolescent Well-Care Visits, Total, 3-21 years 2. Controlling High Blood Pressure, 18-64 years 3. Initiation and Engagement of Alcohol and Other Drug Use or Dependence Treatment, Engagement, Total, 18+ years 4. Screening for Depression and Follow-Up Plan, Adults, 18+ years

In 2023, the quality-based auto-assignment distribution amongst health plans is as described in Table V.2.4.

Table V.2.4. Current distribution of auto-assignment of new Medicaid members

Health Plan Rank	% of allocated members for 5 competing plans	% of allocated members for 4 competing plans
1	36.0%	37.0%
2	21.0%	28.0%
2	21.0%	21.0%
4	13.0%	14.0%
5	9.0%	-
Total	100%	100%

Implemented VBP and APM Arrangements by Health Plans in CY2020

In 2020, Health Plans implemented a total of 18 VBP arrangements. Table V.2.5 indicates the initiatives implemented by Health Plan and the category of the APM Framework.

In summary, Health Plan 1 implemented three category 2 initiatives: rewarding achievement on select performance measures (P4P) and successful completion of reporting on other measures (P4R) with a bonus payment; one category 3 APM built on FFS architecture, and one initiative utilizing population-based payments in category 4. Health Plan 2 implemented two initiatives on level 4 of the APM framework, incorporating population-based payments. Health Plan 3 implemented one initiative at category 2 of the framework, providing P4R bonus payments for reporting quality measures, and one initiative using population-based payment at level 4 of the APM framework. Health Plan 4 implemented three initiatives using FFS incorporating a bonus for reporting and quality improvement; and two initiatives using population-based payments. Finally, Health Plan 5 implemented two initiatives that provided bonus payments based on quality improvements within FFS payment structures; one initiative on level 3, and one initiative applying population-based payments (see Table V.2.5).

Table V.2.5. Initiatives Conducted at Each Category of the APM Framework, 2020

	APM Category		
	2. FFS Link to Quality & Value	3. APMs Built on FFS Architecture	4. Population-Based Payments

Total number of initiatives	***n=9***	***n=2***	***n=7***
Health Plan 1	3	1	1
Health Plan 2			2
Health Plan 3	1		1
Health Plan 4	3		2
Health Plan 5[a]	2	1	1

Notes: PCP = Primary Care Provider

[a] Health Plan 5 reported initiatives that do not incorporate VBP methodology, but reimburse for needed care on a case bases including the: Waimanalo Health Center - Traditional Methods of Healing Program that compensates Hawaiian health methods; Hawaiʻi Care Choices - Palliative Care/Kupucare Program that reimburses palliative care; Paniolo Pediatrics and Family Medicine - Case Rate that reimburses EPSDT E&M codes on preventative care rates.

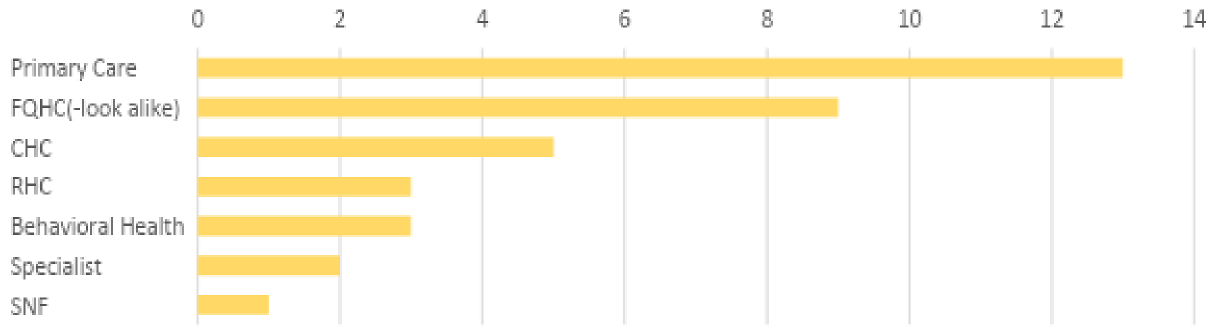
[b] Some initiatives operate multiple payment methodologies at the same time. Initiatives were organized in this framework in line with the initiative's highest qualifying level.

Providers Included in Bonus Payments

In total, 18 VBP initiatives were implemented by the Health Plans collectively, of which six were implemented for a single provider type (primary care providers) and 12 initiatives were implemented for multiple provider types. Primary care practices were most frequently targeted by Health Plans for implementation of VBP and AMP models, followed by FQHCs and CHCs. Figure V.2.2 illustrates the number of initiatives targeted at different provider types.

Health Plans reported that a total of 1,091 providers were included in VBP and APM arrangements.

Figure V.2.2. Provider Types Targeted by Initiatives in 2020



Health Plans described different levels of diffusion of their VBP arrangements. Health Plan 1 included 254 unique providers participating in VBP arrangements out of 2,437 contracted providers; Health Plan 2 reported 648 providers to be included in VBP arrangements; Health Plan 4 reported 474 providers participating in VBP programs; Health Plan 5 included 246 out of 409 providers in VBP programs; and Health Plan 3 reported 4 large provider organizations to be reimbursed through VBP (no individual providers were reported for CY2020). Most plans reported information on the bonus or incentive payments to their providers for reporting or meeting quality goals.

In total, the 1,091 participating providers earned $7,097,064.50 in incentive payments in 2020. Table V.2.6 indicates the number of providers included VBP arrangements by Health Plan and paid incentive or bonus payments per Health Plan. Aside from bonus payments, some providers were levied downside risk or penalties to a total amount of $4,548,707.34.

The majority of VBP arrangements were aimed at primary care providers: VBP programs in Health Plan 1 included 218 primary care providers; Health Plan 2 included 533 primary care providers; Health Plan 4 included 470 primary care primary care providers, and Health Plan 5 included 197 primary care providers. Of note, there is overlap between contracted providers across different health plans.

Table V.2.6. Number of Providers Included in Alternative Payment Methodologies and Additional Payments Made, 2020

Health Plan	Number of Providers in VBP arrangements	Incentive or Bonuses Payments	Penalties/Downside Amount Assessed
Health Plan 1	267	$3,431,484	$0
Health Plan 2	816	$2,072,161	$9,892
Health Plan 3	4	$134,155	$0
Health Plan 4	795	$564,215	$0
Health Plan 5	280	$895,050	$4,538,815
Total	**2162**[a]	**$7,097,065**	**$4,548,707**

Notes: [a] Health Plan 3 did not report on the total number of individual providers within the care provider organizations in CY2020. The total number of providers in VBP arrangements excludes Health Plan 3 providers.

Table V.2.7 demonstrates an overview of alternative payment methods implemented by the Health Plan, as well as what type of payment was used, including if quality metrics were used as a basis for incentive or bonus payments. Most initiatives used selected HEDIS measures to determine any performance payments or track quality of care provision. Some initiatives that were not linked to quality did not include performance measures.

Table V.2.7. Summary of Alternative Payment Methods Key Features, 2020

	Framework level	Name of Initiative	VBP Provider Type(s)	Payment Methodology	Quality Measures
Health Plan 1	2C	Pay-for-Performance	Primary Care, FQHC look- alike/RHC, Behavioral Health	FFS (PPS for FQHC look- alike/RHC)	Selected HEDIS quality measures
	3N	Risk-based Payments Not Linked to Quality	FQHC/CHC	FFS (PPS for FQHC/CHC/RHC) and upside risk pool payment.	NA

	4N	Population-based Capitated Payments Not Linked to Quality	Primary Care, Specialty	PMPM	Selected HEDIS quality measures
	2B-2C	QPP – Quality Payment Program Linked to Quality	FQHCs/CHCs	P4R; P4P	Selected HEDIS measures; SDOH and telehealth utilization reporting
	2B-2C	Special Quality Project- Follow-up After Hospitalization	Behavioral Health (specific Provider)	P4R; P4P	HEDIS FUH
Health Plan 2	4A	Primary Care Payment Transformation Model	Primary Care	PMPM; P4P	Selected HEDIS quality measures
	4A	Federal Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Pay-for-Quality Program	FQHC/CHC/RHC	PMPM; P4P	Selected HEDIS quality measures
Health Plan 3	2A	SIBRP—Skilled Nursing Facility & Intermediate Care Facility Bonus Recognition Program	SNF	CMS PDPM (Patient Driven Payment Model)	Select reporting and quality measures
	4N	Contractual capitated payment arrangement with Hawaiʻi Permanente Medical Group ("HPMG").	Primary Care, Specialty	PMPM Capitation	KFHP, Health Plan 3 Foundation Hospitals and HPMG quality measures
Health Plan 4	4A	FQHC Administrative Payments	FQHC/PCP	PMPM Capitation	NA
	4A	Patient Centered Medical Home payment to PCPs	PCP	PMPM Capitation	NCQA rating 1, 2, 3
	2B	SDOH Payments based on "Z" Codes on PCP claims	PCP and FQHC	P4R	NA
	2B	Continuity of Care Program	PCP and FQHC	P4R	NA
	2C	Adolescent Well Visit	PCP and FQHC	P4R	Yes
Health Plan 5	3A	ACO – Accountable Care Organization	FQHC/CHC/RHC, Primary Care	Shared Savings PMPM	Selected HEDIS quality measures
	2C	Medicaid – CP PCPi	Primary Care	P4P	Selected HEDIS quality measures
	2C	Behavioral Health – Follow Up After Hospitalization (FUH)	Behavioral Health	P4P	7 day FUH
	4A	ACO – Accountable Care Organization (CIP Agreements)	FQHC/CHC/RHC, Primary Care	PMPM; P4P	NA

Notes: PCP = Primary Care Provider, FQHC = Federally Qualified Health Center, CHC = Community Health Center, RHC = Rural Health Center, FFS = Fee for Service, SDOH = Social Determinants of Health, PPS = Prospective Payment System, FUH = Follow Up after Hospitalization, P4P = Pay for Performance , PMPM = Per Member Per Month

Description of Key Features Per VBP / APM Arrangement

In the following section, summaries of the VBP arrangements implemented by the Health Plans are described. These summaries are distinguished by the APM categories across the five Health Plans.

1) APM Category 2 (Fee-for-Service – Link to Quality & Value)

Four of the five Health Plans included initiatives that fall under the second APM category.

Health Plan 1

- Pay-for-Performance (2C): This initiative is available to primary care providers, FQHC look-alikes, RHCs and behavioral health providers. The providers involved in this arrangement receive FFS payments. In addition, they can participate in the program to receive additional bonuses for performance on meeting quality standards for selected Health Plan 1 beneficiaries with higher needs. Performances were rated with the following two items: 1) the NCQA HEDIS MY21 Medicaid Benchmarks and 2) the current measure period rates. The methodology was redesigned over the course of 2020, after which Health Plan 1 implemented a renewed VBP program with links to quality and value which it began to offer in 2021.

- Quality Payment Program (QPP) Linked to Quality (2B-2C): This program was developed in collaboration with MQD to provide supplemental financial support to FQHCs affected by pandemic-response stay-at-home orders during the months of March, April and May 2020. Performance metrics selected to determine payment included care gap closures for specific HEDIS quality metrics, SDOH reporting, and supporting telehealth capability and utilization. The program was limited to CY2020.

- Special Quality Project- Follow-up After Hospitalization for Mental Illness (FUH; 2B-2C): This pilot was implemented as a pay-for-performance program with a contracted behavioral health provider. The goal of the pilot was to improve the HEDIS measure FUH – follow-up visit within 7 days following discharge from a behavioral health acute inpatient stay. Health Plan 1 noted performance increases in its FUH rate subsequent to implementing this program.

Health Plan 3

- Skilled Nursing Facility & Intermediate Care Facility Bonus Recognition Program (SIBRP; 2A): Skilled Nursing Facilities (SNFs) and Intermediate Care Facilities (ICFs) supply payments to providers that accept members with challenging and complex cases to decrease the number of members that would otherwise end up in inpatient care. SNFs and ICFs receive a one-time incentive payment for accepting a member who does not yet have Medicaid coverage. While HEDIS and other quality metrics are tracked for the participating facilities, the payment does not depend on quality improvement. Four SNFs participated in this program.

Health Plan 4

- SDOH Payments Based on "Z" Codes on PCP claims (2B): PCP and FQHC providers are provided annual payments per “Z” code per member per quarter for previous years based on an analysis of the providers’ administrative claims. This initiative therefore provides additional payments for at-risk populations through increased PMPM payments. Health Plan 4 self-evaluated that the initiative had low provider participation.

- Continuity of Care Program (2B): PCP and FQHC providers are paid a bonus incentive based on each risk adjustment form completed and claims coding/payment. Health Plan 4 self-evaluated that the initiative had medium provider participation. The incentive program is a pay for reporting initiative.
- Adolescent Well Visits (2C): Organizes payment for providers based on performance measures. Additionally, providers are paid based on claims, encounters, and supplemental data per member per measure closure. Health Plan 4 self-evaluated the program to have medium provider participation.

Health Plan 5

- Medicaid - CP PCPi (2C): A quality incentive aimed at PCPs that is based on HEDIS measures aligned with MQD's P4P program. PCPs are eligible to receive quarterly incentive payments if they reach HEDIS quality targets. Health Plan 5 identified several challenges to the achievements of targets that include: unestablished patients, lack of resources from providers, and lack of member adherence. Health Plan 5 self-evaluated that the program is successful in creating partnerships with providers to achieve quality targets.

- Behavioral Health - Follow Up After Hospitalization for Mental Illness (FUH; 2C): Provides an incentive for 7-day FUH limited to Medicaid members. All PCPs are eligible for the quality incentive payment to providers based on reaching quality targets built on HEDIS measures.

2) APM Category 3 (APMs Built on Fee-For-Service Architecture)

Two of the five Health Plans included initiatives that fall under the third APM category.

Health Plan 1

- Risk-Based Payments Not Linked to Quality (3N): Providers at FQHCs and CHCs had contracts that included a mix of PPS rates and contract-negotiated rates. Providers were paid within an upside risk sharing arrangement with no link to quality. The FQHC/CHC received a risk pool payment if its calculated medical loss ratio, after factoring in Incurred but not Reported (IBNR) payments, was not negative. The program does not include downside risk sharing. The methodology was improved over the course of 2020, after which Health Plan 1 implemented a renewed VBP program with links to quality and value that they started to offer in 2021.

Health Plan 5

- Accountable Care Organization (ACO; 3A): A PCP-focused incentive program that bestows quarterly or yearly incentive payments to providers who participate. Providers who meet the quality measures are eligible for shared savings. The proportion paid out of the shared savings pool is made based on the extent to which quality measures are met. Payments to providers (payments to FQHCs, CHCs, RHCs, and primary care focused incentive, or payments that are quarterly or yearly) must meet a minimum of three quality measures to be eligible for shared savings pool. Shared savings pool percentage eligibility is determined by the amount of quality measures met. Health Plan 5 self-evaluates that generally, the ACO program is successful in creating valuable partnerships in reducing the overall spend of ACO and focusing on the high-risk patients in efforts to reduce utilization in ED/hospitals and ensure that necessary care is provided to these patients.

3) APM Category 4 (Population-Based Payment)

Each of the five Health Plans included initiatives that fall under the fourth APM category.

Health Plan 1

- Population-Based Capitated Payments Not Linked to Quality (4N): The population-based, capitated payments not linked to quality reimbursed primary care and specialty providers based on a negotiated capitated PMPM rate. While the program does not include a link to quality, participating providers were also eligible for the pay-for-performance program. Only one clinic was reported to be part of the capitated arrangement at the time of reporting. This program included a comprehensive population-based payment.

Health Plan 2

- Primary Care Payment Transformation Model (4A): This program was started in 2016 and based on a value-based reimbursement model with the aim to shift from FFS to a global, monthly payment methodology. Health Plan 2 reported that healthcare providers involved in the payment transformation model receive compensation based on a value-based approach, where their payments are influenced by two main factors: the quality of care they deliver and the utilization of primary care services by their patients. Additionally, physician organizations are evaluated on their capacity to effectively control the overall cost of care for each patient as well as the quality of care provided.

- Federal Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Pay-for-Quality Program (4A): Health Plan 2 has been operating a Pay for Quality program for FQHCs and RHCs since 2011. Health Plan 2 reported that it is evaluating the program in collaboration with the providers to develop quality incentives that account for the services and support they provide to the community. Providers are paid a PMPM rate for engagement and quality metrics following HEDIS specifications.

Health Plan 3

- Contractual Capitated Payment Arrangement with a multispecialty group practice ("HPMG"; 4N): Health Plan 3 contracts with HPMG, primary care and specialty care physicians, on a capitated basis that incorporates overall quality improvement targets. HPMG providers are paid on a PMPM capitation basis. HPMG shares in potential net gains if certain quality metrics are met. This arrangement describes the general integrated payment structure operated by Health Plan 3.

Health Plan 4

- FQHC Administrative Payment (4A): FQHCs were paid fees in support of enhanced care coordination and EMR data integration. Payment was made on a PMPM capitation basis. One provider participated in the program at the time of reporting. The program was implemented with no link to quality.

- Patient Centered Medical Home Payment to PCPs (4A): Implemented to support primary care. PCPs are paid based on their NCQA rating. Moreover, PCPs receive a higher PMPM for opening their panels (i.e., accepting new patients).

Health Plan 5

- Accountable Care Organization (ACO; 4A): Provides a monthly PMPM payment to providers based on meeting selected ACO metrics. The ACO is evaluated through a performance score board. Providers are rated on reductions in ED and hospital utilization, reduction in avoidable ED visits, improvements in access to care, and improvements in the health of high-risk patients. The Health Plan stated challenges including the inclusion of unestablished patients and the lack of available resources from its ACO. The Health Plan found through evaluation that the ACO program was successful in creating valuable partnerships in reducing the overall spend and focusing on high-risk patients in efforts to reduce utilization of ED/hospitals and ensure that necessary care is provided to patients.

Quantitative analyses results

In total, 149,330 adults aged 20 and over were included in the analysis; 76.1% (n=113,629) members were attributed to a primary care provider who participated in any VBP program, and 23.9% (n= 35,701) of our sample was not attributed to a primary care provider in a VBP program.

Table V.2.8. Sample Characteristics

	N	%
VBP attribution		
Attributed to VBP provider	113629.00	76.1%
Not attributed to a VBP provider	35701.00	23.9%
Sex		
Male	66711.00	44.7%
Female	82589.00	55.3%
Not defined	30.00	0.0%
Race/Ethnicity		
Non-Hispanic White	31175.00	20.9%
American Indian/Alaskan native	2923.00	2.0%
Black	2643.00	1.8%
Chinese	13291.00	8.9%
Filipino	23987.00	16.1%
Hawaiian (include part Hawaiian)	23236.00	15.6%
Japanese	7943.00	5.3%
Other Asian	7115.00	4.8%
Other pacific islander	8019.00	5.4%
Other	12842.00	8.6%
Unspecified	16145.00	10.8%
	Mean	***SD***
Age	46.33	16.6

As shown in Table V.2.9, we found no difference in ED visits between members attributed to a primary care provider who participated in a VBP arrangement (p = 0.78, CI 0.39–0.41).

Table V.2.9. Poisson regression VBP attribution associated with ED visits

	B	SE	p-value	Exp(B)	95% CI
VBP attribution					
Attributed to VBP primary care provider (reference)					
Not attributed to a VBP primary care provider	0.00	0.01	0.78	1.00	(0.98, 1.02)
Sex					
Male (reference)					
Female	-0.03	0.01	0.00	0.96	(0.96, 0.99)
Not defined	-2.48	1.00	0.01	0.08	(0.01, 0.59)
Race/Ethnicity					
Non-Hispanic White (reference)					
American Indian/Alaskan native	0.22	0.03	0.00	1.25	(1.19, 1.31)
Black	0.43	0.02	0.00	1.54	(1.47, 1.61)
Chinese	-0.39	0.02	0.00	0.67	(0.65, 0.70)
Filipino	-0.28	0.01	0.00	0.76	(0.74, 0.78)
Hawaiian (include part Hawaiian)	0.18	0.01	0.00	1.19	(1.17, 1.22)
Japanese	-0.23	0.02	0.00	0.80	(0.77, 0.83)
Other Asian	-0.62	0.02	0.00	0.54	(0.51, 0.56)
Other pacific islander	0.27	0.02	0.00	1.32	(1.27, 1.36)
Other	-0.08	0.02	0.00	0.92	(0.89, 0.95)
Unspecified	-0.29	0.02	0.00	0.74	(0.72, 0.77)
Age	0.00	0.00	0.00	1.00	(1.00, 1.01)

Conclusions and Recommendations

MQD employs multiple methods to achieve improved attention to quality outcomes for its Medicaid population. These methods include VBP programs implemented by MQD as well as those implemented by Health Plans. We found that Health Plans are performing increasingly well with regard to MQD's P4P program. Whereas in 2016 Health Plans had an average achievement level of 46.3%, their P4P performance increased to 67.7% in 2019, 87.4% in 2020, and 63.5% in 2021. It should be noted that the high level of achievement in 2020 may be attributed to some ad-hoc adjustments MQD implemented to the program during the first year of the pandemic. It is encouraging that Health Plans seem to have increasingly high levels of achievement, given that their performance is assessed in comparison to national benchmarks. In theory, these higher levels of achievement reflect improved performance by providers and improved health outcomes for participating members. However, P4P performance should be interpreted with caution. The influx of new members during the course of the COVID-19 pandemic with less complex health issues and generally higher health outcome levels may have impacted the average improvement in health outcomes and thus the achievement on the P4P measures. Moreover, it should be noted that the changes in improvement are relative to the national Medicaid benchmark, and do not represent absolute improvements in health outcomes for Medicaid members.

Beyond MQD's P4P programs, Health Plans have several programs in place aimed at improving health outcomes in line with MQD intentions. Our results indicate that most Health Plans still focus on VBP arrangements that are based on an FFS payment structure, with only two initiatives incorporating risk-based payments. The programs vary widely in scope, structure, and covered provider/member populations, making them difficult to evaluate as a whole. Seven arrangements include population-based payments, specifically including PMPM payments. Other, population-based arrangements are generally aimed at adding additional payments for at-risk populations on top of the prevailing reimbursement model, and do not fully integrate population payments for the full patient population. Health Plan 1's Population-based Capitated Payments Not Linked to Quality initiative includes a global capitation payment for the entire provider population; however, only one provider is included in this program. On the other hand, Health Plan 3’s contractual capitated payment arrangement with a large group practice includes all provider types.

Our quantitative analyses indicate no difference exists in ED visits among adult members who are attributed to a primary care provider who participates in a VBP program versus members who are attributed to providers who do not participate in a VBP program. However, these findings are not surprising because the underlying VBP arrangements comprising our composite variable are diverse, non-comparable, and plausibly very different in their individual effectiveness. VBP programs across Health Plans may vary widely and focus on different health outcome measures. Some may be effective in improving a different specific health outcome (such as a follow up after hospitalization for mental illness, or depression screening), rather than result in a reduction of ED visits, which is an overarching outcome metric for primary care that may not be the target of the VBP program. Additionally, this analysis is limited to CY2020 data; therefore, this report represents a single snapshot of VBP arrangements focused on a highly atypical year, during which the world experienced a global pandemic. Future evaluation efforts will need to utilize VBP reports from additional calendar years to provide trends and longitudinal analysis of VBP arrangements and spending. The current analyses were conducted to encourage further, more detailed investigation into the effects of VBP programs, parsing specific programs and arrangements and looking at differentiating factors within each initiative.

Our descriptive results consequently indicate there is opportunity to further implement APMs with novel payment methodologies. MQD’s intention to shift payment methodology to a model with increased risk sharing is still in its early stages. Currently, limited evidence is available on the effectiveness of the implemented models in Hawaiʻi and their potential to increase quality and decrease costs. Moreover, pilots that expand PMPM payment models to cover the full population attributed to a provider, rather than a limited PMPM payment for specific patient populations, would provide further clarity on how to expand APMs for increasingly large population groups. Increased implementation of VBP or APM models will need to take into account any barriers experienced both by providers and Health Plans in Hawaiʻi.

The transition from traditional FFS focused on volume to a focus on value comes with barriers that impede and hinder implementation. Several challenges can be identified in the literature, including 1) lack of (data) system integration; 2) outdated practice workflows; 3) limited internal resources; 4) trouble attaining buy-in; 5) fragmented care delivery; 6) inaccessible clinical data; 7) elevated financial risk, and 8) changing policies and programs (Bartlett 2021, Agilon Health, 2022). Many of these difficulties may be framed as technology-facilitated barriers to successful implementation (Bartlett, 2021). Furthermore, McNulty (2023) discussed attribution as a challenge that arises in VBP. Patients are often attributed to a single provider to simplify reimbursement procedures; however, actual attribution has subjective aspects, as a patient may see multiple providers within a year, potentially confounding reimbursements (McNulty, 2023). McNulty proposes that patient assignment versus attribution may provide a more clear-cut path for contractual purposes and barriers to this problem with VBP, as patients select a PCP versus being assigned to a PCP by some established method (McNulty, 2023).

Hawaiʻi's provider shortage, discussed in several sections above, is ongoing, and the limited capacity of providers to implement new forms of quality reporting and improvements must be considered in communication between MQD, Health Plans and providers. In a recent systematic review of VBP arrangements in the United States published by Pandey et al. (2023), researchers found that higher intensity programs (those combining both non-financial and financial incentives, and involved risk sharing) resulted in higher quality improvements, whereas voluntary participation of providers in lower intensity programs (those programs that did not include a multitude of measures and risk sharing) was more prevalent (Pandey et al., 2023).

When taking steps towards higher intensity VBP structures, barriers to providers need to be carefully considered by MQD and Health Plans. In July 2020, only 24 VBP programs in the United States were evaluated and published in scientific-peer reviewed journals of which two were Medicaid-based VBP arrangements (Pandey et al. 2023). This indicates a knowledge gap in terms of how to best structure VBP models for Medicaid populations. Given the lacuna in evidence-based models, the opportunity for MQD and Health Plans to further investigate, develop, and refine existing arrangements may also provide fertile ground to innovate and adapt arrangements to best fit the needs of Hawaiʻi's Medicaid members.

MQD is currently focused on promoting primary care and increasing the provision of high value primary care services. This is in line with the priorities of VBP arrangements implemented by Health Plans, as the majority of VBP and APM arrangements focus on PCPs and FQHCs.

Health Plans reported that increasing VBP arrangements in the realm of primary care was their main method of increasing high value primary care services. A total of 1,019 primary care providers were reported to be part of an arrangement in 2020 (not considering Health Plan 3's providers).

MQD encourages Health Plans to tie Health Plan P4P program measures to provider-based VBP models and initiatives. As evaluators, we were unable to study the alignment between the Health Plan P4P program and the Health Plan VBP models at this time. Therefore, we plan to investigate how MQD's quality programs currently overlap with how Health Plans structure and implement their own VBP programs to determine if aligned initiatives result in greater impacts on quality as compared to unaligned initiatives. We recommend that Health Plans evaluate their arrangements in collaboration with MQD to test the benefits and challenges of each program, and how any such arrangements contribute to MQD's overall goal of improving quality while reducing costs. Given the novelty of this area, MQD may also benefit by establishing learning communities where Health Plans collaborate to build stronger VBP programs that leverage the strengths of specific programs, and seek to identify and eliminate weaknesses through shared learning.

Lessons Learned and Future Recommendations

It is clear that more insight is needed in regard to the VBP arrangements Health Plans have implemented. The evaluation team has reached out in coordination with MQD to schedule interviews and focused case studies to learn more about VBP arrangements and initiatives Health Plans have established, as well as successes and challenges to these arrangements and implementation. Currently, we have met briefly with one Health Plan and are scheduling a meeting to further discuss their VBP arrangements; an interview guide has been created by the evaluation team to serve as a framework for a semi-structured interview with all of the Health Plans. A more in-depth qualitative analysis may shed light on what has worked within these arrangements and create a framework for future VBP collaborations. The utilization of additional years of VBP data from Health Plans and qualitative insight into these arrangements from Health Plans will strengthen future VBP evaluations.

Project 3A: Community Integration Services (CIS)

Introduction and Background

To meet HOPE Initiative Objective 3, “support strategies and interventions targeting the social determinants of health,” MQD developed Community Integration Services. Community Integration Services (CIS) is a program including outreach, pre-tenancy supports and tenancy sustaining services for members who meet health needs-based criteria and who are experiencing homelessness or are at risk for experiencing homelessness (See Table V.3A.1). Research shows that people who experience homelessness and housing insecurity experience worse health outcomes compared to the general population (Stahre et al., 2015). Not only does homelessness exacerbate existing chronic physical and mental health conditions (Elder & King, 2019; Nikoo et al., 2014), but also homelessness is associated with an elevated risk of mortality (Gambatese et al., 2013). Individuals experiencing homelessness are frequent patients in emergency departments and often require inpatient stays and continued care upon release (Thompson et al., 2019; Thompson et al., 2021). Studies have shown that people who experience chronic homelessness (i.e., people with disabling health conditions who experience homelessness for long periods of time or repeatedly) have disproportionately high annual health care costs due to their extensive use of hospital facilities and emergency departments (Thompson et al., 2019; Thompson et al., 2021).

Table V.3A.1. CIS Eligibility Criteria

CIS Eligibility Criteria per Med-QUEST Memo QI-2105_CCS-2102

Members shall be eligible for CIS if they have:
1. At least one health need:
    - *Mental health need*: presence of a serious mental illness
    - *Substance use need*: has need for outpatient day treatment for substance use disorder (SUD) and was assessed to meet American Society for Addiction Medicine (ASAM) level 2.1
    - *Complex physical health need*: a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support)

AND

2. At least one homeless or homeless risk factor:
    - *loss of residence*
        - homeless (i.e., lacking a fixed, regular, and adequate nighttime residence)
        - at-risk for homelessness
            - written notification that residence will be lost within 21 days of the date of application for assistance; **and**
            - no subsequent residence has been identified; **and**
            - the individual does not have sufficient resources or support networks (e.g., family, friends, faith-based or other social networks), immediately available”)
    - history of frequent or lengthy *institutional stays and/or history of homelessness*
        - Two or more instances of homelessness in the past 12 months **OR**
        - One or more institutional stays that have lasted 60 days or more and member is transitioning out without a residence

(Memo QI-2105_CCS-2102)

In recognizing that housing is health care, MQD hopes to improve member health and decrease costs by addressing housing concerns through Medicaid supported housing services. When stably housed, people are no longer living in a state of emergency and are able to engage in preventative care, to store medicine properly, and to find comfort in a safe and clean environment (Lozier, 2019). In particular, through housing, CIS aims to 1) improve the health care status of beneficiaries; 2) minimize administrative burden by streamlining access to care for enrollees with changing health status; 3) promote independence and choice among beneficiaries to ensure appropriate utilization of the healthcare system; and 4) garner a slower rate of expenditure growth in managed care by decreasing utilization of acute services (emergency and inpatient utilization), increasing engagement in outpatient care services, and decreasing the total cost of care for CIS members.

To reach these aims, CIS includes services that help members (re)connect to housing and healthcare systems, to coordinate care for members with complex health needs, and to help members find stable housing. Billable support services during the evaluation period included:

- Outreach;
- Housing supports;
- Medical re-engagement and care coordination supports;
- QUEST (i.e. Medicaid) and other DOH program referral supports;
- Safety supports;
- Supports to address social risk factors;
- Financial assistance supports;
- Employment and housing readiness supports;
- reassessment and plan revision;
- Other services;
- Case management; and
- Other supports not identified elsewhere.

In 2022, Hawaiʻi was one of 29 states that offered Medicaid-supported housing services (CSH, 2022).

A. Local Context: Hawaiʻi's Homelessness and Homelessness Service System

For the last decade, Hawaiʻi has reported one of the highest homelessness rates in the United States. In 2022, Hawaiʻi ranked 4th behind California, Vermont, and Oregon in percent of the population experiencing homelessness, with 41.4 people per 100,000 experiencing homelessness statewide (USHUD, 2022). On a given night in January 2023, 6,223 people were experiencing homelessness in Hawaiʻi, and 12,855 people accessed homelessness services in 2022 on Oʻahu alone (Ka Mana O Na Helu, 2023; PIC, 2023). On Oʻahu, the numbers of unsheltered individuals (i.e., individuals not staying in emergency shelters or transitional housing), individuals over 60 years, and individuals with mental and physical health disabilities have been rising steadily since 2015 (PIC, 2023). These are populations likely to use the emergency department and to have complex health needs and for whom traditional shelters may be inappropriate.

Homelessness services in the State of Hawaiʻi are coordinated by two Continua of Care organizations, Partners in Care for Honolulu County (Oʻahu) and Bridging the Gap for Kauaʻi, Maui, and Hawaiʻi Counties. These collaboratives manage the Coordinated Entry Systems (CES), the Homelessness Management Information Systems (HMIS), and federal funding for their respective islands. Additionally, the State has two dedicated offices to homelessness. The State of Hawaiʻi Homeless Programs Office

(HPO) provides housing services and oversees state as well as some federal housing programs. The Statewide Office on Homelessness and Housing Solutions (OHHS) works with the Governor and his cabinet to develop housing policies and programs. It also coordinates the Hawaiʻi Interagency Council on Homelessness, which is the statewide homelessness planning and policy development council. These entities work together to coordinate services and to distribute funding to address homelessness in Hawaiʻi.

Direct services and housing for people experiencing homelessness or housing insecurity are typically provided by homeless service provider agencies. The state has over 50 homeless service providers (HSPs) on Oʻahu and over 20 on neighboring islands (State of Hawaiʻi HPO, n.d.). Many HSPs are small agencies that work collaboratively with each other and other social services agencies to meet client needs. CES refers people in need of housing services to HSPs. These "clients" are prioritized for housing programs based on their vulnerability assessed using the Vulnerability Index – Service Prioritization Decision Tool (VI-SPDAT) and placed on a "by name list". Those clients who score higher on the VI-SPDAT are placed higher on the list and prioritized for permanent supportive housing (PSH; i.e., programs that provide both a voucher for independent housing and intensive case management). On the other hand, those clients who score lower on the VI-SPDAT are placed lower on the list and are prioritized for less intensive services (e.g., rapid rehousing programs that provide short-term rental assistance but minimal or no case management). However, in practice, clients high on the list often receive less-intensive services due to lack of resources and limited space in PSH programs.

In recent years, HSPs have voiced concerns over lack of capacity to serve medically vulnerable clients, who often score highly on the VI-SPDAT and are prioritized for permanent supportive housing but are unable to live independently. They also struggle to care for high needs clients who qualify for permanent supportive housing but receive less-intensive services due to needs outweighing available resources. Similarly, medical providers have voiced concerns about treating patients with homeless histories (Terrell, 2023).

B. CIS Pilot

In 2021, MQD collaborated with the five Health Plans and the two largest homelessness service agencies in the state to implement a pilot CIS program to serve members with complex health and housing needs. These agencies agreed to accept 20 members from each Health Plan, with a total of 60 members per provider enrolled at any one time. An internal MQD team met weekly to discuss the pilot for the first half of the pilot year. Additionally, the Health Plans met with the MQD team and participating pilot agencies regularly to assess what was working and what, if anything, needed to be adapted in order for the program to succeed. The intention was to create a "best practices" guide based on lessons learned during this pilot in order to help with a smooth transition into use by other HSPs. To our knowledge, this manual was not created, and meetings ceased in mid-2022. The evaluation team assembled providers from participating agencies to subsequent rapid-cycle assessment (RCA) meetings (discussed below) to present findings from their projects. HSP participation in RCAs allowed HSPs to receive updates on program policies and reporting and to inform MQD and Health Plans about implementation challenges and successes on the ground. The two homelessness service agencies continued to provide CIS services beyond the pilot period and had served the majority of enrolled CIS members as of March 2023.

Evaluation Approach

Due to the novelty of the program, the CIS evaluation focused on both process (formative) and outcomes (summative). The evaluation team worked with MQD to develop a logic model that reflected the intended program design, which was then used to guide the CIS portion of the 1115 waiver Evaluation. The team also employed an RCA approach to understand the program's process and to provide feedback and course correction in real time.

Quarterly Rapid-Cycle Assessments

In addition to the overall evaluation, the evaluation team conducted quarterly RCAs beginning in July 2021. RCA is an evaluation approach that increases the speed of data collection and feedback to stakeholders to enable quicker turnaround from research to scaling, improving, or implementing programs (Vindrola-Padroset al., 2021). This approach allows for iterative refinement of the program and is particularly useful when implementing a new and innovative program like CIS (Riley et al, 2013; Vindrola-Padroset al., 2021). RCAs emphasize partnerships between researchers, funders, government agencies, and community partners to encourage practical, timely, and appropriate research questions that can be adapted as the program and context changes. In this sense, evaluators can be thought of as "part of the solution" and partners in the process rather than as separate entities focused solely on outcomes at the end of the evaluation period (Riley et al 2013; Shrank et al., 2013).

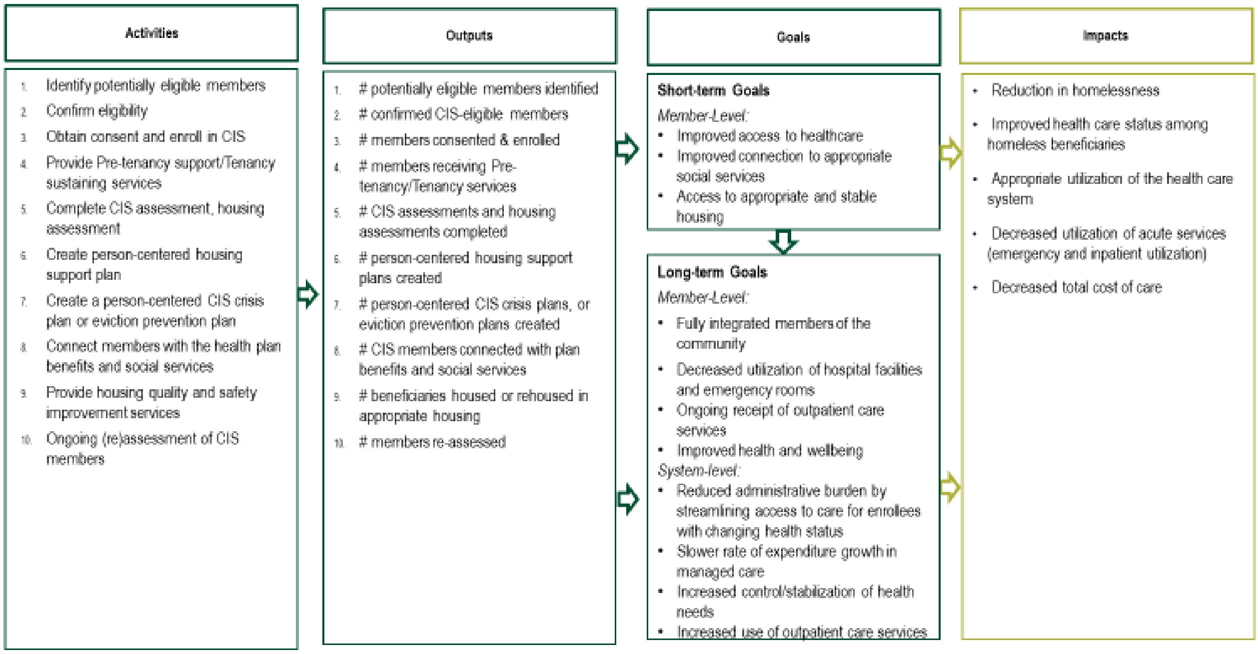
CIS is the first program to implement RCAs as a mechanism for continuous quality improvement at MQD. To facilitate this process, the evaluation team held quarterly meetings with Health Plans, HSPs and MQD. These meetings were used to present RCA findings and to brainstorm solutions to emerging issues. RCAs primarily consisted of analysis of data from quarterly Health Plan reports. Occasionally, the due dates for quarterly submissions were deferred to allow for implementing memo updates or new reporting templates. In these cases, the evaluation team focused on other areas of the current implementation that could be useful to Health Plans or MQD, including review of the CIS logic model, summary of qualitative interviews with Health Plans on implementation, contextualizing homelessness in Hawaiʻi, and sharing lessons learned from other states with similar programs. Additionally, HSPs contracted with the CIS program were invited to attend RCA meetings to share their on-the-ground experience and expertise when relevant. Each presentation was followed by an RCA report to MQD that summarized RCA findings and information shared and discussed at the RCA meeting.

While the goal of RCAs is to implement change much faster than a typical summative evaluation, RCAs must balance speed and quality in order to be effective for real-time program improvement. This balance proved difficult at times for the evaluation team. Reporting delays meant that data may not be ready in advance of RCA meetings. Additionally, data quality was a consistent issue throughout the waiver period. A rapid approach to evaluation does not always align with a system that is impervious to quick change. For example, once a necessary change is identified, a new memo must be drafted, after which Health Plans have 90 days to make the change. In practice, even small changes can take up to a year to implement. Despite these challenges, the RCA has resulted in program improvement and increased collaboration among all stakeholders, discussed below.

Logic Model

RCAs and the evaluation were guided by a logic model developed in collaboration with MQD (Figure V.3A.1). The logic model details CIS intended activities, outputs, goals, and impacts and demonstrates the expected logic between these activities and impacts. For example, outputs measure if program activities occurred, and these activities (e.g., pre-tenancy services) if performed are expected to lead to short-term goals (e.g., increased access to housing), which in turn lead to long-term goals (e.g., improved health and wellbeing) that collectively lead to impacts (e.g., reduced utilization of acute services and total cost of care). This evaluation examined outputs to determine if CIS activities were being implemented and if they were being implemented as planned. It also examined progress towards goals (i.e., were activities associated with intended outcomes). The evaluation team used multiple data sources to assess outputs and progress towards goals, including quarterly reports from Health Plans, interviews with Health Plans and HSPs, and administrative data. Interviews, in particular, were useful for understanding outputs and challenges related to program implementation (activities and outputs).

Figure V 3A.1. Community Integration Services Logic Model



Evaluation Questions

Initial research questions from the evaluation proposal primarily focused on assessing long-term goals and impacts (Table V.3A.2). These questions assumed that program activities would be completed as planned, that short-term goals would be reached, that members would be stably housed while in the program, and long-term outcomes would be achieved within the demonstration period. However, the evaluation team could not rely on these assumptions for several reasons. First, poor data quality during much of the evaluation period made it difficult to track program activities (e.g., how many people received services) and to determine who, if anyone, had been housed or the current housing status of CIS members.

Table V.3A.2. CIS Original Research Questions

CIS Original Research Questions
RQ 3A.1: Do program participants who are stably housed decrease utilization of acute services (emergency and inpatient utilization)? RQ 3A.2: Do program participants who are stably housed increase utilization of outpatient care services? RQ 3A.3: Is total cost of care lower for participants who are stably housed? RQ 3A.4: Does individual health and wellbeing improve as participants' progress through the program? RQ 3A.5: How does program effectiveness vary by client needs and experiences?

Additionally, implementation challenges led to necessary changes in program design and delays in implementation that hindered the ability to assess long-term goals and impacts. For example, the vast number of members who received tenancy or pre-tenancy services did not enroll in CIS until 2022, meaning that at the time of the writing of this report, few members could have been housed for a long enough period of time to be considered "stably housed"—a concept that was not defined or tracked. Therefore, the evaluation team amended research questions to match the program's stage of implementation and to account for available data (see Table V.3A.3). These questions focused primarily on program process (i.e., activities and outputs) and short-term goals (e.g., housing) that precede long-term impacts (e.g., lower health care costs). A focus on process is an appropriate evaluation approach for a program at this stage of implementation; however, the evaluation team aims to answer original evaluation questions in future demonstration periods as the CIS program matures and members are stably housed for longer periods of time.

Table V.3A.3. CIS Amended Research Questions

CIS Amended Research Questions
RQ 3A.1 amended: Is CIS operating as intended?
RQ3A.2 amended: Is CIS reaching the intended population (e.g., high utilizers of emergency services and high costs, those with physical and mental health needs, homeless or at-risk for homelessness)?
RQ3A.3 amended: How are members who received CIS tenancy and pre-tenancy different from those identified for CIS but do not receive services?
RQ3A.4 amended: Do CIS members who receive services achieve housing stability?

Evaluation Methods

Data Sources

To examine these amended questions, the evaluation team used multiple data sources, including qualitative and quantitative data. Quantitative data included:

- member level data submitted quarterly by Health Plans, including housing assessment and re-assessment data not captured by other traditional systems;
- archival data, and homelessness services data–including program data from providers and Homeless Management Information System Data (HMIS);

- data submitted to MQD's HPMMIS system showing the status of each member within the program and any relevant status changes ("H Codes");
- "data dumps" of any and all data collected from Health Plans on 1115 waiver programs;
- administrative encounter data from MQD's HPMMIS system; and
- quality measures.

Qualitative data included interviews with Health Plans and homeless service providers, participant observations of meetings, and qualitative responses in the quarterly Health Plan reports. These data provided important context for quantitative data and allowed for deeper insight into the program process. The evaluation relied most heavily on H Code and encounter data, which are described in more detail below.

H Code Data

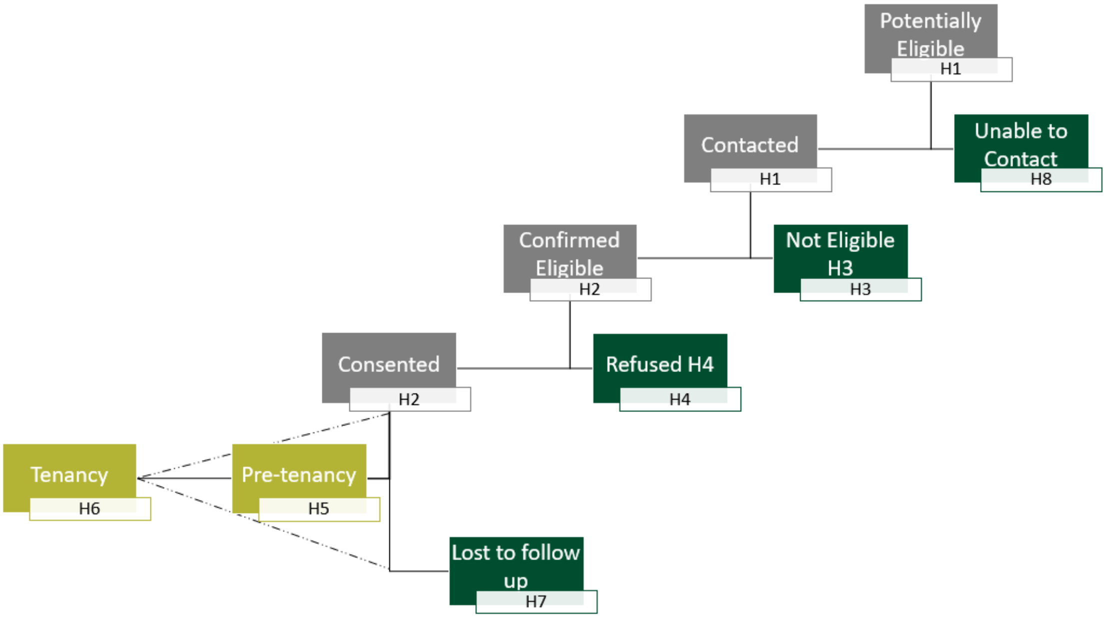
MQD developed H Codes to designate member status in the program (see Table V.3A.4). Health Plans submit a daily file to MQD's HPMMIS system providing updates on CIS beneficiaries' statuses. Potentially eligible members are assigned H1 and once contacted, deemed eligible (H2) or ineligible (H3) for CIS. Those members who are unable to be reached, move to H8. Eligible members who provide their consent, move to tenancy (H6) or pre-tenancy (H5) services dependent upon need. Those members who refuse consent, move to H4. Members who are enrolled (H5 or H6) but are lost to follow up, move to H7. Each time a member's CIS status changes, Health Plans submit a H Code update to MQD, closing out the previous H Code status (if applicable) and opening a new one.

Table V.3A.4. CIS H Code Status

H Code	Status Description
H1	Potentially Eligible
H2	Contacted - Eligible
H3	Contacted - Not Eligible
H4	Contacted - Eligible but Refused
H5	Consented - Receiving Pre-tenancy Services
H6	Consented - Receiving Tenancy Services
H7	Consented - Lost to Follow Up
H8	Potentially Eligible, Unable to Contact

Based on memo QI 2003 (MQD, 2020), the expectation is that members will move through status codes as they are identified as eligible, contacted, consented, and provided services (see Figure V.3A.3). However, members may move through multiple statuses in a day. Because dates cannot overlap, only the last status code is reported for the day. Therefore, some transitions may not be captured with this data.

Figure V.3A.2. H Code Status Flow Chart



H Codes and the H Code Flow helped the evaluation team understand how members identified for CIS moved through the program and how those who are identified eligible but never receive services differ from those who do receive services (RQ3A.3). For the sake of this report, those members in H5 or H6 are considered enrolled. Those in H1 and H2 are considered to be potential CIS members but not enrolled, and those in green in Figure V.3A.2.H are not enrolled. We recognize that members who have consented but have yet to receive services could be considered "enrolled" as well. However, the current H code status system does not allow for us to differentiate those members (i.e., members in H2 may or may not have consented).

Encounter Data

In addition to H Code data, the evaluation team examined encounters reported by Health Plans to MQD during the evaluation period through March 2023. These encounters included both pended and non-pended encounters for services related to CIS (see memo QI 2105 [MQD, 2021]): outreach (HCPCS code: T1023); completion of assessments and plans (HCPCS code: T2024), provisions of housing and other coordination or social services (HCPCS codes: H0043, H0044), and case management (HCPCS code: T1016). UH evaluators used encounter data to understand how many unique members had claims submitted for CIS and what types of services were provided.

Analysis

The evaluation team matched data from encounters (including demographics and H Codes data), quality measures, and Health Plan reports/data releases to gain a comprehensive understanding of unique CIS members and their characteristics. It was then able to compare CIS members to all Medicaid recipients above the age of 18 years on key indicators. Statistical comparisons among members reaching various H

Code Status and/or those that exited the program were conducted to determine whether members who received pre-tenancy (H5) or tenancy (H6) services differed significantly from those who were deemed not eligible (H3), eligible but refused (H4), lost to follow-up (H7), or unable to be contacted (H8).

Definitions

Below are the definitions used in the evaluation analyses:

CIS Member. Member who has been assigned any H Code during the evaluation period (closed or open).

Exited. Anyone whose last H Code has an end date.

Ever Enrolled. A member who has ever consented to CIS and been assigned to H5 or H6.

Enrolled. Someone is currently enrolled if they have an open H5 or H6 code (i.e., the last end code is H5 or H6 with no end date).

Not Enrolled. Member who has never enrolled but may (H1, H2), never enrolled and likely will not (H8, H3, H4) or has disenrolled (H7). While we would expect members who have disenrolled and never enrolled to be “exited”, not all of these members have an end date on their last H Code status, meaning that their status could still change.

Results

The results section is organized by results related to outputs (program process) and outcomes (progress towards meeting short- and long-term goals and outcomes).

Outputs

This section details CIS outputs identified in the logic model and provides data on members identified for CIS and their characteristics, members who received services (i.e., enrolled members), assessments completed, and provision of services. This data is triangulated from encounter data as well as the quarterly reports from Health Plans.

CIS Members

During the evaluation period—January 2020 through March 2023—a total of 4,656 members were identified as potentially eligible for CIS services as shown by enrollment in any H Code (H1-H8). Despite assumptions in the H Code status flow (see Figure V.3A.2), results show that most (88%) but not all CIS members’ initial H Code was H1 (see Table V.3A.5). For example, 6% of CIS members had an initial H Code of H5 (Pre-Tenancy), and 2% of H6 (Tenancy).

Table V.3A.5. CIS Members with Any H Code by Initial and Final H Code, 2020–2023

CIS Members by Current Status Code	Initial H Code		Final H Code	
	Frequency	Percent	Frequency	Percent
H1: Potentially Eligible	4,101	88.1	1,754	37.7
H2: Contacted - Eligible	127	2.7	275	5.9
H3: Contacted - Not Eligible	27	0.6	415	8.9

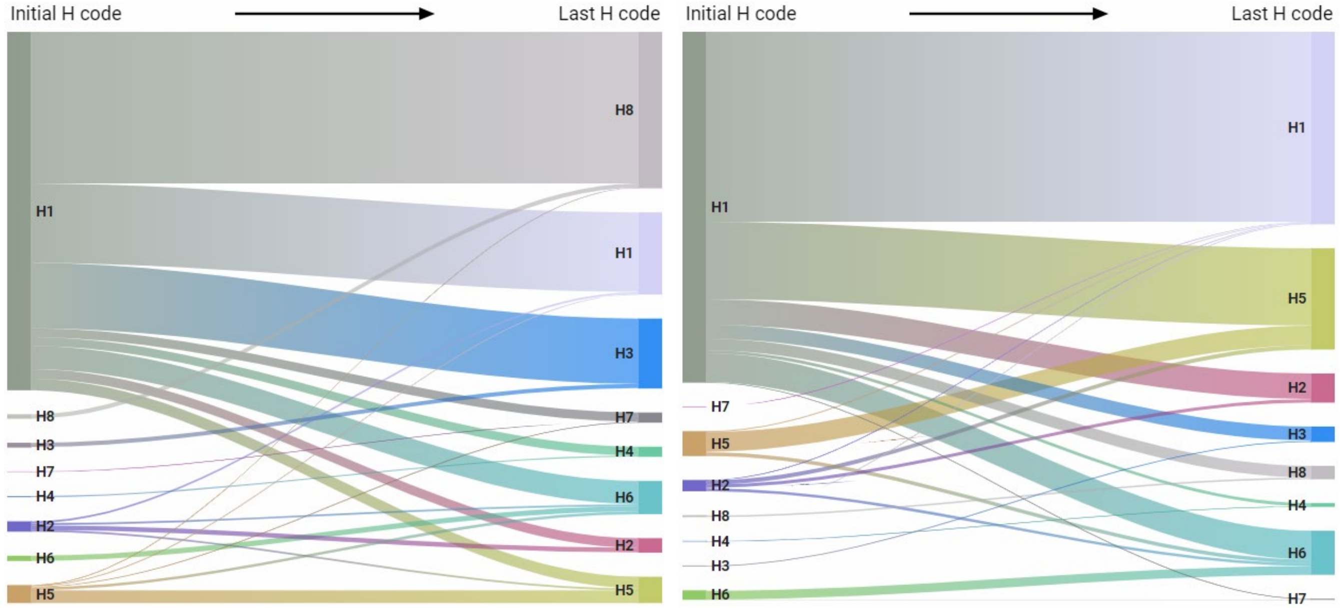
H4: Contacted - Eligible but Refused	NR	NR	71	1.5
H5: Consented - Pre-tenancy	259	5.6	850	18.3
H6: Housing Tenancy - Receiving Services	92	2.0	464	10.0
H7: Consented but Lost to Follow-up	NR	NR	52	1.1
H8: Potentially eligible but unable to contact	33	0.7	775	16.7
Total	4,656	100.0	4,656	100.0

Similarly, the largest percentage of CIS members were also assigned H1 as their *final* H Code as of March 2023. However, this percentage (37.7%) was much lower than the percentage of all members who started in H1 (88.1%), suggesting that members were starting to flow through the H codes despite a notable backlog.

The evaluation team also looked at differences in H Code status flow for individuals who exited (*n* = 1,746) and those who were current members (n = 2,910) in March 2023. Of all current members (with an open H Code) who started in H1, 54.2% were in H1 as of March 2023, compared to 22.2% of exited members who started in H1. Approximately, thirty-nine percent (38.8%) of all exited CIS members had a final H Code of H8—unable to contact—suggesting a bottleneck in determining eligibility for potentially eligible members, a challenge noted frequently in HP's qualitative reports.

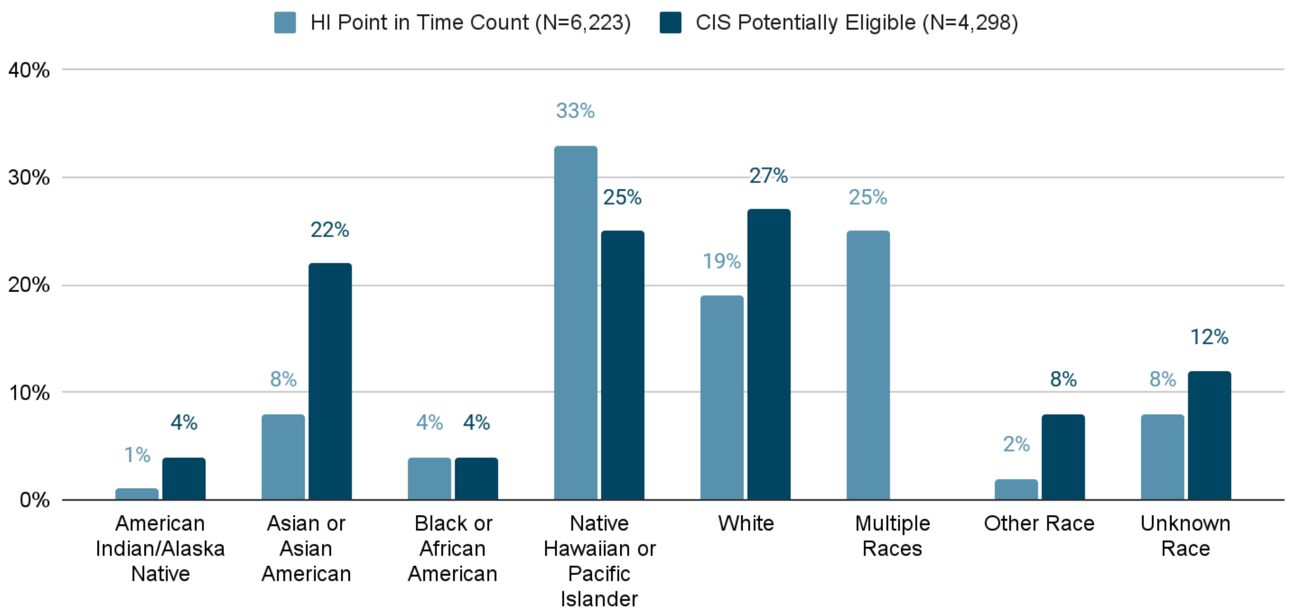
Figure V.3A.3. Flow from Initial to Final H Code by CIS Members–Exited & Current

Left: Exited CIS members (closed final H code) Right: Current CIS members as of March 2023 (open H code)



The largest percentage of all members who have been in any H Code were CIS members who identified as non-Hispanic White (26.45%; *n* = 1,137), followed closely by those who identified as NHPI (23.62%; *n* = 1,015). The evaluation team compared CIS racial breakdown to the racial breakdown of the 2023 Point in Time (PIT) count for the state (Figure V 3A.4). The PIT provides a census of the number of sheltered and unsheltered houseless individuals on a given night in January. CIS members disproportionately identified as Asian, White, American Indian/Alaska Native, and Other Race when compared to the state homeless population. People who identified as NHPI were disproportionately less likely to be CIS members when compared to their representation in the state's homeless population. This finding suggests that CIS may not be identifying CIS eligible NHPI members.

Figure V 3A.4. Race of CIS Potentially Eligible Members Compared to the 2023 State Point in Time Count



Note: Point in Time Count race percentages were calculated using data tables available in the appendices of the Oʻahu 2023 Point in Time Count Comprehensive Report for Honolulu County and the 2023 Bridging The Gap CoC Homeless Point-in-Time Count report for Kauaʻi, Hawaiʻi, and Maui Counties.

The evaluation team also examined racial equity with regard to members who actually received services (enrolled members) compared to all CIS members (all identified for services; Table V.3A.6). Compared to their representation of all CIS members, members who identified as White, Japanese, and Native Hawaiian were more likely to move into tenancy whereas American Indian/Alaska Native, Chinese, Black or African American, Samoan, "other", and unknown race were less likely to move into tenancy. Compared to their representation of all CIS members, members who identified as White were also more likely to move into pre-tenancy whereas those who identified as Other Pacific Islander, Black or African American, and unknown race were less likely to move into pre-tenancy. These findings suggest that some racial groups are more or less likely to be outreached and to receive services once identified for CIS. Notably, CIS data is incomplete for individuals who identify as multiple races. For example, it appears that if an individual identifies as more than one race, the race that comes first in alphabetical order is the only race captured for that individual in MQD databases. This strategy for data reporting erases certain racial identities and obfuscates potential disparities associated with those identities. Thus, interpretation of this data should be made cautiously.

Table V.3A.6. CIS Member Demographics

Race/Ethnicity	Enrolled Ever				CIS Members (Any H Code)	
	Tenancy		Pre-Tenancy			
	Frequency	Percent	Frequency	Percent	Frequency	Percent
American Indian/Alaska Native	11	2.5	36	3.11	149	3.47
Asian	111	24.8	269	23.25	956	22.24
Asian Indian	0	0.00	0	0.00	NR	NR
Chinese	25	5.6	76	6.57	258	6.00
Filipino	42	9.4	111	9.59	396	9.21
Japanese	27	6.0	57	4.93	184	4.28
Korean	NR	NR	18	1.56	59	1.37
Other Asian	NR	NR	NR	NR	45	1.05
Vietnamese	NR	NR	NR	NR	NR	NR
Black or African American	16	3.6	44	3.80	175	4.07
Native Hawaiian/Pacific Islander	118	26.4	269	23.25	1,015	23.62
Guamanian	0	0.0	NR	NR	NR	NR
Hawaiian	103	23.0	229	19.79	836	19.45
Other PI	11	2.5	18	1.56	97	2.26
Samoan	NR	0.9	21	1.82	75	1.74
Other	29	6.5	101	8.73	360	8.38
White (non-Hispanic)	133	29.8	327	28.26	1,137	26.45
Unknown	29	6.5	111	9.59	506	11.77
Total	447	100.0	1,157	100.00	4,298	100.00

Enrolled CIS Members

Of all members identified for CIS, 1,396 (30%) were ever enrolled, meaning they presumably received some form of CIS services—tenancy or pre-tenancy—at any time during the evaluation period. The largest number of service recipients (*n* = 1,248; 27% of all members identified) received pre-tenancy services. Ten percent (10%; *n* = 480) received tenancy services (Table V.3A.7).

Table V.3A.7. CIS Services Provided

CIS Members by Status Code	Frequency	Percent
Identified for CIS but did not receive Services	3,260	70.0
Received CIS Services	1,396	30.1
Pre-tenancy Services Only	916	19.7
Tenancy Services Only	148	3.2
Both Tenancy & Pre-tenancy Services	332	7.1
Total	4,656	100.0

The evaluation team also examined CIS-related encounters to understand how many members received services. According to encounter data, 377 unique people had 5,190 CIS-related billable encounters reported during the evaluation period through March 2023 (See Table V.3A.8). Three hundred twenty-two (322) members had encounters coded as supportive housing per month (3,316 encounters). This number is substantially lower than the number of members reported in H5 or H6 (*n* = 1,396). For the purposes of this report, we focus primarily on those members reported in H5 or H6 because this data allows for comparison of CIS members to non-CIS Medicaid beneficiaries while recognizing that this number is likely an over-estimate of the number of members who have received CIS. This choice was further justified by our awareness of billing challenges experienced by several HSPs, causing fewer claims to be submitted than services provided, and a substantial proportion of submitted claims to be rejected due to insufficient experience in submitted healthcare claims by HSPs.

Table V.3A.8. CIS Billable Encounters, January 2020 through March 2023

CIS Billable Encounter Procedure Codes	Unique People*	Frequency	Percent
T1023--Outreach	327	697	13.4
T2024—Assessments, plan development	301	1,167	22.5
Assessments/Reassessments	283	599	11.5
Plan development	218	475	9.2
Unspecified	32	93	1.8
H0044—Supportive housing per month	322	3,316	63.9
T1016-U2—Case management to support members lost to follow up	NR	NR	NR
Total	377	5,190	100.00

*Unique people may have more than one encounter.

CIS Enrolled Member Assessments

Of the 1,396 members who were ever assigned to H5 or H6 (tenancy or pre-tenancy services), Health Plans reported assessment (first assessment, reassessment, or both) data on 335 members. Of those 335 members, 228 members (16% of all enrolled members) had first assessment data, and 125 (9% of all enrolled members) had re-assessment data (Table V.3A.9). Of those members with first assessment data, only 72 were mostly complete, representing just 5% of all members who were ever enrolled in CIS. It is unclear if additional or more complete assessments exist. Assessment data is reported quarterly by Health Plans based on assessments conducted internally or collected from HSPs who conduct them externally. Lags in data collection and reporting may be partially to blame for the large percentage of CIS members with no assessment or incomplete assessment data. However, the number of members with reported assessments is similar to the number of members with assessment-related encounters. Encounters data shows that 599 assessments were conducted with 283 unique members.

Table V.3A.9. CIS Enrollees with First Assessments

CIS Members by First Assessment Data Type	Frequency	Percent
No First Assessment Data	1,168	83.7
First Assessment Data	228	16.3

Mostly Complete	72	5.2
Mostly Incomplete	156	11.2
Total	1,396	100.0

Of the 125 members with reassessment data reported by Health Plans, 20 had been reassessed more than once. Notably, only 18 of the 125 members with a reassessment had received a first assessment (Table V.3A.10). It is unclear if this discrepancy resulted from an error in labeling (data was actually first assessment but labeled as reassessment), error in reporting (first assessment was completed but not logged or submitted to evaluation team), or another error in data reporting or implementation. Therefore, this data is of questionable quality, and caution should be exercised generalizing results to the broader CIS population.

Table V.3A.10. CIS Enrollees with Re-Assessments

CIS Members by Re-Assessment Data Type	Frequency	Percent
No Re-Assessment Data	1,271	91.1
Re-Assessment Data	125	9.0
With First Assessment	18	1.3
Without First Assessment	107	7.7
Total	1,396	100.0

CIS Services Provided

The evaluation team examined encounter-tracking codes for CIS tenancy and pre-tenancy supports in order to understand what types of services were provided during the evaluation period (see Table V.3A.11). The most frequently reported codes were for case management (*n* = 492) and housing supports (*n* = 400), comprising 48% and 39%, respectively, of all encounter-tracking codes (*n* = 1,026). All other encounter-tracking codes comprised less than 5% of all codes, including the code for supports related to medical re-engagement and care coordination—a key goal of CIS (see introduction and logic model).

Table V.3A.11. CIS Encounter-tracking Codes

CIS Tracking Encounter Procedure Codes	Unique People*	Frequency	Percent
T1016-U1—Case management	41	492	48.0
H0043-U3—Provision of Housing Supports	80	400	39.0
H0043-UB—Re-assessment & plan revision	25	41	4.0
H0043-UC—Other services	14	24	2.3
H0043-U4—Medical re-engagement & care coordination supports	NR	NR	NR
H0043-0—Unknown service	16	18	1.8

H0043-UA—Other supports not identified elsewhere	NR	NR	NR
H0043-U5—QUEST & other DOH program referral supports	NR	NR	NR
H0043-U8—Provision of financial assistance supports	NR	NR	NR
H0043-U6—Provision of safety supports	NR	NR	NR
H0043-U9—Employment & housing readiness supports	NR	NR	NR
H0043-U7—Provision of supports to address social risk factors	NR	NR	NR
Total	117	1,026	100.00

*Unique people can have more than one encounter-tracking code.

CIS Outputs Summary

Returning to CIS outputs—the measurement of program activities identified in the logic model: of the 4,656 members with any H Code during the evaluation period, 38% (*n* = 1,787) were confirmed eligible. This number includes members ever assigned to H5, H6, H2, or H4. Of those members confirmed eligible, 78% (*n* = 1,396) moved into tenancy and pre-tenancy services at some point during the evaluation period. However, the number of members with encounters was significantly fewer than the number of members ever assigned to H5 or H6, with housing support encounters for 322 members.

Of those members who moved into tenancy (H6) and/or pre-tenancy services (H5), 5% (*n* = 72) had a first assessment with completed data and 1% (*n* = 18) had both a first assessment and a re-assessment. Because of significant data quality issues, the evaluation team was unable to determine the accuracy of assessment data as well as whether or not an assessment was a first assessment or a reassessment. Encounters data show 283 people have an assessment-related encounter. Additionally, a total of 218 unique members had encounters for developing a person-centered housing support plan. Based on lack of data, the evaluation team was unable to determine if other program activities related to creating crisis or eviction prevention plans, connecting to plan benefits and social services, providing housing or housing improvement services were completed. Additionally, the team was unable to determine how many members of those determined eligible were consented to participate in CIS because no H Code exists for consented but not yet receiving services (Table V.3A.12).

Table V.3A.12. CIS Logic Model: Outputs

Activity	Output	Definition	Number
1. Identify potentially eligible members	1.# potentially eligible members identified	Members with any H Code	4,656
2. Confirm eligibility	2. # confirmed CIS-eligible members	Members ever assigned H5, H6, H2, or H4, H5 or H6.	1,787
3. Obtain consent and enroll in CIS	3.# members consented & enrolled	Members ever assigned H5 or H6 + Any H7	Unknown*
4. Provide tenancy and pre-tenancy services	4. # members receiving Pre-tenancy/Tenancy services	Members ever assigned H5 or H6 Members with CIS encounters Members with supportive housing per month encounters	1,396 377 322

5. Complete CIS Assessments and Housing Assessments	5.# CIS assessments and housing assessments completed	Assessment data from HP quarterly reports # people with assessment/re-assessment encounters	228 (72 with complete data) 283
6. Create person-centered housing support plan	6.# person-centered housing support plans created	# people with plan development encounters	218
7. Create person-centered crisis plan or eviction prevention plan	7. # person-centered CIS crisis plans or eviction prevention plans created	Data not tracked	Unknown
8. Connect member with plan benefits and social services	8.# CIS members connected with plan benefits and social services	HP quarterly reports–data too incomplete to determine	Unknown
9. Provide housing quality and safety improvement services	9.# beneficiaries housed or rehoused in appropriate housing	Data not tracked; unclear if service is provided	Unknown
10. Ongoing (re)assessment	10.# members re-assessed	Assessment data from HP quarterly reports # people with re-assessment encounters	125 (18 have first assessment) 25

Notes: HP = Health Plan
*Limited to no data–no H Code for Consented but not receiving services. This data is captured in quarterly reports, but the quality of this data is poor and unusable for analysis.

Outcomes: Goals and Impacts

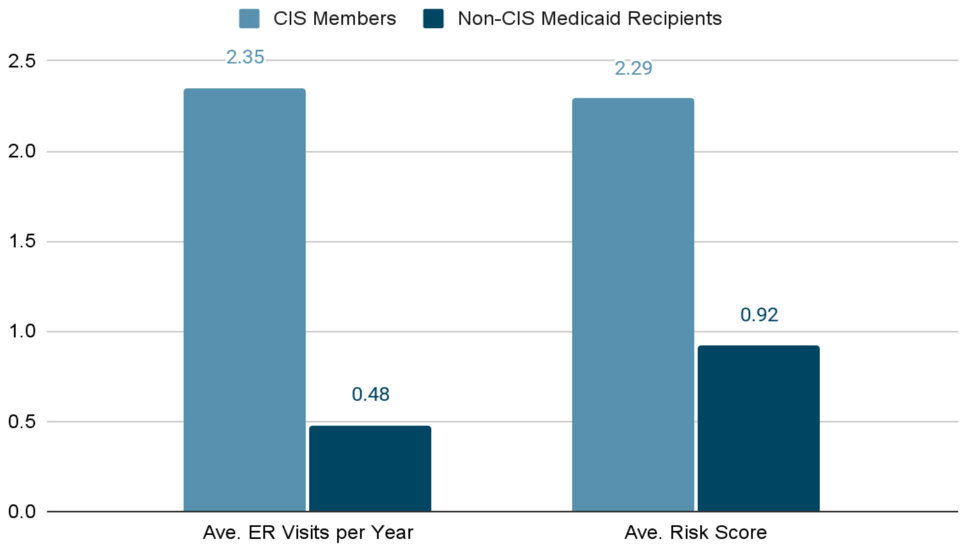
In addition to outputs, the evaluation team examined key outcome measures related to CIS goals and impacts, including emergency department (ED) visits, total cost of care, and CIS member health and wellbeing. However, the team was unable to examine changes in these measures over time due to the fact that the program was not fully implemented until late 2022. Additionally, of the exited members who ever enrolled in services, only a small percentage were presumably housed at any point (i.e., receiving tenancy supports), and housing impacts on outcomes are unlikely in this short time period. Thus, the evaluation team examined these outcome measures at baseline to understand the members' characteristics and to answer revised research questions for the project. In addition to baseline measures, the evaluation team examined exited members' trajectories through CIS. Understanding how members who exited the program flowed in and out of CIS can aid in understanding both program process and program progress toward goals.

Emergency Department Visits and Risk Scores

On average, members identified for CIS had a higher average number of annual ED visits in the year prior to CIS enrollment compared to non-CIS Medicaid recipients. CIS members had an average of 2.35 ED visits per year, which is more than four times the average number of ED visits for non-CIS Medicaid members (0.48; Figure V.3A.5). Enrolled members had higher average number of annual ED visits compared to members identified as potentially eligible for CIS but who did not receive services (Table V.3A.13). For example, members whose final H Code as of March 2023 was H5 (pre-tenancy) had an average of 3.45 ED visits in 2021; those in H6 (tenancy) had 2.55, compared to 2.14 for members who were eligible but did not receive services. Notably, those members identified as potentially eligible but eventually determined ineligible (H3) had an average of 2.19 ED visits, which is still much higher than the average non-CIS Medicaid recipient, suggesting that these members may need additional supports outside of CIS.

The team also examined risk scores, which are used to estimate future cost and morbidity, for CIS members compared to other non-CIS Medicaid recipients. CIS members had an average risk score of 2.29 compared to 0.92 for the average non-CIS Medicaid recipient. Examining CIS members by final H Code status, members who were determined eligible but did not receive services and those who were lost to follow up had the highest average risk scores (3.13 and 3.30, respectively), even higher those of members who received CIS tenancy and pre-tenancy services.

Figure V.3A.5. Average Risk Score and Annual ED Visits by CIS Member Status



Note: The number of member annual ED visits was extrapolated by dividing the number of ED visits by the number of months the member was enrolled in Medicaid and the resulting number multiplied by 12.

Total Cost of Care

Examining total cost of care in 2022, the evaluation team found that members identified for CIS tended to have higher costs of care compared to non-CIS Medicaid members. Among Medicaid members over 18 years-old who received any care in 2022 (N = 111,768), the overall total cost of care averaged $9,671, while the cost of care for CIS members averaged $20,297. Notably, CIS members whose final H Code in March 2023 was H2 (confirmed eligible but not yet receiving services) had a higher average total cost of care ($29,114) than any other H code.

Table V.3A.13. CIS Member Acute Services Utilization, Risk Scores, & Total Cost of Care by Final H Code

Final Status Code	ED Visits		Risk Score		Total Cost (2022 Health Plan)	
	Frequency	Mean	Frequency	Mean	Frequency	Mean
H1: Potentially Eligible	1754	2.40	1754	2.20	1365	$17,829

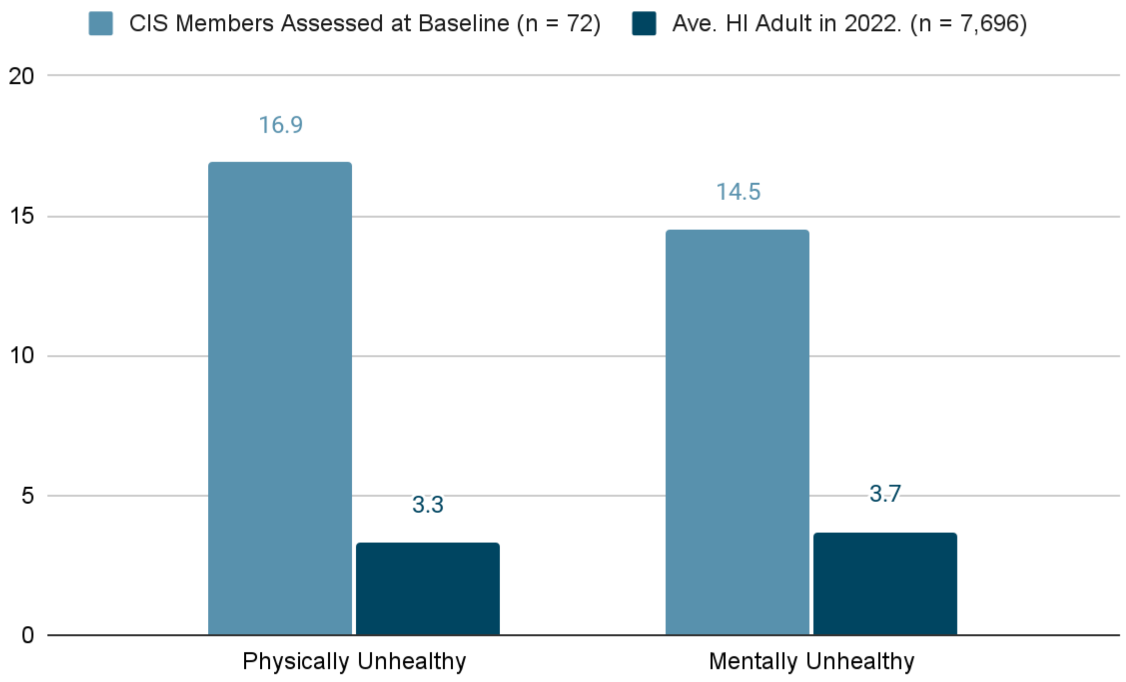
H2: Contacted - Eligible	275	2.14	275	3.13	247	$29,114
H3: Not Eligible	415	2.19	415	2.59	347	$24,783
H4: Refused	71	1.71	71	1.66	56	$11,185
H5: Pre-tenancy	850	3.45	850	2.74	779	$23,698
H6: Housing Tenancy	464	2.55	464	2.90	431	$22,072
H7: Lost to Follow-up	52	1.62	52	3.30	44	$20,455
H8: Unable to contact	775	1.23	775	1.41	485	$13,541
Total	4,656	2.35	4,656	2.29	3754	$20,297

Note. This table does not represent long-term changes in H-code movement as some members entered directly into H5 or H6.

Member Health and Well-being

To examine member self-reported health and well-being at baseline, the evaluation team analyzed assessment data for CIS enrolled members. A total of 72 members had complete first assessment data. These 72 members reported feeling physically unwell an average of 16.9 days in the previous month at first assessment. This number is substantially higher than the 3.25 (95% CI: 3.02–3.47) days reported by the average adult in Hawaiʻi in 2022 (USCDC, 2022). Similarly, CIS enrolled members reported a substantially higher number of mentally unwell days compared to the general state population, at 14.5 days compared to 3.7 (95% CI: 3.28–3.96) days. The average number of days members reported that they were unable to do their daily activities due to mental and physical issues was high at 16.9 days in the last month at first assessment, compared to 4.4 reported by the general state population. These data further support the evaluation team's preliminary findings that CIS is reaching members with high mental and/or physical medical needs. However, the evaluation team was unable to analyze change over time because of incomplete data and the fact that so few members had both a first and reassessment. The evaluation team hopes that with data quality and reporting improvements, it will be able to assess changes in these in the near future.

Figure V.3A.6. Average Number of Unhealthy Days Reported in Last 30 Days at First Assessment (USCDC, 2022)



Exited CIS Member Trajectories

To understand trajectories through CIS by status code, the evaluation team examined H Codes for any members identified for CIS who have exited CIS at first code and last code as well as final H Codes for exited members who were ever confirmed eligible and who ever received tenancy and pre-tenancy services. A member is considered "exited" if the last H Code for that member in Med-QUEST's HPMMIS system has an end date. In this section, we present findings on exited CIS members' initial and final H Codes from January 2020 through March 2023.

A total of 1,746 CIS members had exited CIS by March 2023—about 38% of all CIS members with any H Code (Table V.3A.14). The largest percentage of exited members had a final H Code of H8, unable to contact (*n* = 678; 39%), followed by H1, potentially eligible (*n* = 356, 20%), and H3, not eligible (*n* = 303, 17%). It is unclear why members' last H Code would be H1, potentially eligible. One possible explanation is that Health Plans were able to determine a member was not eligible prior to contacting them. Additionally, members may have disenrolled from Medicaid, changed Health Plans, passed away, or moved to another state before Health Plans were able to assess eligibility.

Table V.3A.14. Exited CIS Members Final H Code Status as of March 2023

CIS Members by Current Status Code	Frequency	Percent
H1: Potentially Eligible	356	20.4
H2: Contacted - Eligible	63	3.6
H3: Contacted - Not Eligible	303	17.4
H4: Contacted - Eligible but Refused	44	2.5
H5: Consented - Pre-tenancy	114	6.5
H6: Housing Tenancy - Receiving Services	144	8.3
H7: Consented but Lost to Follow-up	44	2.5
H8: Potentially eligible but unable to contact	678	38.8
Total	1,746	100.0

Note. This table does not reflect movement back and forth throughout members' time in the program. For example, one member may start out as potentially eligible (H1), confirmed eligible and move into pre-tenancy (H5), then into tenancy (H6) before exiting the program. In this case, only H1 and H6 would be reflected in this table.

Of the 1,746 exited CIS members, 439 (25%) were confirmed eligible at some point during the waiver period (i.e., ever assigned H2). Of these members that were confirmed eligible, 20% were assigned H5 (Pre-Tenancy) and 33% were in H6 (Tenancy) as their final H code. Notably, 23% of those ever confirmed eligible remained in H2 at exit, and 12% were lost to follow-up. These findings suggest that of those members found eligible for CIS, 53% (*n* = 145) were receiving tenancy or pre-tenancy services at exit.

Of those members who exited CIS, 153 (9%) were enrolled in tenancy at some point, the vast majority of which (93%; *n* = 143) remained in tenancy (H6) at exit. Two hundred fifty-five members (*n* = 255; 55%) were in pre-tenancy at some point during the waiver period. Forty-five percent (*n* = 114; 45%) of these members were still enrolled in pre-tenancy at exit, and 33% (*n* = 100) had transitioned to tenancy at exit. Taken together, these findings suggest that of those exited members who received tenancy services, the majority remained housed at exit, while 45% of members receiving pre-tenancy services exited without stable housing.

However, a significant limitation is that data is not collected on exit destinations. Therefore, assumptions based on H Code status at exit must be considered cautiously. For example, it is possible that members who exited while still in pre-tenancy may have exited because they secured stable housing and no longer needed tenancy or pre-tenancy services. To address this limitation, MQD added exit destination information to CIS forms and assessments as part of the "CIS Reboot" discussed below.

Program Implementation

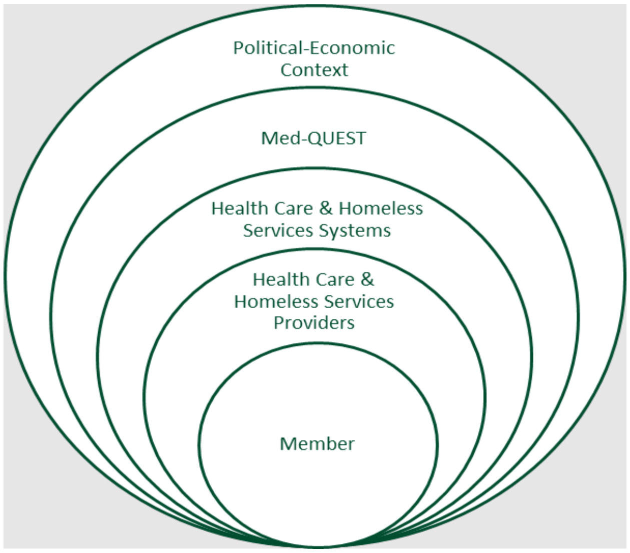
Based on interviews with Health Plans and providers, participant observations of hours of meetings, and qualitative portions of quarterly data, the evaluation team documented program implementation challenges and responses to those challenges. These findings also provide context for quantitative data.

Implementation Challenges

Many of the following challenges were initially brought up in interviews conducted in the early stages of CIS implementation (Summer 2021) and remained barriers to implementation throughout implementation of the CIS program. The evaluation team organized these challenges within a multilevel framework (see Figure V.3A.7). Taking a multilevel approach to program implementation and evaluation can help stakeholders identify how challenges at one level can impact other levels as well as can be useful in determining what challenges are solvable and by whom.

Reviewing these challenges, the evaluation team realized that many of them were reflective of other states who have implemented similar Medicaid supported housing benefits. Experiences of other states that are further along in the implementation process offer the opportunity for Hawaiʻi to benefit from their lessons learned. The Rutgers Center for State Housing Policy (Thompson et al., 2021) identified common challenges among states who were early adopters of Medicaid-funded tenancy supports. Many of these issues overlap with the challenges experienced by Hawaiʻi's CIS program. The team hoped that outlining these shared challenges within a multilevel framework as well as reviewing successes from other programs will help Health Plans, HSPs, and MQD build a successful program in Hawaiʻi.

Figure V.3A.7. Community Integration Multilevel Framework



Housing Supply Issues

One of the most common challenges involved housing supply. While referring to the lack of affordable housing broadly, particularly for low-income renters, housing supply issues also include lack of sufficient housing subsidies to address the needs and limitations of Medicaid support coverage (e.g., inability to use funds to pay rent). Additionally, finding appropriate housing for members with special needs can be challenging—a large proportion of those eligible for CIS. For example, many CIS members have complex physical health needs that require certain housing characteristics (e.g., wheelchair access) that are in low supply. While this issue is largely dictated by the political-economic context—and thus, outside of the control of the Health Plans and providers—it is an issue that impacts every other level, including the CIS member. This issue may also explain the relatively small percentage of members who transitioned from pre-tenancy to tenancy.

Enrolling and Retaining Members

Many states, Hawaiʻi included, have difficulty enrolling and retaining members in CIS-type programs. One reason for this difficulty includes the fact that members belonging to a population that is medically vulnerable and experiencing housing instability/homelessness are hard to reach because of those vulnerabilities. Typical strategies for engagement do not work (e.g., phone calls, mailers), and reaching these members requires daily coordination between Health Plans and HSPs. The Health Plans have noted increased difficulty in reaching members throughout COVID-19 as there have been restrictions on face-to-face interactions which is one of the only ways that many members within this particular population can be reached regularly. Additionally, determination of eligibility and subsequent enrollment require access to both homelessness services and Medicaid systems that are siloed and are not easily accessible across silos. These roadblocks can lead to “churning enrollment” as members are lost to follow up and lose eligibility despite continued need for the benefit (Thompson et al., 2021, pg. 20). These issues have direct consequences for members, with those experiencing housing instability being most at risk for not being enrolled in programs for which they qualify. These challenges also may help explain racial disparities identified in H Code data. It may be more difficult to find members in geographic locations where certain racial groups may be more likely to reside (e.g., rural areas of the state that have higher concentration of Native Hawaiian and Pacific Islander groups).

Bridging Two Siloed Systems: Healthcare and Housing Services

The coordination between healthcare and housing services is vital to the success of a program like CIS. These systems are complex and often siloed. CIS-type programs have struggled to bridge the two sectors without overburdening either Health Plans or HSPs, both of whom often struggle to find a shared language. Almost every other challenge identified is related directly or indirectly to this issue. Here in Hawaiʻi, most HSPs are not medical providers and have limited background in health care or capacity to bill for services. This lack of capacity has proven to be a challenge, particularly when it comes to assessments and associated data collection and sharing. As it stands, HSPs and Health Plans use different data collection and sharing platforms, and sharing access between systems has proven difficult. Currently, no infrastructure exists for sharing the data, and much of the assessment data is faxed and filed on paper rather than inputted into a connected, electronic system. Additionally, each Health Plan has their own system in place, requiring HSPs needs to understand and navigate five separate processes to ensure a successful partnership.

Contracting and Paying Homeless Services Providers

Directly related to bridging health and homeless services, contracting with and paying the HSPs participating in CIS has proven challenging for CIS in Hawaiʻi and across the US. The contracting process is often long and tedious and is an administrative burden for HSPs. Once contracted, HSPs often lack the capacity to manage and submit claims, resulting in rejected claims and delayed payment, which is often inadequate to cover costs of service provision. MQD began addressing this issue in the 2023 CIS “reboot” discussed later. HSPs also face “supplantation” challenges which involve piecing together multiple funding sources to serve members while ensuring that funding sources do not overlap (Thompson et al., 2021, pg. 24). This challenge has impacted the number of participating HSPs and system capacity to provide CIS. All of these challenges are exacerbated by the fact that many CIS-type programs don’t not cover start-up funding or overhead costs, which are necessary to implement the program at the HSP level. Some local HSPs have noted their desire to be contracted but said they are waiting to contract when implementation is fine-tuned and challenges have been addressed.

Recruiting and Retaining Staff

Health Plans and HSPs reported hiring difficulties, a challenge reported across industries nationwide. For example, here in Hawaiʻi, 15 homelessness service agencies were hiring for over 40 positions at the end of June 2023 (PIC Weekly Update, 2023). Health Plans and HSPs nationwide reported recruiting difficulties due to the lack of job security that the impermanence of a waiver demonstration creates. They also noted difficulties finding staff that have both the skills to provide services and to document and bill for them. Often the individuals who are most skilled at providing direct services are those with less formal training and qualifications. Beyond the challenge of hiring the staff, building a cohesive unit of staff across sectors was a common challenge mentioned that leads to retention issues. An integrated health and housing program requires many types of staff working together, and these staff members often have different levels of expertise, have different values, and lack a shared language.

Durability beyond Current Waiver

Another concern regards the uncertainty about the continuation of funding beyond the funding cycle. This uncertainty can lead to less buy-in from stakeholders given the potential for discontinuation of the program after the demonstration. In Hawaiʻi, this concern impacts the extent to which HSPs are willing to participate in the program—particularly small HSPs with less capacity. Given the start-up costs and administrative burden of integrating Medicaid billing into existing financial structures, many local HSPs have adopted a "wait and see" approach before investing time and money into what could be a short-term program.

CIS "Reboot" and Technical Assistance

In response to these challenges, in January 2023, MQD developed an internal "Core CIS Team." The team consisted of two CIS leads (one with a public health background and another with a social work background), a project manager, an administrator with Health Plan background and billing expertise, an administrator with extensive Medicaid knowledge, and a local homelessness research psychologist from the evaluation team. Through collaboration with Health Plans, homeless service providers, homeless service system leaders, and the evaluation team, the core team re-envisioned CIS as it fit within the local context and could be used to meet local needs. It also worked to resolve specific issues related to program implementation. In particular, the team addressed the billing and payment issue and worked to carefully balance stakeholder needs and requests. The team also worked to reduce bureaucratic barriers for both HSPs and members. For example, it significantly reduced the length of assessment and action plan forms in order to streamline the process and maximize other data collection forms and clinical assessment information. The team continues to hold bi-monthly meetings with both Health Plans and providers.

In addition to the reboot, MQD collaborated with Health Plans to troubleshoot issues related to forms, data, and reporting. For example, beginning in January 2022, MQD and the evaluation team began providing ongoing technical assistance to Health Plans related to CIS reporting and H Code status assignment. In April 2022, in response to HP challenges with reporting member level data (discussed in limitations below), MQD worked with the evaluation team and a consulting group to map the report template to CIS forms and to include formulas to assist Health Plans in calculating their progress toward key performance indicators (KPIs).

HP Success Strategies

Health Plans also developed internal strategies to meet these challenges. For example, to enroll and retain hard to reach members, Health Plans reported accessing and checking the state's Homeless Management Information System (HMIS) and patient charts internally for information, scheduling face-to-face meetings rather than phone contact, connecting regularly with HSPs, and working together to plan and troubleshoot. Additionally, in order to develop sustainable partnerships with HSPs, Health Plans worked to integrate into and invest in the community and to leverage existing relationships with service agencies (e.g., those involved in CCS). To continue help build system and HSP capacity, Health Plans reported providing ongoing education and outreach to HSPs and the local Continua of Care (CoCs).

Limitations

All results and conclusions should be considered in light of the following limitations.

Data Quality

Data quality proved to be a consistent issue throughout the evaluation period. Health Plans often submitted quarterly reports with a considerable amount of missing data, in formats that were inconsistent with the reporting templates, and with quantities that were inconsistent with other forms of data submission. For example, it was the norm for the total number of CIS members reported in detailed member-level files to not match numbers reported in the corresponding aggregate tables or the qualitative sections of the same report. Additionally, these numbers did not match H Code data or encounter data submitted through other mechanisms to MQD's HPMMIS system. These inconsistencies made both RCAs and overall evaluation analyses difficult because the evaluation team was unsure which data gave the most accurate and complete picture of CIS implementation. In 2022, MQD hired a consultant group to work with Health Plans to improve data quality through technical assistance as well as by updating reporting tools to include data validation functions. Subsequently, the evaluation team has seen a noticeable improvement in data quality; however, continued improvement and consistency in reporting will be necessary to determine long-term impacts of CIS.

Lack of clarity between stakeholders

As noted previously, in using the RCA process, the evaluation team and other stakeholders had hoped for regular, ongoing improvements to the program. However, healthcare and homelessness service systems can be slow to change even when all updates are agreed upon and being put into motion. Throughout the evaluation period, there were cases in which the lag between recommendations, agreed upon changes, and actual formalized updates created confusion between stakeholders. For example, deciding on what it meant for a member to be "enrolled" in CIS or deciding if "days" in the original memo is referring to calendar days or business days. While these questions may seem trivial, stakeholders all held their own definitions and interpretations, which impacts the data collected and the conclusions that can be drawn.

Data do not show impact or outcomes

Although the initial evaluation plan included an analysis of long-term goals and impacts, the current data submitted to and obtained by the evaluation team does not allow for such analyses. CIS faced considerable roadblocks in the early stages of implementation (e.g., lag with contracting and onboarding HSPs, data quality issues, needed clarifications and edits in the memo and reporting documents) that resulted in a delay in implementation and data collected. Additionally, the data collected is not exhaustive of the CIS experience and does not capture variables needed to determine progress towards long-term goals and impacts. For example, without information on exit locations (e.g., were CIS members housed when they exited the program?) or specific services received (e.g., were they ever housed?), the evaluation team was unable to get a clear picture of all impacts and outcomes.

Conclusions and Recommendations

Despite limitations, the evaluation team was able to answer most amended research questions and to provide the following conclusions and recommendations based on triangulation of data.

RQ 3A.1 amended: Is CIS operating as intended?

Qualitative and quantitative data suggests that CIS has undergone major and necessary programmatic changes in order to best serve members and to adapt to local system needs. MQD worked to reduce bureaucratic barriers by reducing form length and frequency and by simplifying billing. MQD also provided ongoing technical assistance and improved the reporting process. To make these changes, MQD collaborated with Health Plans, government agencies, CoCs, and experts across the homelessness services system. By mid-2023, CIS was operating more smoothly and collaboratively at the systems-level.

How CIS was operating at the member level is less clear. Member reported data is captured in assessment data reported quarterly by Health Plans, but this data has suffered from data quality issues with regard to collection and reporting. Overall, challenges related to data and reporting make it difficult to determine how many members have received CIS. The number of people who have been in pre-tenancy or tenancy statuses is three times the number of members who have had CIS-related claims submitted. Even fewer have had assessments reported. Anecdotal feedback from Health Plans suggests that H Code status data for pre-tenancy or tenancy may be inflated due to errors in status code assignment early in the program implementation. These errors predate technical assistance and may stem from miscommunication and confusion over when to assign a member to pre-tenancy or tenancy.

A major assumption of CIS and the initial evaluation questions is that members will be housed or will achieve housing stability during the program. However, this intermediate but important outcome was not consistently monitored. Much of the program activities and outputs tracked are administrative in nature (e.g., filling out assessments and reassessments). Services and their immediate outputs (e.g., number of people housed) were not tracked as consistently. These activities represent a crucial intermediate step to achieving program outcomes and impacts. It is imperative that MQD and Health Plans consider tracking intermediate goals and outputs of the program, particularly those related to housing outcomes. In response to this concern raised in RCAs, MQD has included housing outcomes on its revised assessments and action plans as part of the CIS Reboot.

Findings suggest that CIS has undergone major and necessary programmatic changes in order to best serve members and to adapt to local system needs. Effectiveness of CIS as operating at the member level (e.g., how many people have been served and what services they received) is less clear.

RQ3A.2 amended: Is CIS reaching the intended population?

Findings suggest that CIS is, in fact, identifying the intended population–members who are high utilizers of emergency services and likely to be associated with higher costs and morbidity as predicted by risk score. Members identified for CIS have a higher average number of annual ED visits, average total cost of care, average risk scores, and rates of homelessness compared to the average non-CIS Medicaid recipient, suggesting the program is identifying high utilizers of emergency services, those with high health care costs, those with physical and mental health needs, and those who are homeless or at-risk for homelessness. Likely the need for housing and health care services outweighs the capacity of HSPs to address them as seen in the higher number of members who are eligible for CIS but are not receiving services. However, those members who are eligible but do not receive services and those lost to follow up are still at risk and may benefit from CIS. Additionally, CIS members whose final H Code in March 2023 was H2 (confirmed eligible but not yet receiving services) had a higher average total cost of care ($29,114) than any other H code.

Quantitative and qualitative data suggest a backlog both in determining eligibility and in providing services once eligibility is confirmed. Overall, these findings are consistent with barriers brought up within qualitative data that was submitted quarterly by the Health Plans throughout the CIS program. Health Plans discussed challenges with physically finding members who were referred. Additionally, since Health Plans were delegating the CIS assessment paperwork to HSPs, they relied on their contracted organizations to have the capacity to assess the members, which may not always be the case for smaller agencies, leaving members in limbo between referral and determining eligibility. Health Plans listed even larger backlogs of members awaiting confirmation of eligibility and services in their quarterly submissions than were included within this table.

Data suggests that Health Plans are identifying the intended population for CIS; however, much of those members have yet to receive services due to backlog and lack of HSP capacity.

RQ3A.3 amended: How are members who received CIS tenancy and pre-tenancy different from those identified for CIS but do not receive services?

Because racial disparities exist regarding which groups experience homelessness and housing insecurity, the evaluation team attempted to examine race for those who were identified for CIS as well as for those members who actually received CIS. On Oʻahu, individuals who identify as White are under-represented in the homeless population but are over-represented in permanent supportive housing programs (Pruitt et al., 2022). On the other hand, individuals identifying as Native Hawaiian or Pacific Islander (NHPI) are over-represented in the homeless population and under-represented in permanent supportive housing programs.

Results suggest that people who identify as White are more likely to both be identified for CIS and to receive services once identified. NHPI members are less likely to be identified for CIS when compared to their proportion of the overall homeless population, suggesting that eligible NHPI members may not be being identified for CIS and/or may not be receiving Medicaid. More outreach to these populations may be needed. Additionally, examination of policies and procedures for potential implicit racial bias may be necessary. For example, the criteria to qualify for CIS, particularly for at-risk for homelessness, may be too restrictive and/or more likely to capture risks experienced by certain demographics. Research suggests that Native Hawaiians are more likely to list breakup of family as a cause of homelessness (PIC, 2022) and thus, are unlikely to have a written eviction letter. Amending criteria to account for risks and experiences of certain demographics may be necessary.

Additionally, those members identified as potentially eligible but eventually determined ineligible (H3) had an average of 2.19 ED visits, which is still much higher than the average non-CIS Medicaid recipient, suggesting that these members may need additional supports outside of CIS.

Examining those exited members who were eligible for CIS, approximately half received tenancy or pre-tenancy services. Given that only about half of exited CIS members who were confirmed eligible actually received services, it appears there is a backlog. Thus, there is a need for more on the ground work and field work to outreach these members. Additionally, due to the fact that there is no way to accurately track members who were consented but didn't receive services, we are unable to fully answer this question. We suggest MQD work with Health Plans to either develop an H Code status for Members who have consented or develop another strategy for capturing this data. This strategy may also address issues with inflated H5 and H6 numbers.

While those members receiving tenancy and pre-tenancy services had the highest average annual ED visits, those who were eligible for services but not receiving them had the highest average total cost of care, suggesting the need to address the backlog to have systems-level impact on cost of care. Additionally, findings suggest that members identifying as White may be disproportionately likely to receive tenancy and pre-tenancy services once identified for CIS.

RQ3A.4 amended: Do CIS members who receive services achieve housing stability?

It is unclear if CIS enrolled members achieve housing stability due to limited data and lack of clarity on what is meant by "stably housed". We recommend MQD define "stably housed" and continue to build in mechanisms to capture housing status of CIS members throughout the program. The CIS reboot has added some of these metrics to the CIS Action Plan, including exit destinations. Based on the data available, the number of members moving to H5 (pre-tenancy) suggests progress toward housing. Additionally, those members in H6 (tenancy) tend to stay in H6, suggesting stability. More data and definition are needed to determine if services lead to housing stability.

While a third of members who were in pre-tenancy had transitioned to tenancy at exit, it is unclear if this transition represents stable housing and whether these members ever received services. Clearer definitions of stably housed is needed.

Other Conclusions

Data collected and emphasized by MQD heavily focuses on health care outcomes. Given that services provided are primarily housing-related, it is difficult to assess short-term goals and outcomes that necessarily precede long-term health impacts and particularly impacts on the healthcare system.

Race data suggests disparities in service provision; however, the strategy for reporting race data erases certain racial identities and obfuscates potential disparities associated with those identities. Given that a quarter of Hawaiʻi residents identified as two or more races in 2022 (US Census Bureau, 2022) and the fact that known disparities exist in housing and healthcare for certain racial groups, it is imperative that MQD and Health Plans capture race data accurately so that they can ensure CIS is not inadvertently perpetuating racial disparities.

All other encounter-tracking codes comprised less than 5% of all codes, including the code for supports related to medical re-engagement and care coordination—a key goal of CIS (see introduction and logic model). Given that CIS eligibility criteria includes having a physical health need and HSPs have reported difficulties in serving medically vulnerable clients, it is imperative that Health Plans work to provide health coordination for CIS members.

The RCAs were valuable in that they allowed MQD to course correct in real-time. MQD responded to recommendations and issues, leading to significant progress in the first half of 2023. The RCA would have been a useful tool for the pilot program. Unfortunately, the evaluation team learned of the pilot upon its conclusion. In future pilot projects, the evaluation team recommends leveraging RCAs to better understand program process and impacts.

Many of the challenges described here are expected when implementing a novel program like CIS. Despite these challenges, CIS has the potential to have impacts at the system and individual level. Recognizing this potential impact and the need for collaboration, MQD began “rebooting” CIS in January 2023. The “reboot” approach has resulted in more providers applying for MQD provider status, including clean and sober programs, and in increased collaboration among MQD, Health Plans, HSPs, and other systems involved in homelessness services. For example, MQD is working with the two continua of care to integrate CIS into the coordinated entry system and is regularly meeting with state agencies involved in coordinating statewide homeless response. This intense, hands-on approach has led to increased awareness of CIS among HSPs and in reduced burdens for Health Plans, HSPs, and hopefully by extension, eligible members.

Recommendations

Based on available data and findings, the evaluation team makes the following recommendations:

Clean H Code Status Data

Given that monthly capitation payments are based on status code data, the evaluation team recommends that MQD work with Health Plans to clean this data so that it more accurately represents the number of members receiving tenancy and pre-tenancy services. MQD has implemented a risk corridor to retrieve capitation payments not tied to actual service provision; nonetheless, more work is needed to achieve alignment in reporting and service provision.

Continue to Improve Race Data Collection and Reporting

MQD has made substantial improvements in reporting over the evaluation period. The evaluation team recommends continued investment in data quality and reporting improvement. Given the importance of detecting and addressing racial disparities in health and homelessness service provision and the issues related to race data, the evaluation team recommends that MQD implement improved race data collection and reporting, especially for members who identify with multiple races. Race data should be collected and reported in a disaggregated format.

Use CIS to Meet System Needs

Given the high level of need and lack of capacity as seen in the backlogs of members potentially eligible and eligible but not receiving services, it will likely be necessary for Health Plans to prioritize eligible members. The evaluation team suggests that MQD and Health Plans examine existing needs and gaps in the homelessness service system when identifying who to prioritize. For example, the homelessness service system’s coordinated entry system prioritizes people with complex physical and mental health and housing needs (i.e., people who qualify for CIS) for permanent supportive housing—a much more intensive program than CIS. CIS might be most effective when paired with other less intensive programs that serve high needs people due to lack of resources. In other words, CIS might be paired with a voucher or other housing program that provides money for rent but not for wraparound services.

Emphasize Health Coordination and Re-engagement Services

Results show that CIS members are highly vulnerable mentally and/or physically. However, existing data suggests the amount of health coordination and re-engagement in care services are few. The evaluation team suggests that Health Plans work to emphasize these services, which will likely require more on-the-ground work on the part of the HP and their health coordinators.

Capture Housing-Related Data

The evaluation team recommends MQD continues working to implement forms and data collection methods that capture current housing for CIS members as well as exit destinations for exiting members. This data will help illuminate progress toward short-term goals related to housing upon which long-term goals and impacts rely.

Include Member Perspectives and Perspectives of Those with Lived Experience

Homeless and housing leaders with lived experience are heavily involved in homelessness services and advocacy and offer an opportunity to learn from people on the ground what they need to take care of their health and meet their housing needs. For example, the Oʻahu Lived Experience Council has a list of these leaders with both current and past lived experience with homelessness who are available for consultation and speaking engagements. The evaluation team highly suggests that MQD and Health Plans involve members with lived experience in their programming and in determining success of the program. For example, meeting outcomes such as decreased total cost of care might not actually show success at the member level if those members may need to be reconnected to care (and thus, may see a short-term spike in cost).

Project 3B: Assessing the process of planning and implementing support strategies addressing social determinants of health

Introduction and Background

Social determinants of health (SDOH) refer to 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 choices, access to transportation, social support networks and connection to culture, as well as access to healthcare are all determinants of health. These factors impact social groups differently, which leads to disparities in health outcomes. In Hawaiʻi, the island geography and historical context has given rise to great diversity at the local community level. Different communities face unique challenges related to access to healthcare, transportation, and other resources (Wong et al., 2008). Rural communities, for example, may have limited access to healthy food options and struggle to attract healthcare providers, which can further exacerbate health disparities between different groups (Yoshimura et al., 2015). Additionally, factors such as higher poverty rates, discrimination, and cultural barriers may make it more difficult for some communities to access healthcare and engage in healthy behaviors (Mau et al., 2009). Moreover, historical trauma and ongoing colonization experienced by Native Hawaiians can further contribute to poorer health outcomes (Sentell et al., 2016).

Addressing SDOH has been a key guiding principle for MQD in achieving the goals of the HOPE strategy (MQD, 2017). During the 1115 waiver demonstration period, MQD intended to develop integrated solutions that address SDOH within the context of the healthcare delivery system. To this end, MQD released a quality strategy in 2020 (MQD, 2020) that dedicated a major objective (Objective 11) to the description of various intended SDOH initiatives. Objective 11 outlined a multi-pronged strategy to assess and address SDOH needs across the population, including the development of a statewide SDOH Transformation Plan, along with aligned work plans at the Health Plan level that operationalize the goals of the statewide plan; identification of social risk factors through robust data collection, and linking and referring members to support supports to addressed identified risk factors; augmenting efforts to address SDOH by integrating SDOH work into the Advancing Primary Care (APC) initiative and increasing investment in SDOH through the targets set within the APC initiative; enhancing attention to health disparities through reporting and quality improvement initiatives; and incorporating SDOH efforts as feasible into MQD's VBP efforts.

Subsequent to the release of the Managed Care Quality Strategy, MQD re-procured its managed care contract in 2021 with substantial new requirements related to SDOH included within the new contracts. In 2022, MQD contracted a consultant to support the development of the Statewide SDOH Transformation Plan.

The purpose of this evaluation is to assess the extent to which Health Plans, MQD, and the State of Hawaiʻi are currently measuring and addressing SDOH and reducing health disparities among members. Specifically, this evaluation aims to answer three research questions: 1) What kinds of support strategies and interventions addressing the social determinants were chosen by Health Plans and how do these strategies translate to provider and patient behaviors? 2) In what ways did Health Plans develop and adopt a SDOH Work Plan within their Quality Assessment and Performance Improvement (QAPI) plans? and 3) In what ways did the State develop the SDOH statewide Transformation Plan?

Evaluation Approach

Data Sources and Description

Health Disparities Report

The Health Disparities Report was created during this waiver demonstration period with the new managed care contract in 2021. In 2020, MQD required Health Plans to begin submitting member-level quality measure data files that include quality measure and utilization data to support and augment efforts to conduct disparities-based analyses. These data are used by Health Plans within the Health Disparities Report to identify health disparities across a select set of quality measures, and to develop support strategies and interventions to target specific health disparities affecting their member populations. The Health Disparities Report focuses on HEDIS measures, which are already gathered and reported by the Health Plan in four areas within which health disparities may exist: 1) Cancer screenings, specifically breast cancer screening; 2) Access to preventative pediatric care for children and adolescents, as measured by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Screening Ratio; 3) Early intervention for mental illness and substance use, including Follow-Up After Hospitalization or ED Visit for Mental Illness or AOD Abuse or Dependence, Engagement with AOD Abuse or Dependence Treatment, and Depression Screening and Follow-up Plan; and 4) Plan All-Cause Readmissions. Within the report, Health Plans are required to stratify these data across race/ethnicity, members for whom English is a second language, geographical region, and members living with and without serious mental illness in order to identify disparities across these four dimensions. Next, Health Plans are asked to select three disparities they identify in their reports, justify their selection, and develop interventions to address and mitigate these disparities. Health Plans continue to report on the progress and results of the interventions they selected throughout the calendar year. The report rotates to a new measurement year of data for the same HEDIS measures in the following year and the quality improvement cycle restarts.

Quality Assessment and Performance Improvement Program (QAPI)

MQD has developed and maintained a Medicaid Quality Strategy for the state of Hawaiʻi as a comprehensive program built on continuous quality improvement; the most recent revision to the Quality Strategy was completed in 2020. As part of the Quality Program, and in conjunction with the new managed care contract in 2021, MQD developed and implemented a revised data-driven, outcomes based, continuous Quality Assessment and Performance Improvement Program (QAPI) report requirement for its Health Plans. The QAPI report requires Health Plans to report on the progress of their QAPI plan; and focuses on rigorous outcome measurement of relevant targets that are matched against specified benchmarks, and supports providers and beneficiaries in advancing quality goals and health outcomes. This process includes considerations for tracking outcomes and addressing deficiencies when improvement is not occurring. The QAPI aims to meaningfully demonstrate alignment with MQD-developed plans. It covers all demographic groups, care settings, and types of services. With the QAPI, 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 QAPI report is a critical resource used by MQD to ensure population health management, including the capability to identify subpopulations (for example, by race, ethnicity, primary language or special populations) experiencing disparities. The Health Plan’s QAPI plan 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 subpopulation 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 Dual Special Needs Plan (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 collaborated with DHS, other state agencies, and as needed, with other Health Plans, to develop and implement a SDOH work plan within their QAPI plans that adopts a whole-person-care approach through the provision of SDOH resources at the community and member levels. Health Plans include information about their SDOH work plans within their QAPI reports; SDOH work plans are evaluated by the second research question.

Social Determinants of Health State Transformation Plan

In 2022, MQD developed a Social Determinants of Health (SDOH) Transformation Plan in partnership with various community partners and providers including, but not limited to, its Health Plans. This plan represents MQD’s strategy 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. The SDOH Transformation Plan aims to develop a shared MQD and Health Plan Road Map to address health disparities comprehensively and systematically. Early implementation stages of the plan emphasize the use of analytics and analytic methods by MQD and the Health Plans to identify and monitor health disparities, and increase identification of unmet social needs through enhanced data collection methods. Later implementation stages 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 paves the way for the development of financial mechanisms to address and mitigate health disparities and unmet social needs.

Hawaiʻi Med-QUEST SDOH Initiatives: Current State Assessment and Resources

In preparation for the SDOH Transformation Plan, MQD conducted a statewide assessment to detail SDOH initiatives in progress in Hawaiʻi; the assessment helped influence the development and content of the State Transformation Plan. Details around the process and findings of the assessment will be described in the results of evaluation research question 3.

Data Analysis

This section of evaluation relies on qualitative data. The evaluation team members reviewed three documents mentioned in the data source section and analyzed the data using thematic coding based on the research questions. Each document was coded independently by at least two members of the evaluation team. The evaluation team met regularly to debrief and discuss the coding process and to resolve any concerns or inconsistencies. The evaluation team identified exemplar quotes of themes and included these within the outputs section.

Results

In this section, we firstly describe health disparities and their root causes that are identified by Health Plans and guide HPs' program development to address health disparities. We then present three subsections—strategies and interventions addressing SDOH, adoption of SDOH work plan, and development of the statewide SDOH Transformation Plan, to answer the three research questions respectively.

Health Disparities in Hawaiʻi

To guide the development of work plans that target existing health disparities, the Health Disparities Report first asked Health Plans to report on several outcome measures across areas of potential disparity, including among racial/ethnic groups, geographical regions, groups with different language abilities, and people with serious mental illness. These disparities were examined across the utilization of several health services, including screening for depression and follow-up plan (18–64 years), adults' access to preventive/ambulatory health services, breast cancer screening, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), initiation and engagement of substance abuse or dependence (AOD) treatment, and plan all-cause readmissions. These results were used by Health Plans to guide the development of special programs targeting health disparities.

Across Health Plans, patterns of disparities emerged:

- Members identifying as Native Hawaiian, other Pacific Islander, Filipino, and White had lower utilization of preventive health services, breast cancer screening, and follow-up after hospitalization for mental illness compared to other ethnic and racial identity groups. Members identifying as Japanese, Filipino, and Chinese had higher rates of screening for depression across age groups compared to other ethnic and racial identity groups.
- Members for whom English is not their first language (ESL) had lower utilization of preventative health services, fewer EPSDT screenings, and reduced rates of initiation of substance use disorder treatment compared to members for whom English is their first language.
- Rural communities (i.e., Hanalei/Kapaa, Lānaʻi/Molokaʻi, Lihue/Waimea, Nanakuli/Waianae, North Shore Oʻahu, North Shore/Upcountry Maui, South Hawaiʻi) reported fewer breast cancer screenings and EPSDT screenings compared to more urban communities. However, other disparities existed across specific neighborhoods regardless of urbanicity. For instance, initiation of AOD abuse or dependence treatment occurred at lower rates for some urban areas (i.e., Aiea/Pearl City/Waipahu, Downtown/Waikiki) and rural areas (i.e., Hanalei/Kapaa, Lānaʻi/Molokaʻi, Nanakuli/Waianae), thus highlighting the need to take a fine-grained approach to geographical service disparities.
- Individuals living with serious mental illness (SMI) also showed higher rates of plan all-cause readmissions and lower utilization of initiation and engagement of AOD treatment compared to members not living with SMI.

Potential Root Causes of Health Disparities

Health Plans were also asked to describe potential root causes of health disparities within the Health Disparities report. Among the potential root causes of health disparities that Health Plans identified, several patterns of SDOHs were highlighted including:

- Lack of transportation
- Language barriers
- Cultural beliefs about health services
- Limited health literacy skills
- Unstable housing or homelessness
- Unemployment, having to work multiple jobs, or jobs with unreliable schedules
- Lack of daycare support for parents
- Discrimination
- Stigma of mental illness in the community
- Healthcare access and quality

Several Health Plans emphasized that their patients had to forgo healthcare due to a lack of transportation or not being aware of the availability of transportation services. For example, one health plan noted that:

> *"Health Center A reported getting calls regularly from patients who need to cancel their appointments or postpone their appointments because they just can't find transportation to the clinic. Because of this, these patients either have important health care delayed, or, in some cases canceled altogether. Public transportation is extremely limited, and access to Medicaid-paid transportation is also limited on these islands."*

Another significant SDOH contributing to health disparities among members were language barriers and cultural beliefs about health services, and their impact on limited health literacy skills. Health Plans noted several barriers that stemmed from language barriers or cultural beliefs about health services:

> *"Language barriers and a lack of cultural understanding and norms, among other social need disparities, have prevented many from getting the care they need. These barriers have made chronic disease awareness, education, and understanding of treatment options very difficult among these populations, which creates and sustains health disparities in our community."*
>
> *"For Samoan women, important predictors for obtaining a mammogram include access to care, knowledge about risk factors and screening guidelines, psychosocial factors, and culture-specific beliefs. It is likely that access to care and health education, combined with culture-specific beliefs and mistrust of the health system contribute to disparities in screening rates."*

Health Plans agreed that experiencing housing instability or homelessness is often associated with barriers to accessing healthcare or causes disruptions to services already initiated. Health Plans indicated that regions with geographical health disparities were overlapped with regions with high homelessness rates.

> *"In this region, there is a high percentage of members who are homeless while experiencing a substance use disorder, creating additional social barriers to accessing care."*
>
> *"It is difficult to quickly identify and coordinate with members who need to initiate and stay engaged with treatment, particularly members who are difficult/unable to locate such as those who are homeless."*

Multiple causes regarding healthcare access and quality were identified by Health Plans, such as long travel distance to the healthcare provider, lack of availability for appropriate services, limited appointment availability, lack of care coordination, and healthcare system inconsistency.

> *"Results from our outreach revealed that members did not want to switch from their assigned PCP due to the provider's multiple clinics being in close proximity to member homes/working locations."*
>
> *"Appointments are not always available to complete EPSDT screenings timely."*
>
> *"Services at the clinically appropriate level of care may not be readily available when the member does reach a stage of change and is ready to take advantage of services."*

In summary, as part of the Health Disparities report, the Health Plans provided data on health disparities across specified domains and identified a breadth of potential root causes leading to these disparities. Common themes emerged across reports submitted by Health Plans and serve as an encouraging first step in monitoring health service disparities. These data and root causes were used as the foundation for developing support strategies and interventions to address SDOH, detailed below.

Strategies and Interventions Addressing SDOH

This section aims to answer the research question 1: What kinds of support strategies and interventions addressing the social determinants are chosen by Health Plans and how do these strategies translate to provider and patient behaviors?

Health Plans described support strategies and interventions addressing SDOH in their SDOH work plan within QAPI reports and Health Disparity Reports, which provide answers to the first evaluation question.

Strategies and Interventions Identified in SDOH Work Plans

Health Plans have begun to work on SDOH workplans within their QAPI plans. As part of this work, specific quality activities were proposed or implemented across multiple levels to address SDOH, including for members and Health Plan employees, and at the Health Plan systems level.

In total, 24 quality activities were reported across Health Plans. At the member level, two Health Plans proposed or implemented quality activities focusing on homelessness, including programs that focus on landlord engagement and triage for unsheltered members. The landlord engagement program enrolled 31 landlords, housed 108 chronically homeless veterans, and assisted 146 homeless veterans. Triage for unsheltered members vetted 592 members for participation in outreach, connected 469 to next step resources, and housed 19 members. Three Health Plans proposed or implemented quality activities focusing on food insecurity, including programs that provide members in need with meals, produce, or financial supplements to ensure proper nutrition. Health Plan 5 provided monthly food credit and transportation to the grocery store for 15,400 Dual-Eligible Special Needs Plan (DSNP) members. Health Plan 3 provided meals for low-income pregnant women and new moms and provided fresh produce for those who are food insecure. Additional member-level activities described by Health Plans focused on reducing emergency department utilization, promoting maternal health, providing educational opportunities for members (e.g., high school equivalency certificate program), developing programs providing Native Hawaiian traditional practices (e.g., lomilomi, hula, ho'oponopono), encouraging

COVID-19 recovery efforts targeting Native Hawaiian and Pacific Islander communities, improving access to information about social services, and addressing social isolation.

At the Health Plan employee level, SDOH training for staff was proposed by one Health Plan. At the Health Plan system level, two Health Plans proposed quality activities that aimed to develop a system to screen and document SDOH data and improve coordination of social services. Health Plan 3 reported that 133 providers were enrolled in the web-based coordinated care network focusing on coordinating resources to address SDOH and treat needs of the whole person. Health Plan 5 established a web-based resource and referral platform and made 112 referrals to free or reduced cost, need-based social services in 2022.

Strategies and Interventions Identified in Health Disparity Reports

Support strategies and interventions implemented (or to be implemented) in the Health Disparities Reports included efforts to increase patient or community engagement and outreach; and improve health care coordination and access to health care through such interventions as providing transportation or relieving travel burden, and scheduling access to services outside of the regular weekday clinic hours.

Patient engagement and outreach activities were proposed to address root causes of SDOHs such as language barriers, cultural beliefs about health services (e.g., stigma), and limited health education and literacy skills. These activities included incentives that encourage patients to seek preventive services, creation of multi-language communication toolkits, participation in regional health fairs, and mailing campaigns containing education materials and healthcare provider information. See Table V.3B.1 for examples of patient engagement and outreach activities.

Table V.3B.1: Example Patient Engagement and Outreach Activities

Example Patient Engagement and Outreach Activities
Health Plan A will implement an engagement strategy with members and providers in which members are incentivized with a $25-dollar gift card for completing the well child visit, and office staff are incentivized for outreach associated with successful attendance of well child visits.
Health Plan B will employ a Motivational Interviewing approach to encourage members to access services, utilizing Certified Substance Abuse Counselors (CSAC) and Certified Peer Support Specialists (CPSS) as part of a member engagement strategy.
Health Plan C has preliminarily developed a disparity toolkit for the Filipino population. The toolkit provides an evidence-based framework for use when communicating directly with members (in-person, over the phone, and via email), developing materials (written, electronic, and recorded), and developing interventions. Components of the toolkit includes messaging checklists for use when developing educational materials for members, intervention recommendations when developing programs, and multicultural messaging charts
Health Plan D will run a 'Pink Ticket' mailing campaign targeting eligible members from underperforming regions who did not complete a breast cancer screening in 2022. The mailer will educate members on the importance of mammography and will encourage them to schedule a free mammogram with a provider. It will also offer tips on how to prepare for a mammogram and will provide the address and contact information for imaging centers or facilities that are convenient to the member's location.

Each Health Plan also described interventions that focus on collaboration with communities, community-based organizations, community health workers, and peer-support specialists. These community-based interventions integrated programs that improve patient engagement and health coordination. The collaboration with communities was proposed to address SDOH with the intent of addressing the following community-level challenges: 1) Ethnic communities and community leaders often have significant cultural, social, and language capital, including trust with patients, which may be key to engaging patients within groups that experience health disparities; 2) navigation and coordination services supported by communities expand access to healthcare for patients, and may address root causes such as lack of availability to appropriate services, limited appointment availability, and healthcare system inconsistency. See Table V.3B.2. for examples of Health Plan community-based engagement activities.

Table V.3B.2. Health Plan Community-Based Engagement Activities

Health Plan Community-Based Engagement Activities
Health Plan A is partnering with community health clinics to create a Community-Based Chronic Kidney Disease Care Management Program. This effort intends to reduce disparities for Native Hawaiian and Pacific Islander (NHPI) communities. The most crucial component of this effort will be utilizing Community Health Workers, Patient Navigators, Interpreters, Health Educators, and other support specialists from NHPI communities.
Health Plan B is partnering with community health clinics and CIS providers as part of a member engagement strategy given the number of homeless individuals with co-occurring substance use disorders.
Health Plan C is identifying members due or overdue for breast cancer screening and scheduling them for mammogram appointments. Planning includes partnering with different community organizations to provide education on different health related topics.

Lastly, other interventions focused on expanding existing service options, including providing transportation or mobile services, promoting awareness of transportation benefits, and expanding services outside of the regular weekday clinic hours, see Table V.3B.3.

Table V.3B.3. Health Plan Service Expansion Activities

Health Plan Service Expansion Activities
Health Plan A has partnered with a community health center to provide a van and Non-Emergency Medical Transportation Program that will support closing the transportation gap on the island.
Health Plan B has developed a mailer that includes information about the non-emergency medical transportation benefit available for members who have no other transportation options available
Health Plan C is piloting Saturday Health Fairs to provide access to services outside of the normal Monday-Friday clinic hours

Overall, Health Plans proposed several support strategies that target patient engagement, community engagement, and service expansion in order to address some of the root causes of health disparities noted above. Some support strategies specifically target disparities identified in the data from the Health Disparities Reports (e.g., expanded outreach for breast cancer screenings, incentives for EPSDT screenings), while others target root causes identified by Health Plans (e.g., transportation, scheduling).

Adoption of SDOH Work Plan

The following themes are summarized to answer research question 2: In what ways did Health Plans develop and adopt a SDOH Work Plan within its Quality Assessment and Performance Improvement (QAPI) plan?

The Health Plans' SDOH work plans were submitted as a component of the QAPI plan, and each plan specified timelines, benchmarks, milestones, and deliverables. The Health Plans' initial SDOH work plans were required to include:

- Plans for increasing the systematic collection and documentation of member-level SDOH data through screening;
- Plans for promoting the use of the International Classification of Diseases Tenth Version (ICD-10) Z codes for SDOH documentation;
- Plans to increase provider understanding of SDOH;
- Plans for incorporating SDOH strategies into the overall QAPI by:
- Linking beneficiaries to identified SDOH needs; and
- Providing relevant SDOH value-added services offerings;
- A description of how the Health Plans directly address and adapt their QAPI to accommodate SDOH needs for the following target populations:
    - Special Health Care Need (SHCN), Expanded Health Care Need (EHCN), and LTSS populations, including adults and children, for whom social needs have been identified through the SHCN, EHCN, and LTSS assessment;
    - CIS populations; and
    - Other populations with complex physical, behavioral, and social conditions.

The evaluation team reviewed quality activities identified by Health Plans in their SDOH work plans and evaluated how the quality activities meet the requirements for the initial SDOH work plans.

Systematic Collection and Documentation of Member-Level SDOH data

Two Health Plans implemented three quality activities that aimed to systematically collect and document member-level SDOH data through screening. For example, one Health Plan indicated that they are leveraging available data to proactively identify members that may be experiencing one or more social risk factors in order to link them to interventions. Additionally, the Health Plan indicated that they created an SDOH Flag to prompt providers to ask members SDOH-pertaining questions regarding their living situations and access to food, every 6 months.

International Classification of Diseases Tenth Version (ICD-10) Z Codes for SDOH Documentation

Health Plan 3 identified an initiative to promote the use of ICD-10 Z codes for SDOH documentation for CIS members. The initiative started with screenings on homeless members first and where appropriate, referral of members into the CIS workflow. Collaborating with primary care providers and educating providers/clinical partners about this process are also included in this initiative.

Increase Provider Understanding of SDOH

Along with promotion of ICD-10 Z codes for SDOH documentation, Health Plan 3 also provided annual trainings to educate providers and clinical partners on this process. Health Plan 3 aimed to raise awareness and build the SDOH documentation into workflows. Another activity by Health Plan 3 built a web-based coordinated care network to connect health care providers and social services providers and enrolled 78 providers in the network. This network focuses on coordinating resources to address SDOH and treat the needs of the whole person, which is naturally expected to increase providers' understanding of SDOH. As previously described, Health Plan 5 established a web-based resource and referral platform and made 112 referrals to free or reduced cost, need-based social services in 2022.

Incorporating SDOH Strategies into the Overall QAPI

As described in above section "Strategies and Interventions Identified in SDOH Work Plans," Health Plans incorporated SDOH strategies in the QAPI reports by initiating quality activities at multiple levels to address SDOH, including for members and Health Plan employees, and at the Health Plan systems level.

Those quality activities focused on homelessness, food insecurity, reducing emergency department utilization, promoting maternal health, providing educational opportunities, providing Native Hawaiian traditional healing practices, encouraging COVID-19 recovery efforts targeting vulnerable communities, improving access to information about social services, and addressing social isolation, SDOH training for staff, and the development of a system to screen and document SDOH data.

Accommodate SDOH Needs for Target Populations

Among quality activities to address SDOH in the work plan, activities focusing on reducing emergency department visits among homeless individuals attempt to address SDOH needs for target populations, including members enrolled in SHCN and CIS. For example, Health Plan 3 initiated a COVID-19 homeless triage and transfer program that provided public health outreach to the most vulnerable unsheltered homeless. Health Plan 1 initiated an "ER high needs program" for members with high needs but without regular primary care source and/or connection to community supports.

Additionally, the evaluation team also identified themes such as Health Plans' understanding of social risk factors, their collaborations with other parties to address SDOH, and the measurement of their progress in addressing SDOH.

Social Risk Factor (SRF) Understanding

Health Plans appear to have a clear understanding of how to tie interventions to social risk factors (SRFs) when it comes to food insecurity and homelessness, in that they appear to be aware that experiencing housing and food insecurity has negative impacts on members' health outcomes, and have proposed specific interventions to address these SRFs. Given that there is no natural bridge between the healthcare system and social services systems, there are many barriers to addressing these SRFs, and the Health Plans' proposed interventions represent an important first step in implementing such a bridge. For example, some Health Plans are attempting to create an electronic referral process, so that a provider (MD) can prescribe/refer members to a social service (e.g., a food bank), and this referral is electronically conveyed through a bridging system to the social service provider (who reaches out to the member, provides the outreach, and communicates back with the provider through the system). These types of systems are becoming increasingly popular, and when implemented can connect to various types of social services based on the needs of members. We look forward to Health Plans continuing to expand their reach in addressing social risk factors beyond food insecurity and or homelessness, such as their efforts to improve access to healthcare with providing transportation and alternative appointment times outside of the standard Monday to Friday workday to target working families and those who cannot afford transportation and/or live in rural areas in Hawaiʻi.

One Health Plan described a project that provides linkage to adult education programs for members to attain high school equivalency. This Health Plan specifically noted that they aim to target adult educational level as a SDOH and provide a clear link between their activity and the SDOH they aim to address. Although this example could benefit from more details about why adult educational level is linked to health outcomes, it is a clearly defined program that targets a specific SDOH.

Collaboration with other Parties

Health Plans are expected to collaborate with DHS, other state agencies, and as needed with other Health Plans, to develop and adopt an SDOH work plan within its QAPI. Plans for collaboration with parties outside of Health Plans were documented in the "Contributing Partner(s)" column in the SDOH work plan. Three Health Plans noted collaboration with community sites (e.g., schools, community health centers, Office of Aging, Honolulu Police Department), healthcare providers (e.g., hospitals, physicians, nurse practitioners, and emergency department staff), and social services providers. Only one Health Plan specified plans to collaborate with another Health Plan. Two Health Plans lacked clear plans to collaborate with partners outside of their organization across any quality activities. The managed care reporting workflow provides opportunities for MQD to monitor, evaluate, and send feedback to Health Plans where gaps are noted to support iterative and continuous process and quality improvements.

Measurement of Progress

Although Health Plans were expected to develop timelines, benchmarks, milestones, and deliverables for their quality activities, only 12 (50%) of the 24 quality activities included a performance measure. Among these 12 quality activities, two quality activities did not include any follow-up data for milestones or deliverables.

Many of the indicated progress measures lack the details necessary to evaluate the fit of the measure to the quality activity. For example, for the quality activity focusing on emergency department visits, the listed performance measure is simply "ED High Needs Program" with some data that lacks adequate context for interpretation. Data driven QAPI reporting is a new concept for MQD's Health Plans. Quantifying the types of activities occurring; and identifying measures that evaluate the efficacy of these activities require substantial technical assistance and support to Health Plans. Unlike with the CIS program, UH SSRI collaborators have not engaged in rapid-cycle assessments to support iterative improvements in understanding of MQD's expectations for other programs.

Six quality activities reported clear quantitative measures that included a Year 1 Target, milestones, and deliverables. For example, one quality activity focused on a program that provides food assistance proposed the use of the "percent of members who used the benefit," as the performance metric and successfully reported data across three quarters. MQD intends to build Health Plan capacity by building upon these types of examples of successful initiatives with clear objectives, performance measures, and targets.

Development of SDOH Statewide Transformation Plan

This section aims to answer research question 3: In what ways did the State develop the statewide SDOH Transformation Plan?

To develop the statewide SDOH Transformation Plan, MQD worked with partners to complete an assessment to 1) understand the current state of SDOH initiatives in Hawaiʻi; 2) articulate the desired future state of SDOH initiatives in Hawaiʻi; and 3) identify strategies to make progress toward that future state of SDOH initiatives in Hawaiʻi. MQD utilized interview and survey methods to collect information from several community stakeholders including Health Plans, hospitals, federally qualified health centers (FQHCs) and Native and Hawaiian Health Centers, community-based organizations, and state and local government agencies. This information was used to prepare the Current State Assessment and Resources document to inform the SDOH Transformation Plan.

Med-QUEST's SDOH Transformation Plan is organized around four goals:

Screening and Referrals: Healthcare organizations and community-based service providers use validated, evidence-informed standardized screening and assessment tools to identify individuals' health-related social needs and connect individuals to community resources;

SDOH Data and Information Sharing: Data, information, and interoperable IT systems facilitate gathering and sharing of individual health-related social needs and information on community resources at the point of care;

Community Supports: Strong networks of community-based resources to address SDOH needs, with a focus on access to health and social services benefits including housing, financial assistance, and nutrition; and

Payment and Funding: Incentives, value-based payments, and braided resources that support SDOH work.

Regarding the first goal, the assessment recommended enhancing SDOH information sharing, providing standardized tools and additional guidance, and expanding SDOH screening domains and population screened. The SDOH Transformation Plan identifies key strategies to support Health Plans in expanding, enhancing, and aligning SDOH screening and referrals. Planned support include providing billing and coding guidance on social risk factors screening and referrals and including SDOH screening domains in the Health and Functional Assessment.

For the second goal, Health Plans recognized a need for a centralized approach to gather and share SDOH information to streamline data collection, referral sharing, and service navigation. Priority activities included: 1) Development and submission of a Planning Advanced Planning Document (PAPD) application to support a planning period to gather information and test the feasibility of data exchange platform options that encompass SDOH information; 2) Development of guidance based on national best practice to support the collection of race, ethnicity, and language (REL) and sexual orientation, gender identity, and expression (SOGIE) population and subgroup data; and 3) Development of resources to support Health Plans to develop evidence-based interventions to address health disparities identified through the Health Plan Health Disparities Report.

Regarding the third goal, stakeholders recognized a need for the development of referral workflows and payment models that balance the different operational needs of healthcare and social service providers. The SDOH Transformation Plan identifies strategies to strengthen the CIS program and expand access to other social services and public programs. MQD noted a commitment to working with Health Plans and provider partners to implement programmatic operational changes to support successful implementation of CIS, and work with community partners and other state agencies to identify opportunities to strengthen connections with social services and public programs that address SDOH needs.

For the fourth goal, the key strategy is to expand opportunities to leverage Medicaid funding and development of payment incentives to support SDOH services and the delivery of integrated care that addresses an individual's social and health needs. Three priority activities identified include: 1) the expansion 1115 demonstration authority to pay for SDOH services and interventions via the renewal process (that MQD is seeking as part of the 1115 waiver renewal process); 2) support for Health Plans' ability to utilize in Lieu of Services (ILOS) benefits to meet SDOH needs; and 3) sustain and expand existing hospital SDOH pay-for-performance opportunities.

Conclusions and Recommendations

There has been an increasing interest in understanding how the social determinants of health interact with health and healthcare; a growing body of literature has demonstrated a causal connection between the presence of social risk factors and poor health outcomes. Medicaid agencies by their very nature target and serve populations that are disproportionately impacted by social risk factors that put them at risk for higher morbidity and mortality. Therefore, it is unsurprising that Medicaid agencies are leading the way nationwide in attempting to implement strategies that seek to identify, address and mitigate these additive negative impacts on the health and cost of care for their populations. A related concern is the impact of health disparities on health outcomes, where certain subpopulations (typically differentiated based on one or more demographic characteristics such as race, geography or language; but also based on the presence of one or more social risk factors) experience relatively poorer health outcomes. For Medicaid agencies, it is important to be aware of the sociocultural contexts within which healthcare is delivered, and the need to intentionally focus on efforts to reduce healthcare disparities through a variety of methods.

The National Academies of Sciences, Engineering, and Medicine (NASEM, 2019) proposed a framework for integrating social care into the delivery of healthcare that focuses on 1) improving Awareness of social risk factors through increased screening in the healthcare setting; 2) utilizing SRF data to make Adjustments as appropriate to clinical regimens; 3) providing patients Assistance by linking/referring them to additional services to address their social needs; 4) achieving Alignment across community settings and organizations to mitigate emerging social needs; and 5) supporting healthcare organizations and social care organizations in engaging in Advocacy to promote policies that support greater coordination and alignment of systems of care to prevent the emergence of unmet social needs.

This qualitative analysis sought to evaluate three research questions that focused on the Hawaiʻi Medicaid program's progress in addressing SDOH during the current 1115 waiver demonstration period. The three questions focused on MQD's implementation of the statewide SDOH Transformation Plan (RQ.3); MQD's translation of its SDOH goals into its managed care contract and subsequent requirements for its Health Plans to develop and adopt SDOH Work Plans (RQ.2); and the actual work to date by Health Pans in implementing a variety of strategies and interventions on the ground that support SDOH efforts in general, and additionally attempt to reduce identified health disparities (RQ.1).

Overall, information gathered from a variety of reports indicate MQD and its Health Plans have conducted substantial planning and begun to implement a variety of strategies to address SDOH across multiple levels, including the patient-, provider-, Health Plan- and systems-levels. During the demonstration period, MQD successfully included a number of SDOH requirements into the Health Plans' managed care contract that was reprocured in 2021; implemented a new QAPI report that requires data-driven evaluations of the Health Plans' QAPI including but not limited to their SDOH Work Plans; implemented a new Health Disparities Report that requires Health Plans to identify and implement interventions to address health disparities across a series of quality metrics stratified by multiple demographic dimensions; and worked with partners statewide to implement a SDOH Transformation Plan that includes a roadmap for continued work to support SDOH efforts at multiple levels of the healthcare system.

Through our investigation, the evaluation team learned of several interventions and support strategies identified by both MQD and Health Plans to address the root causes of SDOH, improve data collection and outcome measurement, and implement interventions that mitigate identified social needs. However, the majority of these activities remain in planning and have not yet been implemented; and of those activities that are implemented, the quality, depth, and breadth of such strategies varied significantly. Nonetheless, it is heartening that much work has begun and effective planning for additional work has been completed.

In their Health Disparities Report, most Health Plans successfully identified pockets of disparities across all the measures evaluated in the report (including breast cancer screening, all-cause readmission or adult's access to preventive/ambulatory health services, and initiation/engagement of alcohol and other drug abuse dependence treatment). These varied by geographical regions and race/ethnicity, with substantial disparities identified among NHPI and Filipino populations. Health Plans identified several health disparities in the utilization of health services by members for whom English is a second language, and among members living with serious mental illness.

However, when asked to identify the root causes of these disparities, details regarding the etiology of the disparity were often lacking. For example, Health Plans noted that issues such as discrimination or homelessness often overlap with health disparities, but they did not explain how discrimination or homelessness might cause health disparities. Moreover, the interventions that Health Plans implemented were often limited and generally not at a systems level. For example, some Health Plans addressed transportation barriers by providing a van, but they did not have adequate financial support to sustain it and reach many rural/urban regions in the state. Another Health Plan opened Saturday Health Fairs to increase access to breast cancer screenings and adolescent wellness checkups, due to many members not being able to go to appointments during the weekdays; however, this intervention does not address the issue at a systems level.

Health Plans highlighted differences in cultural practices/beliefs and how that could be related to mistrust in healthcare providers, but solutions were more focused on language barriers and relying on community partners to help. Healthcare coordination was mentioned as an issue, especially for those with serious mental illnesses and experiencing homelessness, but the Health Plan's solutions were not outlined specifically at this stage. Thus, although the Health Plans proposed several projects to target SDOH, it is unclear the extent to which they target SDOH via underlying root causes. The evidence-based interventions that were described were often somewhat limited, preliminary, and needed more funding to continue or be successful. Progress tracking was often delegated to the community partners rather than performed primarily by the Health Plans themselves. The Health Plans were concerned about SDOH and wanted to better educate providers and inform members about the importance of screening as an intervention to increase access to healthcare and improve health outcomes.

Regarding the QAPI plan, Health Plans similarly identified several projects to target SDOH at the member, provider, and health system level. The focus areas covered a rich range of SDOH, including housing and homelessness, food insecurity, education, cultural factors, and social isolation. However, similar to the strategies noted above, the root causes of these SDOH were often unclear or lacked detail. Additionally, the quantitative measures selected to track the effectiveness of these interventions were only reported for half of the projects, and often reflected engagement in the program rather than specific health-related outcomes that would reflect the effectiveness of the intervention.

For Health Plans to identify interventions that effectively target social determinants of health, it will be important for them to accurately and specifically identify and define the mechanisms of these root causes. There may be a role for rapid-cycle assessments (RCAs) and other strategies to support Health Plans in evolving their understanding of SDOH and in brainstorming innovative solutions to address the issues identified. Further, Health Plans may learn from examples of effective interventions in the context of collaborative learning communities.

In summary, while SDOH have a strong impact on health outcomes, and addressing them in the context of healthcare is important, the implementation and operationalization of these important priorities into strategies, initiatives, and activities is new and underdeveloped. Data driven approaches to measuring performance and evaluating the impact of interventions also represent an area of emerging knowledge. MQD has established a clear pathway to implementing SDOH interventions for Hawaiʻi's Medicaid Program, and required itself and its Health Plans to operationalize initiatives with demonstrable efficacy. Tremendous progress has been made, and work to impact SDOH has begun at multiple levels. Continued and consistent effort is needed for MQD to realize the potential of the work that has begun. Additional resources including investments in systems, and opportunities for shared learning and collaboration are needed, to support the state's ability to successfully address SDOH as part of its overall HOPE initiative.

Lessons Learned and Future Recommendations

MQD's intention to promote SDOH initiatives with data-driven quality improvement has been clarified, however, the Health Plans continue to struggle to understand and meet these expectations. The evaluation team recommends the inclusion of RCAs to strengthen the formative evaluation of managed care delivery system across various key areas of the 1115 waiver demonstration, particularly in novel areas such as SDOH where Health Plan experience is limited. Given that it is a new expectation for Health Plans to identify and address specific root causes of SDOH, it is recommended that they be provided with common resources to educate staff about SDOH, including the most prevalent SDOH impacting members in Hawaiʻi, research on root causes of SDOH, and evidence-based interventions for addressing SDOH.

More resources need to be provided at the state and federal levels to aid Health Plans in selecting outcomes measures that adequately indicate whether a particular intervention is effective in addressing the root causes of SDOH. As a next step, Health Plans are encouraged to communicate more with each other to address SDOH and identify more effective, evidence-based strategies and interventions. Also, member-level data collected over longer periods of time, rather than only quarterly or over one year, will lead to better tracking of health disparities and the effectiveness of interventions for different groups and locations. Data privacy issues need to be addressed carefully to help Health Plans collaborate with community partners to better serve the needs of their members.

Overall, the SDOH State Transformation Plan is a vital step to improve population health and Health Plans are becoming more informed, so they will be better positioned to improve access to health care and the quality of care for their members.

VI. Conclusion

In this concluding chapter, we bring together the key findings and insights from the Medicaid demonstration evaluation. The evaluation focused on six priority areas including 1) Primary Care, 2) Care Coordination for Beneficiaries with Complex Conditions, 3) Home and Community Based Services, 4) Value-Based Purchasing, 5) Community Integration Services, 6) Social Determinants of Health.

We offer a summary of the main findings for each priority area as well as two overarching lessons learned throughout this demonstration period focused on reporting and measurement developments on the one hand and outcomes on the other.

Main Conclusions by Priority Area

Primary Care

First, Med-QUEST (MQD) developed several novel and useful operational definitions to track primary care spending and set targets for additional investments (i.e., primary care visits, beneficial primary care services and primary care supports). Overall, spending and utilization of primary care services decreased during the waiver demonstration period, however, this decrease was not uniform between definitions. Spending reduced significantly more than utilization, with spending per primary care visit remaining relatively steady, likely the result of the Primary Care Provider-Enhancement program's stabilizing effects on the rate of reimbursement per visit. Primary care visits were linked to an increase of several preventive care quality metrics, including increased adults' access to preventive services, well-child visits, and optimal comprehensive diabetes care. Effects of beneficial services and supports however, will need more time to materialize due to the noted delay in the impact of the outcomes. Results show support for efforts taken by MQD to increase the use of valuable primary care services, and encourage a continued investment in this area.

Health Coordination Services (Expanded and Special Healthcare Needs)

Second, continuous, multi-year engagement with health coordination services (HCS) was associated with increased home health and primary care services expenditures, lowered inpatient and emergency department utilization and emergency department cost. However, a high proportion of individuals eligible for and enrolled in HCS, including expanded and special health care needs populations, were not continuously engaged in services, underscoring the need to develop long-term engagement strategies. Although these results are derived from a single Health Plan, they suggest HCS has the potential to shift spending and utilization from emergency services to primary care and home health services for populations with high health needs.

Long-Term Services and Supports / Home- and Community-Based Services

Third, evaluation of home- and community-based services (HCBS) demonstrated that members receiving At-Risk services and those residing at home stayed longer in community dwellings, had higher goal attainment, and lower total cost of care. Long-term services and supports-receiving members with similar level of care scores, age, and sex at baseline who were in home settings had a substantially lower rate of functional decline over time than those in community-care foster homes or nursing homes. There appear to be benefits to in-home care that may surpass those realized with care provided in community-care foster homes, which mirrored outcomes observed in nursing homes. Furthermore, the likelihood of placement in diverse settings varied widely by level of care and diagnosis, suggesting the need for greater in-home supports for people with higher functional needs. These findings suggest that continued investment in At-Risk and HCBS will assist in rebalancing efforts while promoting longer community integration tenures.

Value-Based Purchasing

Fourth, we found that Health Plans are increasingly successful in meeting benchmarks set by MQD in its pay for performance program. Health Plans have designed and implemented several value-based purchasing (VBP) programs aimed at improving health outcomes in line with MQD intentions. At this time, most initiatives implemented by Health Plans are focused on primary care. Most VBP arrangements are based on a fee-for-service payment structure, with only two initiatives incorporating risk-based payments. Seven arrangements include population-based payments, specifically including per-member, per-month payments. These population-based arrangements are generally aimed at providing supplemental payments that go beyond the prevailing reimbursement model as incentives for providing care to high risk, complex-needs populations, and do not yet extend to comprehensive, integrated population payments for the full member population. Efforts by MQD to develop basic functional concepts for VBP programs and disseminate this information to Health Plans have been successful. More work is needed to identify successful elements across initiatives and promote the use of these elements across Health Plans; and encourage or incentivize the development of more innovative VBP programs targeting different provider types and quality outcomes.

Community Integration Services

Fifth, findings suggest that the community integration services (CIS) program has benefited from evaluation rapid-cycle assessments (RCAs). CIS has undergone major, necessary programmatic changes in order to effectively serve members and to adapt to local system needs. Health Plans are identifying the intended population for CIS (i.e., members with high total costs of care and who are high utilizers of emergency services); however, many of those members have yet to receive services due to backlog and lack of Homeless Service Provider capacity. Much of the data Health Plans reported to MQD does not yet capture important short-term goals related to housing, and long-term outcomes are still being monitored. Additionally, clearer definitions of ‘housing stability’ are needed, as long-term goals and impacts such as reduced cost of care rely on members achieving this status. Ongoing efforts to improve data collection will allow for monitoring of members receiving CIS services and impacts on health outcomes and total expenditures as the program matures.

Social Determinants of Health

Sixth, information gathered from a variety of reports indicates that strategies have been identified to address social determinants of health (SDOH) and eliminate health disparities across multiple levels, including patient-, provider-, and system-level interventions. However, the quality, depth, and breadth of such strategies varied significantly by Health Plan, suggesting a need for education and enhanced technical assistance. Finally, MQD took a community participatory, multi-stakeholder approach to develop the State’s SDOH Transformation Plan which will allow a coordinated and systematic approach to eliminating health disparities statewide.

Lessons Learned and Future Recommendations

Across the different programs and initiatives started during this demonstration period, we can draw two main lessons.

1. **This demonstration period initiated significant collaborations between MQD, Health Plans, and the evaluation team to transform program development and improvement, measurement and reporting in all priority areas**

MQD used this demonstration as a vehicle to implement the Hawaiʻi ʻOhana Nui Project Expansion (HOPE) Initiative. MQD made strong developments in measurement and reporting for this demonstration period across all priority areas. Prior to this demonstration, Health Plans were generally not required to collect or report member-level data beyond administrative encounter data. Collaborative fora in which to discuss challenges, prepare strategies for process/program improvements, and learn about data-driven approaches were not typically employed. Transitioning to a robust data collection regime required MQD, Health Plans and UH SSRI to engage in substantial collaboration, as well as capacity-building and coordination. In a collaborative manner, the implementation of RCAs for CIS created the foundation for establishing shared learning and program improvement models for other novel initiatives implemented by MQD. These strategies may lay a foundation for robust data culture and reporting strategies which integrate data-driven decision-making over future demonstration periods and into the long term. Below, we outline some of these advancements.

First, in the area of primary care, innovative definitions of primary care were developed to track increased utilization of high-impact primary care services and reduction of low-value services, and Health Plan reporting mechanisms were developed in accordance with these new definitions. As Health Plans become familiar with these new definitions as well as the reporting care provided, it will become easier for Health Plans and researchers to monitor process and outcome developments continuously over the course of years.

Second, in the area of care coordination, Health Plans in collaboration with members of the evaluation team and MQD set up a first reporting and evaluation collaboration for the 1115 waiver evaluation. Experiences in this collaboration serve to further revise reporting guidelines to improve consistency across plans with specific attention to defining care coordination and operationalization of care coordination in practice by different health plans for SCHN populations. This resulted in ongoing transformation of reporting guidelines and improved reporting quality for SCHN/EHCN and LTSS.

Third, value-based health care reports were developed to map the advancement of payment transformation to more advanced forms of reimbursements both qualitatively and quantitatively. This effort resulted in a well-defined reporting framework that allows for analysis of yearly advancement in accordance with the advanced payment model (APM) Framework. Improvements in provider attributions to VBP programs and lessons learned from attributing members to different providers participating in these programs will provide a data infrastructure that will support robust evaluations in the future to provide essential analysis of ongoing payment transformation.

Fourth, RCAs were implemented for CIS, allowing for speedier data collection and regular feedback to stakeholders, which promoted iterative refinement of the program. The RCA proved to be a particularly useful device for the implementation of the new and innovative CIS program. Although some challenges were imposed on stakeholders and UH SSRI project collaborators due to the high turnaround demanded by the RCA, it has resulted in program improvement and increased collaboration among all stakeholders.

The benefits of RCAs may also prove useful for other priority areas in the future—providing substantial opportunities for collaborative learning as programs are developed and implemented.

Fifth, MQD and UH SSRI collaborated to improve reporting templates and to provide technical assistance to Health Plans. Streamlined and improved reporting templates, including key metrics identified by evaluation staff during this waiver period, will allow for ongoing monitoring of program maturation, examination of CIS processes and outcomes and refinement of ability to produce data quickly for RCAs.

Sixth and lastly, MQD developed an SDOH transformation plan including new requests by MQD to Health Plans on addressing SDOH. For example, under the new managed care contract, Health Plans are required to submit SDOH reports on health disparities and quality improvement activities. Health Plans also developed and adopted an SDOH work plan within the Quality Assessment and Performance Improvement Program (QAPI) plan which is used to monitor the impact and progress of SDOH quality improvement activities.

Reports, measurements, and opportunity for process evaluations through RCA made strong improvement throughout the evaluation, and Health Plans gained experience and familiarity with the structure of reporting. Thus, the current demonstration period served as an initiation period and groundwork for more detailed evaluation in further demonstrations. This waiver demonstration period marked the first time that Health Plans in Hawaiʻi were required to provide such a high volume of detailed, individual-level metrics; incorporate those data and metrics into their quarterly reports; and participate in RCAs as part of the implementation of a new program. These enhanced evaluation and monitoring needs required substantial collaboration between UH SSRI, Health Plans and MQD. As the reporting transformation is ongoing, the newly-established infrastructure will aid further evaluation and improvement efforts in future demonstrations, and should involve other crucial stakeholders, such as patient advisory groups and providers.

Recommendation: Continue revisiting and improving reporting and measurement methodologies, focused on reducing reporting burden while capturing crucial process and outcome metrics that align across Health Plans that are informed by cross-stakeholder feedback, including members and providers. Expand the use of RCAs to other novel program implementations as needed.

Recommendation: Focus on developing a systematic process for incorporating member feedback into evaluation, program development, and program improvement.

2. The impact of the investments made by Health Plans and MQD in the priority areas are only partially visible at the time of evaluation due to ongoing implementation efforts and multi-year theory of change timelines

The results from most of the program evaluations did not mark conclusive, significant improvements in health outcomes, utilization of care services, and spending throughout the short period of evaluation. In part this may be due to the multi-year timelines needed to examine the impact of innovative, multi-stakeholder, and systems-changing strategies of the HOPE initiative. However, some encouraging signals were already observable for members receiving HCS and HCBS, and Health Plan achievement of quality outcomes set in MQD’s value-based P4P program. Results indicate that continuous engagement in HCS and HCBS is associated with improved health outcomes. Also, in the realm of value-based care, Health Plans made advancements towards achieving higher rates of performance (i.e., improved member health outcomes) in MQD’s P4P program. For CIS, short-term outcomes suggest that the program is enrolling the intended population with significant physical and behavioral health needs; and long-term effects will be measurable in future demonstration periods. Similarly, Health Plans' strategies to measure and develop interventions to address root causes of SDOH are likely to lead to measurable impacts on reducing health disparities.

Nevertheless, more time and work are needed to establish effectiveness of the implemented programs as reporting of process and outcome measures improve over time. Several factors impacted our ability to draw definitive conclusions from the current data.

First, new reporting mechanisms were developed, and data quality improvement activities were ongoing during the demonstration period. Essential information such as member engagement in HCS and CIS, service providers' activities, implementation of VBP program quality development, and records of program specific outcomes such as achieving housing for CIS, were not yet collected or reported across Health Plans. Furthermore, inconsistencies in reporting by Health Plans were noticed across these programs. While these are being addressed by MQD, quality and unified reporting (with minimal administrative burden) is needed to reliably track the level of implementation over time and their relation to the intended outcomes.

Moreover, the evaluation hypotheses are broad and focused on long-term outcomes that are impacted by many factors. The effects of the various components of the demonstration are entangled, implemented simultaneously and often targeting large, overlapping populations (e.g., populations with social needs, homeless population, and LTSS beneficiaries). To meet the HOPE objectives, these components were designed to be cross-cutting and mutually reinforcing. The crossover delivery of programs engenders inability to perform random assignment of members, creating analytical challenges to the evaluation. With increased access to data reports, it will become possible to specify both short- and long-term goals for each priority area in future demonstration periods. This will allow the evaluation team to isolate effects of different programs and how they might intersect to contribute to the system-wide goal of reducing costs and improving outcomes.

In addition, most investments are aimed at long term effects that have not yet occurred in the short period of three years during which the changes were evaluated (2019–2022). Many changes and investments were progressively implemented throughout the demonstration period, resulting in delayed occurrence of change. The evaluation team furthermore did not address all factors that contribute to health and cost outcomes such as the impact of the COVID pandemic during the evaluation period. MQD sought additional authorities and waivers of existing authorities relating to the public health emergency that may have impacted eligibility requirements, payment models, and delivery of services in specific areas such as LTSS, therefore affecting specific evaluation priority areas.

Finally, implementation of several programs is still relatively limited. In the case of SCHN/EHCN, only 15.3% of enrolled members for the Health Plan under study were continuously engaged and receiving services. This lack of implementation is potentially linked to case burden of individual case managers. Most Health Plans have described issues with capacity, and on average, Health Plans have reported caseloads of 100–300 members per care coordinator. Further root cause analyses are needed to identify other causes of disengagement, so that effective strategies to increase participation and engagement in these services can be implemented.

Health plans have faced several restraints in costs and available care workers during the COVID-19 pandemic that can explain limited implementation. Consequently, more investments need to be made to achieve the intended effects of the implemented programs on a larger scale.

COVID-19 impacts on implementation and evaluation

The COVID-19 pandemic and resulting public health emergency likely had a profound impact on both outcomes and the implementation. First, the pandemic is expected to have had a broad-based impact on several outcome measures of interest, affecting several evaluation priority areas (e.g., service utilization and total cost of care). This makes the impact of several interventions and programs implemented potentially invisible due to the far-reaching consequences of these unforeseen circumstances on members' health conditions, ability to seek care, and provider's restraints in implementation new forms of care provision. Second, the pandemic further aggravated an already strained access issue caused by provider shortages across the state. Third, the economic impact of the pandemic may ultimately affect the interventions implemented by Health Plans and MQD; this evaluation design proposes a multitude of new initiatives tied to MQD's managed care re-procurement. Larger budgetary constraints may morph or dictate MQD's decisions on how and when these interventions are implemented, further impacting evaluation design and restraints.

Concluding Remarks

The UH SSRI evaluation team greatly appreciates our collaboration with MQD and associated Health Plans, who collectively established and refined these innovative programs during this demonstration period. We are additionally grateful for the chance to contribute to the substantial efforts made by the health care providers in delivering these programs for the benefit of the Medicaid population. We look forward to on-going collaborations and partnerships aimed at advancing evidence-based programs and policies in the State of Hawaiʻi.

VII. References

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VIII. Appendices

Appendix I. Data Sources

The evaluation included the following data sources:

- Hawaiʻi Prepaid Medical Management Information System (HPMMIS) Administrative Claims and Encounter Data (encounter data): Health Plans in Hawaiʻi are contractually required to submit complete, accurate, and timely encounter data to HPMMIS. Encounter and claims data were used by the evaluation team to access information on diagnoses, utilization of services, and cost of care over time for a variety of analyses requiring these parameters. MQD receives encounter data up to twice per month from Health Plans, and the data is subject to a comprehensive encounter data validation process. Encounters that do not meet validation criteria are either rejected or pended in the system. Health Plans are required to review their pended encounters, make corrections and submit replacements as needed. Hawaii's encounter data does not currently meet actuarially acceptable completeness and accuracy standards; a variance of up to 10–15% on average is detected during encounter data reconciliation. Additionally, encounter data does not capture services provided to beneficiaries that are not submitted via claims; this may include some non-emergency medical transportation; other value-added services; care and service coordination and housing supports provided by Health Plan administrative staff; self-directed chore services; quality bonuses and other supplemental payments; and sub-capitation payments made to providers (although the corresponding encounters may be submitted). The Hawaiʻi Medicaid program is actively engaged in a multi-pronged strategy to address these data quality issues. As data quality is enhanced, the completeness and accuracy of data will improve; while this improvement is beneficial for evaluation, various analytic considerations were accounted for differences that arise from increases in cost and utilization attributed to improved data quality, as opposed to the interventions.
- HPMMIS Health Plan Enrollment Data: HPMMIS is the Hawaiʻi Medicaid Program's enrollment system. As such, beneficiaries eligible for Medicaid are enrolled in a Health Plan and the managed care plan begins to receive capitation payments as of the date of enrollment. Data sent to Health Plans from HPMMIS, which includes member demographics extracted from the member's application (age, sex, race, geography, ethnicity, etc.), eligibility category (Aged, Blind, Disabled; Low Income Adult, etc.), enrollment in special programs (LTSS, "at risk", CIS, etc.) and capitation payment amounts, were extracted and provided for analysis. Most data pertaining to Health Plan enrollment and capitation payment is heavily reviewed and checked for quality.

- Actuarial Risk Score data: The evaluation team used the Chronic Illness and Disability Payment System (CDPS) This is "diagnostic-based risk adjustment model that is widely used to adjust capitated payments for health plans that enroll Medicaid beneficiaries." (hwsph.ucsd.edu). The evaluation team used individual risk scores for the evaluation purposes. An individual risk score is calculated on age and gender, and diagnoses categories, with multiple diagnoses for different categories leading to higher risk scores. Risk scores are developed for rate setting purposes and are considered predictors of costs. Scores provide insight into multimorbidity and are a predictor for care utilization. The scores are therefore used by the evaluation team to control for health status across population groups under study.

- Health Plan Reports (as dictated by Health Plan contract requirements): Clinical information to support the evaluation, such as a beneficiary's housing situation and functional limitations, were gleaned through Health Plan reporting requirements, independent of administrative claims or encounter data. MQD implemented new reporting requirements at the start of the demonstration period for Health Plans to provide information that would otherwise not be available through other standardized data sources. The evaluation team used reports developed by MQD for VHC, Primary Care, CIS, SCHN/EHCN, LTSS and QAPI. To construct the different reports, Health Plans retrieved information from EHRs, case management systems, etc., and standardized this information into MQD's standardized reporting format. Reports were under development for the duration of the demonstration; therefore, limitations were imposed on the evaluation team in the use and interpretation of the data reported.

- Healthcare Effectiveness Data and Information Set (HEDIS®) and Other Quality Measure data: MQD has historically collected data on HEDIS quality measures, and other performance measures, from Health Plans in an aggregate format. Beginning in 2021, MQD implemented a patient-level data file requirement that allows for more granular data collection. This file includes identifiers that allow for linking quality-based outcomes with other member-level information including demographics, utilization, cost of care, and other metrics. MQD began with a subset of measures for patient-level reporting to phase implementation, therefore reducing the total amount of data available for evaluation. Also, no historic patient-level data was available for comparison or analysis.
- External data sources holding information collected by MQD-contracted providers (e.g., HILOC database, HMIS data system)
    - HILOC Database: This database is maintained by the Health Services Advisory Group (HSAG), MQD's EQRO, and collects data on the level of care (LOC) assessments requested by Health Plans and community providers for Medicaid members who require nursing facility level of care (NF LOC) or who are "at risk" of deteriorating to the NF LOC. The dataset includes comprehensive assessments of individuals' functional status during the initial request, annual review, or as changes occur. It also includes information about demographic characteristics and the availability of caregivers, which allows the evaluators to conduct matching and subgroup analyses. The data are collected primarily through a secure Web application developed by HSAG. Through this application, submission and review/approval of LOC requests are accessible to registered users from the State, Medicaid Health Plans, and service providers. Compared to paper-based methods, this automated data collection and processing method is more efficient and can provide faster reporting with more accuracy. HILOC interfaces with the State's prepaid medical management information system and can provide the necessary information to produce monthly, quarterly, annual, and ad hoc reports. Data timeliness and completeness may be impacted by the COVID-19 pandemic; through additional public health emergency related waiver authorities, individuals receiving LTSS services may begin or continue to receive services without an assessment during the public health emergency period.
    - HMIS. The Homeless Management Information System (HMIS) is a local information technology system that is used to collect and report client-level data for individuals who have experienced homelessness or at risk of homelessness and receiving support services. In Hawaiʻi, Health Plans work closely with the Continuums of Care responsible for managing the database. The evaluation team leveraged this data to account for ancillary services that complement services delivered via the CIS project. The database is limited by the quality and timelessness of the data entered by service organizations who provide direct care to clients experiencing homelessness. It is also relatively rigid regarding the types of data that can be entered. Moreover, it is not designed to be a research tool, but as a mechanism for

accessing individual client records and histories. Despite these limitations, the quality and timeliness of data entry is monitored by the Continuums of Care (there are two CoCs for the state of Hawaiʻi) to ensure that data files are appropriate for program evaluation and monitoring purposes.

- Surveys and in-depth interviews developed by the evaluators explicitly for our purposes, such as in-depth interviews with Health Plans conducted by the evaluators or qualified contractors.

Appendix II. Approved Evaluation Proposal Summary Tables

Demonstration Objective 1. Improve health outcomes for Medicaid beneficiaries covered under the Demonstration

Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes	
Component	**Description**
Corresponding Demonstration Hypothesis	Increasing utilization for primary care, preventive services, and health promotion will reduce prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.
Target populations	● Populations with one or more chronic conditions such as diabetes, hypertension, and chronic kidney disease ● Pregnant women ● Infants and children eligible for well child visits ● All adults
Evaluation questions and testable hypotheses	Evaluation Hypothesis H1.1: (1) Hypothesis 1.1.1: What are time trends in utilization, spending (as a percentage of total spending), and quality of primary care for Demonstration populations? a. Hypothesis: The Initiative will increase utilization, spending (as a percentage of total spending), and quality of primary care for demonstration populations, as measured by progressively broad definitions of primary care. (2) Hypothesis 1.1.2: a. Are changes in primary care utilization associated with plausibly relevant health outcomes? b. Are changes in primary care spending associated with plausibly relevant health outcomes? and c. Are changes in primary care quality associated with plausibly relevant health outcomes? Selection of health outcomes will be based on literature review and stakeholder (i.e. provider and beneficiary) consultation to identify and select health measures which are plausibly relevant to improvements in primary care utilization, spending, and quality, respectively (see Methodology and Limitations sections above).

Data Strategy, sources and collection frequency	**Administrative data.** Potential administration data for analysis include encounter, claim, and beneficiary-level report data regarding primary care utilization, spending, and quality measures, as well as beneficiary sociodemographic characteristics. The administration data are housed in the data warehouse of the State of Hawaiʻi Department of Human Services (DHS). Indicators that would be considered include HEDIS, state-defined health care quality and outcome measures, measures of total costs of care per beneficiary, as well as the measures of patient satisfaction and patient-reported outcomes e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS). Indicators chosen will depend on data availability and quality. Current indicators under consideration include HEDIS measures pertaining to Adult Access to Preventive/Ambulatory Health Services for distinct age groups, as well as other HEDIS measures and other quality measures as feasible. Examples of specific HEDIS measures that may be chosen for the evaluation include: ● Well-Child Visits in the First 15/30 Months of Life (W15/30-CH); ● Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH); ● Prenatal and Postpartum Care (PPC-AD); ● Adolescent Well-Care Visits (AWC-CH); ● Adults' Access to Preventive/Ambulatory Health Services (AAP); and ● Children and Adolescents' Access to Primary Care Practitioners (CAP-CH). Examples of specific CAHPS measures that may be chosen for evaluation include: ● Getting Needed Care ● Getting Care Quickly

Statistical framework for measuring impacts	For all quantitative analyses, regression analysis using matching will be applied. Patient use of primary care is not random, and characteristics by plans, providers, and patients may systematically differ on observable characteristics. Propensity score matching will be used to assess whether use of primary care (as an endogenous treatment) is associated with changes in plausibly relevant health outcomes, based on a set of observable covariates. Time-series or longitudinal analysis will also be applied to examine time trends and discontinuities over time when data is available. (1) Hypothesis 1.1.1 a. Main Quantitative Analysis: Overall time trends in primary care utilization, spending, and quality will be examined, with a focus on geographic disparities and sociodemographic determinants and stratified by specific Medicaid demonstration populations (pregnant women, infants, children, etc.) b. Subgroup Quantitative Analysis: Medicaid beneficiaries who did not seek primary care prior to the current demonstration period will be identified. Changes in primary care measures of utilization, spending, and quality (using progressively broader primary care definitions) for these populations will be examined over time, with the expectation and hypothesis that primary care measures will increase over time. c. Qualitative analysis: In-depth interviews (n=25) will be conducted with plans, providers, and patients regarding patients who previously did not seek primary care to explore factors that led to changes in use of primary care and possible consequences or impacts of increased primary care utilization, spending, and quality. (2) Hypothesis 1.1.2: a. Hypothesis 1.1.2 is contingent upon seeing changes in Hypothesis 1.1.1. If there are no improvements in primary care observed, then this hypothesis is not relevant. b. Literature Review and Main Qualitative Analysis: This Hypothesis explores whether the changes in primary care as a result of this demonstration also lead to improvements in health outcomes. It cannot be assumed that increased primary care utilization, spending and quality necessarily leads to improvements in health outcomes (see Methodological Limitations). As such, for this study component, we propose to carefully choose a measure of health outcomes through literature review and stakeholder consultation in order to identify and select one health outcome that is plausibly associated with improvements in primary care utilization, spending, and quality. c. Quantitative analysis of the chosen health outcome will depend on the literature review and qualitative analysis. This basic form of this analysis would regress the chosen health outcome on a chosen measure of primary care utilization, spending, or quality, respectively, and holding other factors constant; and examined in the four years prior to the start of the program and each quarter thereafter.

Subgroup analyses to assess disparities and differences	Individual subgroup populations will be explored and may include consideration of factors or groupings, such as selection of one's health plan versus automatic assignment, selection of one's own Primary Care Physician (PCP) vs auto-assignment, participation in a Patient-Centered Medical Home (PCMH) vs not, or populations with discontinuous coverage vs those with full coverage.

Project 1B: Care Coordination for Beneficiaries with Complex Conditions	
Component	**Description**
Corresponding demonstration Hypothesis	Improving care coordination (e.g. by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).
Target populations	Medicaid beneficiaries identified as those having complex health needs
Evaluation questions and testable hypotheses	(1) Hypothesis 1.2.1: Care coordination for individuals identified as having complex health needs will result in improved health outcomes and (2) Hypothesis 1.2.2: Care coordination for individuals identified as having complex health needs will result in lowered utilization of the healthcare system, and a slower rate of expenditure growth
Data Strategy, sources and collection frequency	Administrative data will be used for analyses. Potential administration data for analysis include encounter, claim, and beneficiary-level report data regarding utilization, spending, and quality as well as beneficiary sociodemographic characteristics. The administration data are housed in the data warehouse of State of Hawaiʻi Department of Human Services (DHS).
Statistical framework for measuring impacts	For all quantitative analyses, regression analysis will be applied to assess whether individuals identified by MQD as having complex health needs experienced changes in plausibly relevant health outcomes and costs of care. MQD will provide information on the criteria for selection of individuals as having complex health needs. That criteria will be used to identify a plausible comparison group with similar or slightly lower levels of need and cost, which may lend itself to a regression discontinuity design. If a cutoff is not available (to enable regression discontinuity design), propensity score matching, using full optimal matching will be conducted. We will then pair the matching procedure with a time-series analysis to compare health outcomes, health utilization, can changes in expenditure growth in the four years prior to program evaluation and after the program was initiated on a quarterly basis for both the treatment and comparison groups.

Subgroup analyses to assess disparities and differences	Individual subgroup populations will be explored and may include consideration of factors or groupings, such as gender, age, and presence of multiple chronic conditions or behavioral health conditions.

Project 1C: Home- and Community-Based Services (HCBS)	
Component	**Description**
Corresponding demonstration Hypothesis	Improving care coordination (e.g. by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).
Target populations	● For hypothesis 1.3.1, the target population is Medicaid beneficiaries who use long-term services and support (LTSS) in the home and community based setting or institutional setting among individuals meeting NF LOC criteria. ● For hypothesis 1.3.2, the target population is individuals meeting NF LOC and receiving HCBS services. ● For hypothesis 1.3.3, the target population is beneficiaries who do not meet institutional level of care but are at-risk of deteriorating to an institutional level of care (i.e. the at-risk population).
Evaluation questions and testable hypotheses	Evaluation questions pertain to understanding whether: (1) Hypothesis 1.3.1: HCBS slow the deterioration of health as reflected in the level of care (measured by the timing of deterioration to a certain LOC level where entry into nursing home care becomes essential) among individuals meeting NF LOC criteria. (2) Hypothesis 1.3.2: Length of time to enter a nursing home, patient-reported health outcomes (PROs), and total cost of care vary depending on a variety of client characteristics among individuals meeting NF LOC criteria and receiving HCBS services. (3) Hypothesis 1.3.3: Length of time to enter a nursing home, PROs, and total cost of care vary depending on a variety of client characteristics among the at-risk population.
Data strategy, sources and collection frequency	**Administrative data.** Potential administration data for analysis include encounters, claims, and beneficiary-level report data such as LTSS utilization, Hawaii's health and functional assessment used to assess the health status of LTSS beneficiaries, and sociodemographic characteristics. The administration data are housed in the data warehouse of State of Hawaiʻi Department of Human Services (DHS). Functional assessment (LOC assessment) data are managed by an External Quality Review Organization — Health Services Advisory Group (HSAG). The LOC assessments are collected annually and when changes occur or when requested by beneficiaries in between two annual assessments.

	Primary data collection. Primary data may include the collection of patient-reported health outcomes annually and when changes occur.
Measures	The outcome measures include ● Length of time for the LOC to deteriorate to a certain level ● Length of time for beneficiaries to enter a nursing home ● Patient-reported health outcomes (e.g., beneficiaries' perception of health, quality of life, or satisfaction) ● TCOC We will consult the HCBS staff at the State of Hawai'i Med-QUEST Division to determine a certain LOC level as the threshold, and measure the length of time from the baseline (prior to any LTSS use) to the time point when a LTSS qualifying beneficiary's LOC reaches the threshold. Potential questions for patient-reported health outcomes may be adapted from nationally recognized sources such as PROMIS, GLOBAL10, and the HCBS survey from Consumer Assessment of Health Care Providers and Systems (CAHPS). Other measures pertaining to LTSS and variables for matching or controlling in the analysis may include, but are not limited to: ● Utilization of LTSS (e.g., whether one uses HCBS/nursing home, types of HCBS used, intensity and duration of HCBS/nursing home used, health plan). ● Factors that affect personal needs for care (e.g., health conditions and functional limitations). ● Factors that may predispose, enable, or impede those who use services (e.g., age and sex).

Statistical framework for measuring impacts	**Quantitative impact analysis.** For hypothesis 1.3.1, the evaluation will be based on a pre-post comparison of one period before the treatment (receiving HCBS or institutional care) and one or multiple periods after the treatment. Archived administrative data allow us to identify time points when Medicaid beneficiaries first started receiving LTSS and when they develop severe limitations in their functional status (as measured by the LOC and to be defined). The duration between the two time points is one measure of health outcome (i.e. length of time to duration). We plan to use a combination of matching methods and survival analysis. Matching methods are likely to create two balanced groups before beneficiaries receive the treatment. Matching variables may include, but not limited to, age, sex, health conditions, and the availability of caregivers. Hypotheses 1.3.2 and 1.3.3 will focus on identifying within-group comparisons. Specifically, we plan to examine subgroup differences in the patient-reported health outcomes, the deterioration to the institutional care, and the TCOC among individuals meeting NF LOC and receiving HCBS services and among the at-risk population using methods such as latent class growth analysis and survival analysis.
Subgroup analyses to assess disparities and differences	As described above, subgroup analyses are a major component of the HCBS evaluation. Specifically, we plan to examine subgroup differences in the patient-reported health outcomes, the deterioration to the institutional care, and the TCOC among HCBS users and the at-risk population using methods such as latent class growth analysis and survival analysis. Latent class growth analysis allows the evaluators to identify a specific number of unique classes, with each class containing a proportion of the overall sample who exhibit very similar trends over time. The class identification helps determine unique characteristics that are associated with program participants who are members of each class, some of which may have better, worse, or no change in the health outcomes and total cost of care. This analysis would inform further investigations about the reasons for the (lack of) change among subgroups in the future.

Demonstration Objective 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

Project 2A: Value-based purchasing (VBP) reimbursed at the Health Plan and Provider levels	
Component	**Description**
Corresponding Demonstration Hypothesis	Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the Health Plan level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.
Target populations	Medicaid beneficiaries

Evaluation questions and testable hypotheses	Evaluation questions pertain to understanding whether implementing VBP reimbursements at the Health Plan and provider level will: (1) Hypothesis 2.1.1: result in improved health outcomes; (2) Hypothesis 2.1.2: result in lowered utilization of the healthcare system; and (3) Hypothesis 2.1.3. result in a slower rate of expenditure growth The analyses will consider one or more VBP measures at the Health Plan level only, measures at the provider level only, and measures at both the Health Plan and provider levels.
Data strategy, sources and collection frequency	**Administrative data.** Potential administration data for analysis include encounters, claims, Health Plan-level quality data, and beneficiary-level report data (including beneficiary-level quality information). Health plan level VBP, and health plan data on provider-level VBP adoption and results, beneficiary-provider attribution data, and encounter data will be used in concert to identify beneficiaries served/services provided under different VBP structures.
Measures	The outcome measures may include one or more of the following: selected health outcome(s), total cost of care per beneficiary, and rate of expenditure growth in the managed care delivery system.
Statistical framework for measuring impacts	**Quantitative impact analysis.** To answer the first and second research questions, the evaluation will be based on data provided by MQD on beneficiaries' utilization of the health care system at the Health Plan and provider levels, and select Health Plan-level and beneficiary-level quality measure data as available (e.g. as reported to CMS in the Core Set of Health Care Quality Measures). The third question will be answered with administrative data (claims data), electronic records, and financial summaries submitted by health plans. We will use an interrupted time-series latent growth model to compare health outcomes, health utilization, can changes in expenditure growth in the four years prior to program evaluation and after the program was initiated on a quarterly basis.
Subgroup analysis to assess disparities and differences	As needed
Project 2B: Alternative Payment Models (APM) at the Provider level	
Component	**Description**
Corresponding demonstration Hypothesis	Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the Health Plan level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.
Target populations	Medicaid beneficiaries

Evaluation questions and testable hypotheses	Evaluation questions pertain to understanding whether implementing one or more APMs at the provider-level will: (1) Hypothesis 2.2.1: result in improved health outcomes; (2) Hypothesis 2.2.2: result in lowered utilization of the healthcare system; and (3) Hypothesis 2.2.3. result in a slower rate of expenditure growth
Data strategy, sources and collection frequency	**Administrative data.** Potential administration data for analysis include encounters, claims, and beneficiary-level report data. Health plan tracking of providers' adoption of APM models, beneficiary-provider attribution data, and encounter data will be used in concert to identify beneficiaries served/services provided under different APM structures.
Measures	The outcome measures may include one or more of the following: selected health outcome(s), total cost of care per beneficiary, and rate of expenditure growth in the managed care delivery system.
Statistical framework for measuring impacts	**Quantitative impact analysis.** To answer the first and second research questions, the evaluation will be based on data provided by MQD on beneficiaries' utilization of the health care system, and select beneficiary-level quality measure data as available (e.g. as reported to CMS in the Core Set of Health Care Quality Measures) among one or more provider groups who have implemented an APM. The third question will be answered with administrative data (claims data), electronic records, and financial summaries submitted by health plans. We will use an interrupted time-series latent growth model to compare health outcomes, health utilization, can changes in expenditure growth in the four years prior to program evaluation and after the program was initiated on a quarterly basis.
Subgroup analyses to assess disparities and differences	As needed

Demonstration Objective 3. Support strategies and interventions targeting the social determinants of health

Project 3A: Community Integration Services (CIS)	
Component	**Description**
Corresponding demonstration Hypothesis	Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.
Target populations	Medicaid beneficiaries who are eligible for and consent to participate in CIS.

Evaluation questions and testable hypotheses	Evaluation questions pertain to answering: Do program participants who are stably housed experience decreased utilization of acute services (emergency and inpatient utilization), greater engagement in outpatient care services, and decreased total cost of care? (1) Hypothesis 3.1.1: Participants who are stably housed will decrease utilization of acute services. (2) Hypothesis 3.1.2: Participants who are stably housed will increase utilization of outpatient care services. (3) Hypothesis 3.1.3: Total cost of care will be lower for participants after being stably housed. How does quality of life change as program participants progress through the CIS program? (4) Hypothesis 3.1.4: Individual health and wellbeing will improve as participants' progress through the program. How does program effectiveness vary by client needs and experiences? (5) Hypothesis 3.1.5: The effectiveness of the CIS program will vary depending on a variety of client characteristics.

Data strategy, sources and collection frequency	Archival administrative data will be used to identify trends in program participants' health care utilization at least one year prior to starting the program (compiled quarterly) and made available to the evaluation team. We aim to have service staff administer a validated electronic survey quarterly with their clients and have results made available to the evaluation team. **Administrative data.** Potential administration data for analysis include encounters, claims, and beneficiary-level report data such as CIS utilization, functional assessment, and sociodemographic characteristics. The administration data are housed in the data warehouse of State of Hawai'i Department of Human Services (DHS). **Primary data collection.** Housing and Case Management Assessment Tool (obtained face to face with client) Potential secondary data sources: ● Homeless Management Information System (HMIS) ● Contact hours and fidelity checklist The HMIS tracks client-level service utilization data across all homeless services providers. This system can be used to acquire social service use data not captured in health utilization records. Specifically, shelter stays, case management (not managed by a Medicaid provider) substance use treatment, and housing support. These records will help account for whether program participants are receiving concurrent services through other agencies. Service delivery hours will be a measure of dosage. These are the billable units filed by the case managers. This information, in conjunction with a fidelity checklist submitted by the case managers on a quarterly basis will be used to determine the extent that the program is being implemented as intended. **Note:** *DHS/MQD has not finalized the content of the eligibility screener, data collection forms used by health plans to support initial/ongoing assessment of CIS beneficiaries, and reporting requirements for the health plans. Evaluation methods will be adapted to the finalized tools as needed. The proposal submitted here assumes the use of certain tools for data collection. The evaluation team has offered its recommendations to MQD on the need for these instruments.*

Measures	Initial client needs and progress will be assessed using a validated survey tool. This tool was purposely designed to directly inform service providers of clients' needs and conditions while also providing a rich, empirically valid source of data for ongoing analysis. This tool will be administered quarterly to clients by the contracted providers. This tool will be used to track changes in self-reported access to healthcare, health outcomes, substance use, employment, income, service use/needs, and overall quality of life. The included measures were selected because they have shown adequate sensitivity to detect dynamic changes in wellness in a short time period and appropriate for the target population. Potential measures are outlined below: Access to Healthcare. A potential measure will include four items from the Behavioral Risk Factor Surveillance System (BRFSS; Centers for Disease Control and Prevention, 2013) that represent access to healthcare (e.g. "Do you have one person you think of as your personal doctor or health care provider?" and "Was there a time in the past month when you needed to see a doctor but could not because of cost?"). Two additional items ("How long do you have to travel to get to your health care provider?" and "If I need to see a specialist, it is easy for me to find one.") will be included to assess other domains of individual differences in participants' access to health care and to more fully capture the construct. Health-related Quality of Life Outcomes. Subjective perceptions of mental and physical health and stress will be measured. Overall perceived physical and mental health may be measured by the 9-item CDC Health-Related Quality-of-Life measure (HRQOL; the 4-item Core Module and 5-item Symptoms Module). The HRQOL is an empirically validated scale (Barile et al., 2013; Horner-Johnson et al., 2010) that consists of a 4-item physical health scale and a 4-item mental health scale that measures both anxiety and depression. Previous research using items from the HRQOL measure have demonstrated content, construct, and criterion validity with the Short-Form 36 (CDC 2000; Moriarty et al 2003; Moriarty et al 2005). Perceived stress will be measured by the Perceived Stress Scale-4 (Cohen, Kamarck, & Mermelstein, 1983; Cohen & Williamson, 1988). The Perceived Stress Scale also has been found to valid and reliable. This scale includes items such as, "In the last month, how often have you felt that you were unable to control the important things in your life?" Previous literature has found the measure to have a two-month test-retest reliability of .55 (Cohen, Kamarck, & Mermelstein, 1983) and to have construct and discriminant validity (Cohen & Williamson, 1988; Cohen, Tyrrell, & Smith, 1993). Substance Use. Substance Use may be monitored by including items from the Patient-Reported Outcomes Information System (PROMIS) Alcohol Use – Short Form. This measure assesses individuals' drinking behavior regarding the amount and impact by asking whether individuals drank heavily, had trouble controlling their drinking, or had difficulty getting the thought of drinking out of their head. This measure will be modified to assess any substance that a program participant has had a history of using. The measures chosen here are based on previous stakeholder feedback. However, the evaluation team may select additional or alternative measures based on literature review and stakeholder consultation to ensure that measures that are plausibly relevant to improvements in beneficiary health outcomes and total cost of care are considered comprehensively.

Statistical framework for measuring impacts	**Quantitative impact analysis.** Our primary evaluation questions will be assessed using multi-level sequential process growth mixture modeling (SPGMM), with adjustment for the nesting of participants within CIS case manager. We will answer secondary questions using latent class analyses and/or multinomial logistic regression. Latent growth modeling, more generally, is a method of estimating change over time that allows the researcher to test associations among time invariant (conditions that do not change) and time varying covariates (conditions that likely do change) and growth. Traditional latent growth curve modeling assumes that individuals within the sample likely change at similar rates over time. This level of homogeneity is unlikely, particularly with community-based samples. “Mixture” models allow the researcher to estimate heterogeneity in growth and identify naturally occurring “classes” or subsamples who follow similar trends. Multilevel modeling will be employed to account for the nesting of participants within case managers, as the outcomes for each participant are likely dependent upon how each case manager implements the program. To conduct a growth mixture model, the data analyst will systematically compare the fit and appropriateness of a series of models to the data with one or more “classes” – most commonly between 2 and 8. This approach aims to identify a specific number of unique classes, with each class containing a proportion of the overall sample who exhibit very similar trends over time. For our evaluation, we will employ sequential process growth mixture modeling because it will allow to identify unique classes before and after the start of the intervention, with class membership prior to start of the intervention likely predicting class membership after the start of the intervention. This process will allow us to determine what unique characteristics are associated with program participants who are members of each class, some of which may have excelled in the program while other deteriorated (or exhibited other unique trends over time). The first step in the analyses will be to identify growth trajectories based on longitudinal medical utilization records. The potential for two or more unique subgroups or classes that emerge from this data will then be examined, this is represented by Latent Class 1 in Figure 2. The second stage of the analyses identifies growth trajectories based on longitudinal data since starting the program (Latent Class 2). This will include medical utilization trends since starting the program (compiled quarterly) and predicted by covariates and moderators listed in Figure 2. Finally, associations between being a member of a specific class since starting the program and the patient reported outcomes, specifically the quality of life indices will be observed. This analytical approach will be used to assess the impact of the program on health care expenditures before and after the start of the program. **Hypothesis 3.1.1 and 3.1.2:** Slopes (changes over time) identified prior to the start of the program using health care utilization records will be used to identify statistically significant changes in slopes identified after the start of the program. These analyses can be conducted after participating in the program one year, with four quarterly aggregated expenditures observed before and after the start of the program. **Hypothesis 3.1.3 and 3.1.4:** Survey data assessing patient reported outcomes will be integrated into the health care expenditures model, with health care expenditure slopes being used to account for baseline needs when examining program outcomes, such as quality of life. Intermediate findings included in the rapid-cycle assessments will focus on the program’s implementation, fidelity, and adaptions. Dosage data, defined as the amount of face-to-face

	time that case managers spent with their client, and transitions from pre-tenancy to tenancy will be used to predict short-term outcomes. Depending on the number of case managers, multilevel modeling will be employed to account for the nesting of individuals with service providers (participants are nested within a case manager, and case manager are nested within their health care organization). Have multiple case managers will also allow us to examine the impact program implementation at the provider level. These intermediate, process-focused indicators will help inform providers of how implementation might be adapted to obtain the best results for their clients. The impact of dosage and other measures of fidelity will be used to predict classes or clusters of program participants demonstrated a range of success in the program as measured by the quality of life indicators and health expenditures in the previous six-months. These assessments will help identify necessary program adaptions and provide periodic updates on the health and well-being of participants. **Hypothesis 3.1.5:** will be addressed by examining the unique classes and trajectories of program participants. It is very likely that the program with not be equally successfully for all participants. Because of this, examining the subgroups defined by the classes will inform who might be the best candidate for the program. Potential predictors may include individuals' history of substance use, mental illness, trauma, or years experiencing homelessness.

Project 3B: Assessing process of planning and implementing support strategies addressing social determinants of health	
Component	**Description**
Corresponding demonstration Hypothesis	Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.
Target populations	Medicaid demonstration populations
Evaluation questions and testable hypotheses	This evaluation takes a realist evaluation approach to understanding how MQD has influenced the ecosystem of strategies and interventions that address the SDOH to ask the following contextual questions: (1) What kinds of support strategies and interventions addressing the social determinants are chosen by health plans and how do these strategies translate to provider and patient behaviors? (2) In what ways did Health Plans develop and adopt a SDOH Work Plan within its Quality Assessment and Performance Improvement (QAPI) plan? (3) In what ways did the State develop the SDOH statewide Transformation Plan? We crudely essentialize these questions into the following binary hypotheses: (1) Hypothesis 3.2.1: Different support strategies and interventions addressing the social determinants chosen by health plans will alter provider and patient behaviors. (2) Hypothesis 3.2.2: Health Plans will develop and adopt a SDOH Work Plan within its Quality Assessment and Performance Improvement (QAPI) plan. (3) Hypothesis 3.2.3: The State will develop and implement the SDOH statewide Transformation Plan.
Data Strategy, sources and collection frequency	**Qualitative interviews** In-depth interviews with purposively chosen stakeholders from Health Plans, Regional Health Partnerships (if any), providers in regards to their SDOH strategies and interventions (n=25) with subsequent thematic analysis using grounded theory, and review of MQD-provided documentation including meeting minutes, SDOH methodology, and capitation methodology.
Statistical framework for measuring impacts	Not applicable

Subgroup analyses to assess disparities and differences	Not applicable

Attachment C

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Hawaiʻi Quality Strategy 2023

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

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I.Quality Strategy Introduction and Background

The State of Hawaiʻi 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) 438.340, 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 a Health Plan or PIHP.
- Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each Health Plan, and PIHP contract.

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

Additionally, MQD intends to use the 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 Hawaiʻi

The State of Hawaiʻi 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 Hawaiʻi 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 "Hawaiʻi 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 Hawaiʻi ʻOhana 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 Hawaiʻi ʻOhana 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. ʻOhana 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**
	1. Use **data and analytics** to drive transformation and improve outcomes			

Foundational Building Blocks	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, Hawaiʻi 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 Hawaiʻi. 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

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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.

require aligned state policies, alignment at the Health Plan level and a collaborative and supportive approach to local initiatives, actionable data, transformation support and investment funding. The goal is to support and/or develop partnerships that will design new models to increase integration, collaboration and alignment among Health Plans, local hospitals, community-based organizations, housing authorities, county government and public health agencies, affordable housing providers, corrections, behavioral health and substance use disorder providers.

Achieving the HOPE Vision

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

Health 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 Hawaiʻi has given rise to great diversity at the local community level.

Hawaiʻi 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

HOPE Strategies	Quality Strategy Goals	Quality Strategy Objectives	
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 (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 (HCSB)/ Quality and Member Relations Improvement Section (QMRIS) supervisor; HCSB/ Contract Monitoring and Compliance Section (CMCS) supervisor; HCSB/ Data Analysis and Provider Network Section supervisor; 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, HCSB Administrator, Clinical Standards Administrator, Policy and Program Development Officer, Finance Officer, and Health Analytics Administrator 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 to CMS for review and feedback. . Revisions will be made on the State's Quality Strategy based on CMS' feedback then the final Quality Strategy will be 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

Hawaiʻi 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 2022, there was a physician need for 3,551 FTEs with only 2,962 available; the largest deficit remains in primary care with a shortage of 162 FTEs across all islands. When considering the shortage locally, shortages ranged from a low in Oahu of fifteen percent to a high on the Maui island of forty- 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.

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.

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[3] University of Hawaii. "Annual Report on Findings from the Hawaiʻi Physician Workforce Assessment Project." https://www.ahec.hawaii.edu/workforce-page/act18-sslh2009_2023_physician-workforce_annual-report_508-5%20(1).pdf. Accessed 07/21/23]

[4] https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2019/QI-1921.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 Hawaiʻi (1 in East Hawaiʻi and 1 in West Hawaiʻi); 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 registered nurses who specialize in psychiatric-mental health nursing. • Case management • Inpatient behavioral health hospital services • Outpatient behavioral health hospital services • Mental health rehabilitation services • SUD services • Day Treatment Programs • Psychosocial rehabilitation (PSR)/Clubhouse • Residential treatment programs • Pharmacies • Laboratory Services • Crisis services: mobile crisis response and crisis residential services • Interpretation services • Supportive housing • Representative payee • Supported employment • Peer Specialist (a Peer Specialist is someone who has gone through the same or similar life experience as the member, and will collaborate with the Community Health Worker to address the member's needs in a holistic manner)

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

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 42 CFR §438.208, RFP-MQD-2021-008 Sections 3 and 11, Health Plan Manual, 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 (SHCN) and Expanded Health Care Needs (EHCN). 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 service 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 -person-centered health action plans; and, complete reassessments and develop an updated health action plans according to the timelines and terms specified by the contract. Contractual requirements and compliance with federal regulations are monitored by MQD via Health Plan reporting and other quality assurance activities.

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.[5] MQD requires Health Plans to have in place written prior authorization/pre-certification policies and procedures for processing requests for initial and continuing authorization of services in a timely manner. The procedures must be developed to reduce administrative burden on the providers and Health Plans are required to utilize any MQD-required standardized format for authorization of services.

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

Medical necessity approvals must be made by licensed clinical staff or unlicensed staff under the supervision of licensed staff. Medical necessity denials must be made by licensed clinical staff. All denials of medical, behavioral health, and LTSS shall be reviewed and approved by the Health Plan medical director. In addition, all administrative denials for children under the age of twenty-one (21) years shall be reviewed and approved by the Health Plan medical director.

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

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 42 CFR §441.20.

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

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 receiving ongoing treatments, providing timely responsiveness and communication to providers on PA requests, and reducing provider burden through standardized and automated approaches that require minimal effort[6].

Long Term Services and Supports

The Hawaiʻi 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

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[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]

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

Utilizing the framework developed by the National Quality Forum[7] 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;

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[7] 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

- 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.

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.

Domain Name	Description
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	Person Centered Plan

Domain	Goal	HCBS Requirement
	safety risk factors) and personal goals 42CFR301(c)(1)-(3).	
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
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

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

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

Structure and Operations

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

Provider Selection and Disenrollment

MQD intends to maintain a fair, unbiased, and non-discriminatory provider selection process. Health Plans are required to have written policies and procedures for the selection and retention of providers. These policies and procedures must include a process for identifying and assuring that excluded providers are not part of their network. 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.[8]

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 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.

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;

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[8] "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.

- 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, Hawaiʻi 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 Hawaiʻi 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 Hawaiʻi • Individuals with breast and cervical cancer who are ineligible for Medicaid due to citizenship status
Excluded from Managed Care (i.e.	• Medicare Savings Program Members and Qualified Disabled Working Individuals not eligible for full Medicaid benefits;

Fee-for-service populations)	- Enrolled in the State of Hawaiʻi 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.[9] 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

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[9] 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]

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 • 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	• Pre-existing Medical Conditions • Missed Appointments • Changes to Member's Health Status • Utilization of Medical Services • Diminished Mental Capacity • Uncooperative or Disruptive Behavior resulting from the Member's special needs

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 completed the implementation of Electronic Visit Verification (EVV), another requirement of the 21st Century Cures Act that mandates EVV for all Medicaid personal care services (PCS) and home health services that require an in-home visit by a provider. Both systems enhance program integrity, reduce provider fraud, waste and abuse, and improve the quality of encounter data entering HPMMIS to support a variety of program planning and monitoring purposes.

Hawaiʻi successfully applied and received HITECH funds in 2019 to support a rebuild of Hawaii's immunization registry. The Hawaiʻi Immunization Registry (HIR) is maintained and operated by the Hawaiʻi Department of Health. Unfortunately, due to the COVID-19 pandemic occurring shortly after, the Department of Health had to focus on the pandemic response and thus the funds expired and were not used to rebuild the new registry.

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 Hawaiʻi Health Information Exchange; funds to support enhanced meaningful use initiatives and public health data reporting; and other projects as needed to support MQD quality initiatives and support the overall quality of healthcare in the state.

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

Claims Payment

MQD requires that the Health Plans develop and maintain a claims payment system capable of processing, cost avoiding, and paying claims accurately in accordance with 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). The standards that may be considered for this deemed compliance as referenced in §438.360(a) are those listed in Subpart D of the regulations for access to care, structure and operations, and measurement and improvement. MQD acknowledges that the activities required under §438.240(b)1&2 (for conducting Performance Improvement Projects (PIPs) and calculating performance measures) are an option for deeming only for plans that exclusively serve dual eligible beneficiaries and therefore does not apply to MQD-contracted Health Plans.

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.

In accordance with §438.360, MQD may use information from a Medicare and/or a private accreditation review to avoid duplication with the review of select standards required under an external quality review. This option may be used at the discretion of MQD. MQD may waive certain EQRO validation activities based on the Health Plan's NCQA accreditation.

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, physical, and behavioral health prevention, and treatment services. Routine EPSDT services are captured via a State designed form that providers use to report basic clinical data not available through encounter data for every EPSDT screening. Following development of multiple improved ways for providers to submit this supplemental data, the quality of data has significantly improved. This data will be aggregated and disseminated by MQD for purposes of targeted provider and client oversight, education, and outreach. Additionally, as part of ongoing quality improvement in this area, MQD implemented a more robust periodicity schedule in alignment with Bright Futures guidelines.

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 ʻOhana 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 Hawaiʻi State Department of Health (DOH) on various public health initiatives to reduce unintended pregnancy through encouraging the adoption of a standardized pregnancy intention screening as part of a routine screening to help providers counsel women without bias on either contraception or pregnancy preparedness. This initiative strives to increase the use of contraception of choice 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 and services related to abortion.

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

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. 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 Screening, Brief Intervention, and Referral to Treatment (SBIRT) method, with the intent of transitioning incentives to measures that track the reach of SBIRT screening performed and referrals made. In 2022, MQD contracted with Health Management Associates (HMA) to establish a systematic SBIRT workflow across the various healthcare systems in Hawaii and developed SBIRT manual that would provide overall implementation guidance to all stakeholders. SBIRT training for all primary care providers and ongoing refreshers are conducted statewide by MQD and HMA. SBIRT is a flexible framework for universal SUD screening and intervention for which a solid evidence base has been developed over the past two decades. It provides a broad approach to addressing substance use, including early diagnosis and treatment, for patients who are developing a SUD or already have one. To encourage such early intervention, improve health outcomes, and consequently lower patients' healthcare costs, MQD has set a goal that by 2028, 90 percent of MQD beneficiaries ages 12 and older who present for care in a primary care or ED setting are screened using SBIRT at least once a year.

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 Hawaiʻi 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 Hawaiʻi Immunization Registry (HIR), the state's key repository of immunization data, became non-operational in 2017.

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.

Supporting whole person care, including oral health, MQD restored dental coverage to the adult population effective January 1, 2023. This milestone was the culmination of years of planning, collaboration with stakeholders, and engagement in legislative activities. The 2022 Hawai'i legislature approved funding to restore the benefit and on October 26, 2022, CMS approved a state plan amendment to expand adult dental coverage. MQD realized its goal of starting coverage in January 2023. Individuals twenty-one years of age and older are now eligible to receive preventive, restorative, and some denture benefits. As always, individuals under age twenty-one years continue to receive dental benefits under EPSDT.

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. MQD has began collaborating with DOH and the Health Plans to 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 Hawaiʻi 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 for Calendar years 2021 and 2022. 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 Hawaiʻi 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 contractually require Health Plans to develop joint policies and procedures and coordinate closely on the provision of care to their beneficiaries with the DOH. Beginning 2022, QI Health Plans started working on a performance improvement project (PIP) that seeks to improve the coordination of care of Medicaid members enrolled in one of the five managed care organizations (MCOs) that are also receiving behavioral health services from the Prepaid Inpatient Health Plan (PIHP) Community Care Services (CCS) program and/or from the State of Hawaii, Department of Health (DOH) behavioral health agencies. The DOH agencies include the Adult Mental Health Division (AMHD), Child & Adolescent Mental Health Division (CAMHD), Alcohol & Drug Abuse Division (ADAD), and the Developmental Disabilities Division (DDD). 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 outreach, pre-tenancy supports and tenancy sustaining services.

MQD evaluates 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 are 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.

Development and implementation of the Community Transition Services (CTS) program will commence after CIS has been fully launched and deemed in steady state. CTS will further support members who meet a health needs-based criteria, and additionally are homeless or at risk for homelessness.

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 worked with its Health Plans develop a statewide SDOH Transformation Plan. MQD intends to 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 were 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 launched 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 Hawaiʻi 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 Hawaiʻi 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. Beginning in January 2024, a new law passed in the state of Hawai'i in 2023 will increase all professional fees up to current Medicare levels. 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 ongoing efforts to promote telehealth have strongly benefited access to care during the 2020 COVID-19 PHE and beyond. For example, post-pandemic, MQD continues to cover mental health services furnished through audio-only communication technology.

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 requires 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 are encouraged to offer a Fully Integrated Dual Eligible Special Needs Plan (FIDESNP). Three of the five health plans have selected to offer a FIDESNP in 2024.

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, P4P measures are being utilized to support SDOH; for example, measures that track increased data collection. Future plans include measures for referrals to social services as needed, and work done on SDOH. 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 Hawaiʻi (HAH). Measures are selected in partnership with hospitals to accelerate progress across various MQD quality objectives. Using a similar model, MQD launched 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.

New Initiatives

MQD has expressed interest in pursuing the following services in the 1115 Waiver and Demonstration authority:

1. Medical Respite

   MQD is seeking approval for a new medical respite benefit for eligible QI beneficiaries who are homeless or at risk of homelessness and meet behavioral health and/or medical eligibility criteria. Medical respite offers short-term residential care and ongoing behavioral and /or medical care for up to 90 days to address an individual’s physical or behavioral health conditions that do not meet criteria for hospitalization, but require additional monitoring.

   MQD is also seeking approval for a new short-term post-hospitalization housing benefit for eligible QI beneficiaries who are homeless or at risk of homelessness and meet behavioral health and/or medical eligibility criteria. Short-term post-hospitalization housing is provides services for up to 6 months to eligible individuals to continue their physical/psychiatric/substance use disorder recovery and need for appropriate medical care upon exiting an institution. Based on the individual’s needs and a person’s level of care, the services provided may include appropriate physical, mental health, and SUD care, including psychiatric supports.

2. Rent Assistance- Temporary housing

   MQD is seeking approval for a new temporary housing/rental assistance benefit for eligible QI beneficiaries who are homeless or at risk of homelessness and meet behavioral health and/or medical eligibility criteria. Temporary housing/rental assistance offers rental payments, deposits, utility assistance, purchase down payments benefits for up to a maximum of 6 months for beneficiaries who have an identified permanent supportive housing placement.

3. Pre-release Services

   Hawai'i is requesting approval for federal Medicaid matching funds for the provision of a set of targeted Medicaid services to be provided in the up to 90-day period prior to release for eligible incarcerated individuals. These pre-release Medicaid services include case management and care coordination; physical and behavioral health clinical consultation services provided by carceral or in-reach community-based providers; lab and radiology services; durable medical equipment (DME); and a 30-day supply of medications, including Medication-Assisted Treatment (MAT) for substance use disorders (SUDs), for use post-release into the community. Authority to cover these services is requested for persons incarcerated in Federal prisons, State prisons, local jails (inclusive of county jails and short-term stays at police stations), and youth correctional facilities.

4. Nutrition Supports

   In alignment with the Social Determinants of Health (SDOH) transformation plan developed in 2023, Hawaii is pursuing authority to be able to offer nutrition support benefits to qualifying Medicaid beneficiaries with documented health-related social needs. Waiver authorities we are seeking range from providing medically tailored meals for members with conditions where nutritional adjustments are therapeutically necessary or medically preventive; providing nutrition counseling and nutrition access and food preparation courses; offering meals or pantry re-stocking for special populations like children and pregnant women; and providing prescriptions and subsidies for fruit and vegetables purchases, or protein boxes, to support an increase in consumption of nutritional foods. Where available, Hawaii hopes to support culturally-based nutrition programs such as those offering Native Hawaiian foods and nutrition education such as ʻai pono.

5. Native Hawaiian Healing Practices

   Offering culturally-based Native Hawaiian healing practices is a key health equity strategy for Hawaii. Hawaii is excited to seek waiver authorities to support a range of Native Hawaiian healing practices including but not limited to hula, hoʻolomilomi, hoʻoponopono, ʻai pono, laʻau lapaʻau, and hāpai hānau (pale keiki) as benefits covered by the Medicaid program. The availability of these programs are likely to enhance Medicaid's ability to engage with populations that are more distrustful of Western medical practices, and to increase the availability of supports to populations experiencing some of the greatest health disparities in the State of Hawaii.

Additionally, Hawaii is interested in leveraging an incentive program that provides a way for our beneficiaries to access other services and programs of interest that are not structured as typical Medicaid benefits; the incentive program would provide financial subsidies to beneficiaries to offset the cost of their engagement in these services and programs. Some examples include such Native Hawaiian Healing practices as hoe waʻa and heʻe nalu, but other examples may extend beyond Native Hawaiian Healing practices to other activities that promote health and well-being.

6. Behavioral Health – Contingency Management
   MQD is seeking approval for a new contingency management (CM) benefit for eligible QI beneficiaries with Substance Use Disorder (SUD). CM is an evidence-based treatment that provides motivational incentives such as gift cards for individuals with SUD. It reinforces target behaviors of patients, such as abstinence from substance use.

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 Hawaiʻi 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.

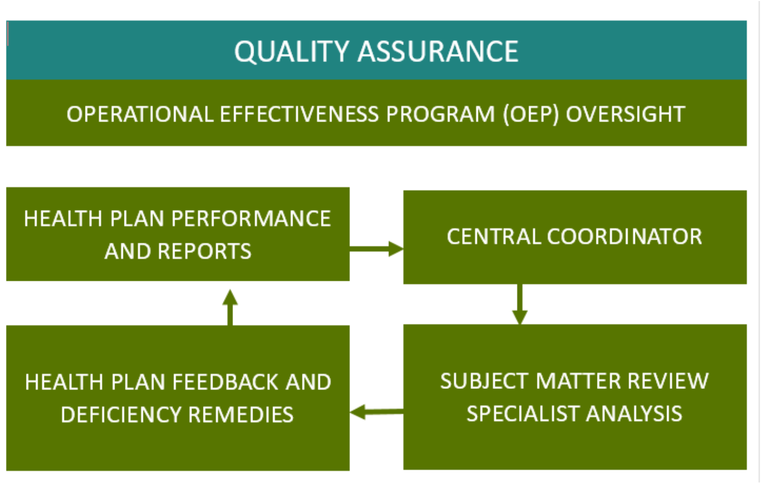
At the state level, MQD has developed roles and responsibilities for team members that focus on either quality assurance or quality improvement while developing robust communication methods across teams and content experts. Together, these teams will systematically address, report on challenges with, 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.

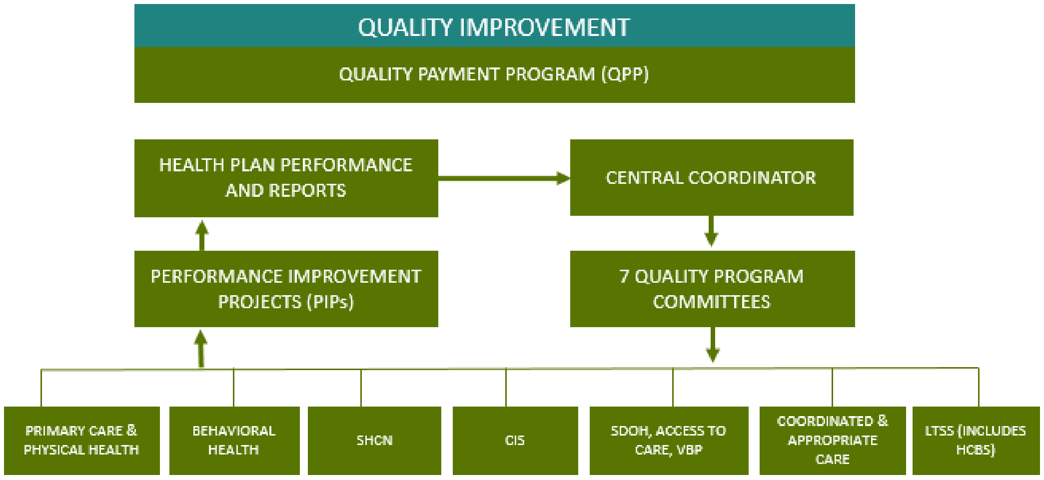
MQD will define process measurement, performance measurement, and targets that will be maintained until sustained improvements are reached. The operational and performance metrics included in the OEP, the specific targets for each, and the time period of assessment for each metric, will be set annually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

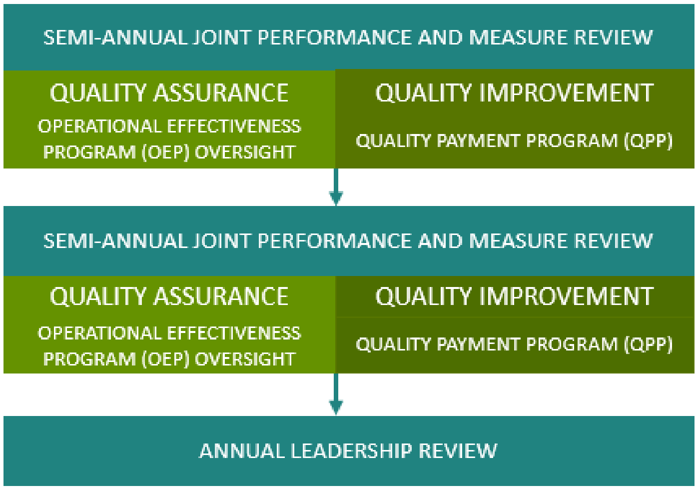
The Quality Payment Program may be implemented based on a withhold arrangement with potential for Health Plans to earn dollars back as the Health Plan meets performance targets in accordance §438.6(b)(3) or implemented as an incentive arrangement program in accordance §438.6(b)(2).

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: Plan All Cause Readmission and Behavioral Health Coordination. The ʻOhana CCS conducted two PIPs: Behavioral Health Coordination and 7-Day Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM).

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/consumer-guides.html

Attachment D

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00001/9**

TITLE: **QUEST Integration Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from August 1, 2019 through July 31, 2024, unless otherwise stated. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted subject to the STCs for the QUEST Integration Medicaid Section 1115 Demonstration. These waivers shall apply to all demonstration enrollees.

1. **Medically Needy** **Section 1902(a)(10)(C) and Section 1902(a)(17)**

   To enable the state to limit medically needy spend-down eligibility in the case of those individuals who are not aged, blind, or disabled to those individuals whose gross incomes, before any spend-down calculation, are at or below 300 percent of the federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, for whom there is no gross income limit.

2. **Amount, Duration, and Scope** **Section 1902(a)(10)(B)**

   To enable the state to offer demonstration benefits that may not be available to all categorically eligible or other individuals.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To the extent necessary to enable the state to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. To enable Hawaii to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932. No waiver of freedom of choice is authorized for family planning providers.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00001/9**

TITLE: **QUEST Integration Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration extension, August 1, 2019 through July 31, 2024, be regarded as expenditures under the state's title XIX plan, unless otherwise stated, but are further limited by the Special Terms and Conditions (STCs) for the QUEST Integration Section 1115 demonstration.

For enrollees in All Components of the Demonstration:

1. **Managed Care Payments.** Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m):

   Expenditures under contracts with managed care organizations (MCOs) that do not meet the requirements under section 1903(m)(2)(A)(vi) of the Act insofar as that provision requires compliance with requirements in section 1932(a)(4)(A)(ii)(I) of the Act, including as it is implemented and interpreted in 42 CFR 438.56(c)(2)(i)). With this expenditure authority, the state may restrict enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, described in STC 36. Enrollees may disenroll for cause at any time and may disenroll without cause at least once every 12 months, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, including as it is implemented and interpreted in 42 CFR 438.56(c)(2)(ii), except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.

   Expenditures for capitation payments to MCOs, and PIHPs, in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3)(A) and federal regulations at 42 CFR section 438.52(a)(1).

2. **Quality Review of Eligibility.** Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

3. **Demonstration Expansion Eligibility.** Expenditures to provide coverage to the following demonstration expansion populations:

a. Demonstration Population 1. Parents and caretaker relatives who are living with an 18-year-old who would be a dependent child but for the fact that the 18-year-old has reached the age of 18, if such parents would be eligible if the child was under 18 years of age.

b. Demonstration Population 2. Aged, blind, and disabled individuals in the 42 C.F.R. § 435.217 like group who are receiving home- and community- based services, with income up to and including 100 percent of the federal poverty limit using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.

c. Demonstration Population 3. Aged, blind, and disabled medically needy individuals receiving home-and community-based services, who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income.

d. Demonstration Population 4. Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance, who would not otherwise be eligible under the state plan, with the same income limit that is applied for Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement under the state plan.

e. Demonstration Population 5. Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance) when placed from age 16 to 18 years of age, or would otherwise be eligible under a different eligibility group but for income, and were enrolled in the State plan or waiver while receiving assistance payments.

4. **Home and Community-Based Services (HCBS) and Personal Care Services**. Expenditures to provide HCBS not included in the Medicaid state plan and furnished to QUEST Integration enrollees, as follows:

   a. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

b. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, *i.e.*, the "at risk" population.

   The state may maintain a waiting list, through a health plan, for home and community-based services (including personal care services). No waiting list is permissible for other services for QUEST Integration enrollees.

c. The state may impose an hour or budget limit on home and community based services provided to individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "at risk" population), as long as such limits are sufficient to meet the assessed needs of the individual.

5. **Additional Benefits:** Expenditures to provide the following additional benefits.

   a. **Specialized Behavioral Health Services:** The services listed below (and further described in Attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
      i. Supportive Employment.
      ii. Financial management services.

   b. **Cognitive Rehabilitation Services:** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical, occupational or speech therapist. Services must be medically necessary and prior approved.

   c. **Habilitation Services.** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.

   d. **Community Integration Services.** Pre-tenancy and tenancy sustaining services as defined in STC 23 of the STCs are available for beneficiaries who are 18 years or older and meet the criteria specified in STC 23.

   e. **Community Transition Services Pilot Program.** Expenditures for the Community Transition Services Pilot Program as set forth in STC 23.

All requirements of the Medicaid program expressed in law, regulation, and policy statement shall apply to the demonstration expansion populations, except those expressly identified on the waiver list or listed below as not applicable.

Title XIX Requirements Not Applicable to Demonstration Expansion Populations

Cost Sharing **Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**

To enable the state to charge cost sharing up to 5 percent of annual family income.

To enable the state to charge an enrollment fee to Medically Needy Aged, Blind and Disabled QUEST Integration health plan enrollees (Demonstration Population 3) whose spend-down liability is estimated to exceed the QUEST Integration health plan capitation rate, in the amount equal to the estimated spend-down amount or where applicable, the amount of patient income applied to the cost of long-term care.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00001/9**

TITLE: **QUEST Integration Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Hawaii's QUEST Integration section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the Hawaii Department of Human Services (hereinafter "state") and the Centers for Medicare & Medicaid Services (CMS). CMS has granted waivers of requirements under section 1902 of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable under section 1903 of the Act, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. These STCs are effective from August 1, 2019 through July 31, 2024, unless otherwise stated. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description, Objectives, and Historical Context
III. General Program Requirements
IV. Eligibility for the Demonstration
V. Enrollment
VI. Benefits
VII. Community Integration Services
VIII. Delivery System
IX. Cost Sharing
X. General Reporting Requirements
XI. Monitoring
XII. Evaluation of the Demonstration
XIII. General Financial Requirements Under Title XIX
XIV. Monitoring Budget Neutrality for the Demonstration
XV. Schedule of State Deliverables During the Demonstration Extension Period

In the event of a conflict between any provision of these STCs and any provision of an attachment to these STCs, the STCs must take precedence.

The following attachments have been included to provide supplemental information and guidance for specific STCs. The following attachments are incorporated as part of these STCs.

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports
- Attachment C: Reserved for Evaluation Design
- Attachment D: Home and Community-Based Services (HCBS) and Long-Term Care Provider Guidelines and Service Definitions
- Attachment E: Reserved for the Behavioral Health Services Protocol

II. PROGRAM DESCRIPTION, OBJECTIVES, AND HISTORICAL CONTEXT

QUEST Integration is a continuation of the state's ongoing demonstration, which is funded through Title XIX, Title XXI and the state. QUEST Integration uses capitated managed care as a delivery system unless otherwise noted below. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria to beneficiaries eligible under the state plan and to the demonstration populations described in STC 21.

The state of Hawaii implemented QUEST on August 1, 1994. QUEST is a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The state combined its Medicaid program with its then General Assistance Program and its innovative state Health Insurance Program and offered benefits to citizens up to 300 percent of the federal poverty level (FPL). This program virtually closed the coverage gap in the state.

The QUEST program covered adults with incomes at or below 100 percent of the federal poverty level (FPL) and uninsured children with family incomes at or below 200 percent FPL. In addition, the QUEST-Net program provided a full Medicaid benefit for children with family incomes above 200, but not exceeding 300 percent FPL and a limited benefit package for adults with incomes at or below 300 percent FPL.

Since its implementation, CMS has renewed the QUEST demonstration six times. In 2007, the QUEST demonstration was renewed under the new name QUEST Expanded. In February 2010, CMS approved an amendment to implement the Hawaii Premium Plus program to encourage employment growth and employer sponsored health insurance in the State. In July 2010, CMS approved an amendment to eliminate the unemployment insurance eligibility requirement for the Hawaii Premium Plus program. In August 2010, CMS approved an amendment to add pneumonia vaccines as a covered immunization.

In April 2012, CMS approved an amendment which reduced the QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL and eliminated the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. Hawaii also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the demonstration; eliminate the QUEST enrollment limit for childless adults; terminate the Hawaii Premium Plus program; and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

In December 2012, the state submitted its request to extend the QUEST demonstration under section 1115(a) of the Social Security Act for 5 years under the name QUEST Integration. This extension of the demonstration included the following program changes:

- Consolidated the 4 programs within the demonstration into a single “QUEST Integration” program;
- Transitioned the low-income childless adults and former foster care children from demonstration expansion populations to state plan populations;
- Added additional new demonstration expansion populations, including a population of former adoptive and kinship guardianship children;
- Increased the retroactive eligibility period to 10 days for the non-long term services and supports population;
- Provided additional benefits, including cognitive rehabilitation, habilitation, and certain specialized behavioral health services;
- Removed the QUEST-ACE enrollment-related benchmarks from the UCC pool; and
- Required additional evaluation on UCC costs after January 1, 2014.

This demonstration integrated the demonstration’s eligibility groups and benefits within the context of the Affordable Care Act (ACA). From a benefit perspective, Hawaii provided all beneficiaries with access to the same benefits based on clinical criteria and medical necessity through capitated-managed care or through managed-fee-for-service delivery systems in certain circumstances.

CMS approved the demonstration renewal in September 2013 for the demonstration period of October 2013 through December 2018. In October 2018, CMS approved an amendment to provide community integration supportive housing services to the population described in STC 22. A temporary extension of the demonstration was approved on December 8, 2018 to extend the demonstration through June 30, 2019. A second temporary extension was issued for July 1, 2019 through July 31, 2019.

Hawaii submitted a request to extend the demonstration in September 2018 for a 5 year period beginning on August 1, 2019. The 2019 extension made the following changes to the demonstration:

- Ended Hawaii’s waiver of retroactive eligibility; and
- Authorized expenditure authority for Community Transition Services Pilot program.

The objectives for the 2019-2024 demonstration approval period are:

- Improve health outcomes for Medicaid beneficiaries covered under the demonstration;

- 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
- Address health determinants to improve health outcomes and lower healthcare costs.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.
5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely

through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state, consistent with the requirements of STC 13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
   b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
   c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
   d. An up-to-date CHIP allotment worksheet, if necessary;
   e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 442 Code of Federal Regulations

(CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
    a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
    b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
    c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
    d. Transition and Phase-out Procedures: The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination, as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
    e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
    f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the

demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted

entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

IV. ELIGIBILITY FOR THE DEMONSTRATION

16. **Eligibility Groups Affected by the Demonstration.** Mandatory and optional State Plan groups derive their eligibility through the Medicaid and CHIP State plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid and CHIP State Plan, except as expressly waived under authority granted by this demonstration or as described in these STCs. Any Medicaid and CHIP State Plan Amendments to the eligibility standards and methodologies for these eligibility groups will apply to this demonstration.

    The beneficiary eligibility groups described below who are made eligible for QUEST Integration by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid and/or CHIP laws, regulations, and policies unless otherwise specified in the not applicable expenditure authorities for this demonstration.

QUEST Integration Medicaid and CHIP State Plan Mandatory and Optional groups

Mandatory State Plan Groups	
Eligibility Group Name	**Qualifying Criteria**
Parents or caretaker relatives	Up to and including 100% FPL
Pregnant Women	Up to and including 191% FPL
	Extended and continuous eligibility for pregnant women
Infants	Infants up to age 1, up to and including 191% FPL

	Deemed newborn children
	Continuous eligibility for hospitalized children
Children	Children ages 1 through 18, up to and including 133% FPL
	Continuous eligibility for hospitalized children
Low Income Adult Age 19 Through 64 Group	Up to and including 133% FPL
Children with adoption assistance, foster care, or guardianship care under title IV-E.	An adoption assistance agreement is in effect under title IV-E of the Act; or Foster care or kinship guardianship assistance maintenance payments are being made by a State under title IV-E.
Former Foster Children under age 26	No income limit
State Plan Mandatory Aged, Blind, or Disabled Groups	ABD individuals who meet more restrictive requirements for Medicaid than the SSI requirements. Uses SSI payment standard.
	Qualified severely impaired blind and disabled individuals under age 65
	Other ABD groups as described in the State Plan
Transitional Medical Assistance	Coverage for one twelve month period due to increased earnings that would otherwise make the individual ineligible under Section 1931

1931 Extension	Coverage for four months due to receipt of child or spousal support, that would otherwise make the individual ineligible under Section 1931
Qualified Medicare beneficiaries*	Standard eligibility provisions for this population as described in the State Plan.
Specified low-income Medicare beneficiaries*	Standard eligibility provisions for this population as described in the State Plan.

*Dual eligibles are included as those with full Medicaid benefits are served under QI health plans and QI health plans pay Part B co-payments and coordinate Medicare services.

Optional State Plan Groups	
Eligibility Group Name	**Qualifying Criteria**
Optional Coverage of Families and Children and the Aged, Blind, or Disabled	ABD individuals who do not receive cash assistance but meet income and resource requirements
	Individuals eligible for assistance but for being in a medical institution
	Individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care
	ABD individuals in domiciliary facilities or other group living arrangements
	Aged or disabled individuals with income up to and including 100% FPL
Optional targeted low- income children	Up to and including 308% FPL including for children for whom the State is claiming Title XXI funding
Certain Women Needing Treatment for Breast or Cervical Cancer	No income limit; must have been detected through NBCCEDP and not have creditable coverage

Medically Needy Non- Aged, Blind, or Disabled Children and Adults	Up to and including 300% FPL, if spend down to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	Medically needy income standard for household size using SSI methodology
Foster Children	Children with non IV-E adoption assistance
Foster Children (19-20 years old)	Receiving foster care maintenance payments or under adoption assistance

QUEST Integration Demonstration Expansion Population Groups

Expansion Population	
Eligibility Group Name	**Qualifying Criteria**
Parents or caretaker relatives with an 18-year old dependent child	Parents or caretaker relatives who (i) are living with an 18-year- old who would be a dependent child but for the fact that s/he has reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age
Individuals in the 42 C.F.R. § 435.217 like group receiving HCBS	Income up to and including 100% FPL
Medically needy ABD individuals whose spend-down exceeds the plans' capitation payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance	Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in the state plan or waiver while receiving assistance payments

17. **Post-Eligibility Treatment of Income and Resources.** All individuals receiving nursing facility long-term care services must be subject to the post-eligibility treatment of income rules set forth in section 1924 and 42 CFR section 435.733. Available income after appropriate deductions, such as for a personal needs allowance, allowances for a spouse and/or family members, and incurred medical expenses, shall be the amount by which Medicaid's payment is reduced for the relevant long-term services and supports. Individuals receiving HCBS must be subject to the post-eligibility treatment of income rules

set forth in section 1924 and 42 CFR section 435.735 if they are medically needy, with or without spend-down, or individuals who would be eligible for Medicaid if institutionalized as set forth in 42 CFR section 435.217.

18. **Financial Responsibility/Deeming.** The state must determine eligibility using the income of household members whose income may be taken into account under the Medicaid financial responsibility and deeming rules, including institutional deeming for aged, blind, and disabled individuals.

19. **Quality Review of Eligibility.** On March 4, 2010 CMS approved the state's MEQC plan to reflect programmatic changes as a result of the section 1115 demonstration program implementation integrating a major portion of the FFS population into Managed Care. The state shall remain relieved of any liability from disallowance for errors that exceed the 3 percent tolerance. CMS permits the state to continue with its effort to implement administrative renewal and MEQC reviews must take that policy into account.

V. ENROLLMENT

20. **Spend-Down for Medically Needy Individuals**.

    a. **Pregnant Women and Children Medically Needy State Plan Groups** are eligible upon determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to STC 20(d). Individuals in this group whose gross income exceeds 300 percent FPL are not eligible.

    b. **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is not expected to exceed the health plans' monthly capitation payment** will be enrolled in a QUEST Integration health plan upon the determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to STC 20(d).

    c. **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is expected to exceed the health plans' monthly capitation payment** will be eligible under the demonstration subject to STC 20(d) and an enrollment fee equal to the medically needy spend-down amount or, where applicable, the amount of patient income applied to the cost of long-term care. This group will receive all services through QUEST Integration health plans.

    d. **Medically needy individuals who are expected to incur expenses sufficient to satisfy their spend-down obligation for a retroactive period only** will not be enrolled in a QUEST Integration health plan. They will receive services on a fee-for-service basis. (This category might include, for example, persons who become medically needy for a short-term retroactive period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically and thus will not meet their spend-down obligations every month.)

VI. BENEFITS

21. **QUEST Integration Benefits.** Benefits provided under authority of this demonstration are delivered through mandatory managed care (except as specified in STC 21(d), and are as follows, for all populations under the demonstration (except as otherwise provided in this STC):

    a. **Full Medicaid State Plan.** Individuals eligible under the demonstration will receive comprehensive benefits including all services as defined in the Medicaid state plan.

    b. **Alternative Benefit Plan:** The Affordable Care Act (ACA) New Adult Group will receive benefits provided through the state's approved alternative benefit plan (ABP) SPA.

    c. **Managed Care Plan Change.** Beneficiaries may change managed care plans per 42 CFR 438.56(d)(2)(iv) if their residential or employment support provider is no longer available through their current plan.

    d. **Benefits Provided to the ID/DD Population.** Medicaid eligibles with developmental disabilities will receive the full Medicaid state plan benefit package through QUEST Integration managed care plans. Case management, section 1915(c) HCBS, and ICF/ID benefits for this group will remain carved out of the capitated benefit package. All QUEST Integration health plans will be are required to coordinate the state plan benefits received by the ID/DD population with the HCBS that are provided on a fee-for-service basis from the Department of Health's (DOH) Developmental Disabilities Division.

    e. **Behavioral Health Benefits.** All QUEST Integration plans must provide a full array of standard behavioral health benefits (including substance abuse treatment) to beneficiaries who may need such services as set forth in the Behavioral Health Services Protocol in Attachment E. The state must also provide specialized behavioral health services to beneficiaries with SMI, SPMI, or SEBD. The state must submit the Behavioral Health Services Protocol to CMS for review within 150 calendar days after approval of this demonstration extension. Failure to submit this deliverable to CMS will result in a funding deferral (STC 49). The Behavioral Health Services Protocol must include the following:
        i. Services provided by the DOH Child and Adolescent Mental Health Division (CAMHD) to children with serious emotional behavioral disorders (SEBD).
        ii. Services provided to adults with SMI or SPMI by the Med-QUEST division's Community Care Services (CCS) behavioral health program, or the contracted plans.
        iii. Reimbursement methodology
        iv. A memorandum of agreement (MOA) between each MCO and the state that reflects the current interagency agreement for behavioral health services provided by the DOH to beneficiaries.
        v. The process(es) and protocol(s) used for referrals between MCOs and the DOH or CCS, as well as the DOH or CCS and MCOs.

f. **Additional Benefits.** Under the demonstration, the state will provide benefits in addition to Medicaid state plan and alternative benefit plan benefits based on medical necessity and clinical criteria. These additional benefits include home and community based services (HCBS), specialized behavioral health benefits, cognitive rehabilitation benefits, and habilitation benefits, as described below.

h. **HCBS:** QUEST Integration health plans must provide access to a comprehensive HCBS benefit package for individuals who meet institutional level of care and are able to choose to receive care at home or in the community and an expanded sub-set of HCBS services for individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "At Risk" population, re-named from "Personal Care-Level I/Chore" population) in order to prevent a decline in health status and maintain individuals safely in their homes and communities. The service definitions and provider types are found in Attachment D of these STCs. The amount, duration, and scope of all covered long-term care services may vary to reflect the needs of the individual in accordance with the prescribed Care Coordination Plan. The HCBS benefits that will be provided through managed care health plans include the following:

Service	**Available for individuals who are assessed to be risk of deteriorating to institutional level of care**	**Available for individuals who meet institutional level of care ("1147 certified")**
Adult day care	X*	X
Adult day health	X*	X
Assisted living facility		X
Community care foster family homes		X
Counseling and training		X
Environmental accessibility adaptations		X
Home delivered meals	X*	X
Home maintenance		X
Moving assistance		X
Non-medical transportation		X
Personal assistance	X	X
Personal emergency response system	X*	X
Residential care		X
Respite care		X
Private duty nursing	X	X
Specialized case management		X
Specialized medical equipment and supplies		X

* Denotes new services for the “At Risk” population under QUEST Integration.

- i. **Specialized Behavioral Health Services**: The services listed below (and further described in Attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
  - i. Supportive Employment.
  - ii. Financial management services.
- j. **Cognitive Rehabilitation Services:** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical, occupational or speech therapist. Services must be medically necessary and prior approved.
- k. **Habilitation Services.** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.

VII. COMMUNITY INTEGRATION SERVICES

22. Community Integration Services (CIS).

- a. Eligibility Criteria. These eligibility criteria apply to all CIS benefits described in this STC.
  - i. Individual meets at least one of the following health needs-based criteria and is expected to benefit from community integration services:
    1. Individual assessed to have a behavioral health need which is defined as one or both of the following criteria:
    2. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or
    3. Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1 indicating the need for outpatient day treatment for Substance Use Disorder (SUD) treatment.
    4. Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).
  - ii. Including STC 22(a)(i), the individual must have at least one of the following risk factors:
    1. Homelessness, defined as lacking a fixed, regular, and adequate nighttime residence, meaning:
       - a. Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for

human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; or

            b. Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals).

        2. At risk of homelessness, defined as an individual who shall lose their primary nighttime residence:
            a. There is notification in writing that their residence will be lost within 21 days of the date of application for assistance;
            b. No subsequent residence has been identified; and
            c. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter; or
            d. History of frequent and/or lengthy stays in a nursing facility
            e. Frequent is defined as more than one contact in the past 12 months.
            f. Lengthy is defined as 60 or more consecutive days within an institutional care facility.

    iii. The state must require that the MCO determine all enrollee's eligibility for the CIS Programs based on the eligibility criteria set forth in STC 22. Once an enrollee is determined eligible to participate in the CIS Program, the state must require that the MCO seek consent from the enrollee to participate in the CIS Program and the enrollee will have the option to opt-out at any time from the CIS Program. An eligible enrollee must have the option to re-enroll in the program at any time following the enrollee's voluntary disenrollment, after being reassessed for eligibility. Enrollees who do not opt-out will remain enrolled in the CIS Program until they no longer meet the eligibility criteria or do not require the applicable services to address an unmet need as determined in the eligibility reassessment. Eligibility reassessments must take place at least quarterly.

    iv. Enrollees determined ineligible must have the opportunity to request to have their eligibility status be reassessed when there is an indication the enrollee's health status or social risk factors have changed. Upon a determination of ineligibility, the state must require that the MCO communicate to the enrollee the process to request a reassessment and provide a right to appeal the determination of ineligibility. The process for such an appeal must comply with the requirements in 42 C.F.R. §§ 438.400 through 438.24 for an adverse benefit determination. Eligibility reassessments will consist of utilizing the same tools previously used to evaluate the enrollee in the initial assessment.

b. Determinations. The state must require the MCOs to use an assessment tool using standardized questions to screen possibly eligible enrollees to determine whether they meet the eligibility criteria to receive Community Integration Services. The state must require that each MCO determines the services to be provided and will review the plan of care with the enrollee after the assessment is complete.

c. CIS Benefits. These services are furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. This Program is voluntary for beneficiaries.

- i. Pre-Tenancy Supports:
  1. Conducting a functional needs assessment identifying the beneficiary's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); providing assistance in budgeting for housing and living expenses;
  2. Assisting beneficiaries with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs.
  3. Developing an individualized plan based upon the functional needs assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
  4. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
  5. Providing supports and interventions per the person-centered plan.
- ii. Tenancy Sustaining Services:
  1. Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
  2. Coordinating and linking the recipient to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
  3. Entitlement assistance including assisting beneficiaries in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
  4. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
  5. Providing supports to assist the beneficiary in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
  6. Providing supports to assist the beneficiary in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
  7. Coordinating with the beneficiary to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
  8. Connecting the beneficiary to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

d. **Requirements for CIS Program.** The following requirements apply to the CIS Program:
   i. MCO Responsibilities. The state must require the MCO to develop an enrollee care plan for each enrollee in the CIS Program. The state must require the MCO to also do the following:
      1. Screen Medicaid managed care beneficiaries to identify those who are eligible for receiving services through this program.
      2. Obtain consent for enrollment in the program.
      3. Determine and authorize the specified services that are necessary and appropriate for beneficiaries.
      4. Work in collaboration with providers to track the provision of services.
      5. Participation in "learning communities" to ensure that MCOs and providers are sharing and adopting best practices throughout the duration of the five-year demonstration period.
      6. Track and report the services provided to beneficiaries, ensuring accountability for service delivery and payment, monitoring against fixed allotments.
      7. Conduct periodic audits of payments to verify accurate reporting and spending. These audits must include verification that services reported are actually received by beneficiaries.

e. **Program Integrity**. The state must maintain program integrity standards in the program, including:
   1. Quarterly accounting on delivered services
      i. Encounter data must include:
         a. Beneficiary name and Medicaid identification number
         b. Provider organization name
         c. Description of services(s) rendered
         d. Date(s) and/or duration of services(s) delivery
         e. Number of unit(s) of services(s) delivered
         f. Cost of services(s) delivered
         g. Service indicator (reason for service delivery)
      ii. MCO Role. MCOs must report the following to the state on a quarterly basis:
         a. Number of enrollees who receive each CIS service.
         b. Total costs for each CIS service.

f. **Audit Process**. The state must require the MCOs to ensure Medicaid payments are for services covered under this program that were actually provided and properly billed and documented by the providers through the following processes:
   1. Encounter Data Analysis
      i. As part of their general Medicaid program integrity requirements, the state must require that MCOs analyze claims submitted by providers to ensure that they: (1) accurately and appropriately represent the delivery of authorized services, and (2) identify irregularities, discrepancies, or outliers requiring further investigation.
      ii. To the extent that MCOs identify irregularities, the state must require MCOs to refer those irregularities to their Special Investigations Unit for follow-up and report them to the state's Program Integrity Division.

2. Visit Verification Procedures
    i. In accordance with the state's Medicaid program integrity requirements, the state must require the MCOs regularly validate services, including those delivered through the pilots, that were rendered as provided and properly billed and documented by pilot providers through conducting visit verification procedures on a random sample of claims/invoices. Verification procedures may include:
        a. Outreach to beneficiaries to confirm receipt of services
        b. Outreach to providers to require documentation of provided services
3. As part of the state's overarching oversight strategy, the state's Program Integrity Division must review and monitor the MCOs' policies, including sample sizes and targeted provider types, and sample visit verification cases. Ensuring action is taken to address identified non-compliance.
4. Recoupment of Overpayments. Under the state's Medicaid program integrity requirement, the state must require the MCOs to monitor payments and identify issues of overpayment. MCOs must regularly monitor their payments to providers to identify potential overpayments.
5. Suspension, Withhold, Sanctions and Termination Activities due to Findings of Fraud or Abuse. In accordance with the state's Medicaid program integrity requirements:
    i. The state reserves the right to direct a MCO to impose a payment suspension or withhold on any provider due to a credible allegation of fraud in accordance with 42 CFR 455.23.
    ii. The state and MCOs will have the right to terminate a provider for reasons related to actions consistent with 42 CFR 455.
    iii. The state will have the right to impose other sanctions or intermediate sanctions on, or require a corrective action plan from a MCO or pilot provider.
    iv. The state must require MCOs to submit monthly reports to the state on all pilot provider terminations or non-renewals due to fraudulent behavior.
        a. Auditing compliance. The state must audit MCOs to ensure their compliance with the program requirements and take action to address any identified non-compliance.
        b. Pilot Termination. The state may suspend or terminate the entire CIS Program if it is found to be ineffective in meeting the state's goals or beneficiaries needs.

g. **Community Participation.** The state, either directly or through its MCO contracts, must ensure that participants' engagement and community participation is supported and facilitated to the fullest extent desired by each participant.

h. **CIS Exclusions.** The following are prohibited under CIS:
1. Payment of ongoing rent or other room and board costs;
2. Capital costs related to the development of housing;
3. Expenses for ongoing regular utilities or other regular occurring bills;
4. Goods or services intended for leisure or recreation;
5. Duplicative services from other state or federal programs

    6. Services furnished to individuals in a correctional institution or an IMD (other than services that meet an exception to the IMD exclusion).

i. **Pathway to Value-Based Payments (VBP)**. The state must use its existing managed care contracts to incentivize the delivery of high quality care to CIS beneficiaries through MCOs by progressively linking payments to progress towards improved health and socioeconomic outcomes among beneficiaries during the demonstration period by using a combination of the following strategies:
    1. Withhold arrangements, as defined in and consistent with 42 CFR 438.6, may be used to incentivize plans to establish processes and protocols to support a variety of mechanisms required for data exchange, reporting, and beneficiary enrollment, as well as to enhance the quality of service delivery and improve beneficiary outcomes.
    2. Incentive arrangements, as defined in and consistent with 42 CFR 438.6, may be used to incentivize plans to enhance the quality of service delivery and improve beneficiary outcomes.
    3. The state must also establish VBP strategies directed at a range of providers to incentivize the delivery of high quality care for CIS Program beneficiaries. The state must work with stakeholders to develop a VBP strategy focused on providers that serve CIS Program beneficiaries. These stakeholders may include, but would not be limited to, hospitals, primary care providers, CIS providers, and post-acute providers. These VBP arrangements will be effectuated through managed care, but the state will need to seek directed payments authority under 42 CFR 438.6 to put payment arrangements into place.
    4. Year by Year Breakdown for Managed Care Plan Incentives
        i. Year 1: In the first year of the CIS Program, a withhold measure may be established to provide the MCOs with time to establish a provider network, develop processes and protocols for program operationalization, operationalize enrollment criteria, collaborate to develop shared data collection forms, and standardize the collection of appropriate process measures and outputs from service providers to support the reporting requirements of the state. The withhold will be released contingent upon submission of the full package of instruments, protocols, and processes, along with a demonstration through test data submission of the ability for MCOs to fully comply with all reporting requirements of the program; the withhold may be treated as a process measure, with full release of payment upon satisfactory completion of requirements within the established timelines.
        ii. Year 2: In the second year of the CIS Program, a withhold arrangement may support evidence of enrollment of beneficiaries in the CIS Program, and the use of various components of the CIS Program. The state must require that MCOs be evaluated on their ability to assess, consent, and enroll beneficiaries into the CIS Program, and sharing information with the state on enrollment phase. The state must require that data submitted by MCOs must demonstrate use of multiple new services offered through the benefit. Reporting must meet data quality standards, and adequately capture data at the desired level of granularity. Output measures such as percent of potentially eligible beneficiaries referred to the CIS Program, percent of qualifying beneficiaries enrolled in the CIS Program may be used to track MCO progress in identifying potential beneficiaries,

conducting assessments to determine eligibility for the CIS Program, and enrolling consenting beneficiaries.

iii. Year 3: In the third year of the CIS Program, a combination of withhold and incentive arrangement measures may be implemented to support increased service utilization. A withhold may be used to support the MCOs' implementation of performance incentives for one or more types of providers in the CIS network to support the delivery of high quality care. Withholds and/or incentive arrangements may be used by the state to incentivize MCOs to (a) support continued enrollment and engagement of beneficiaries, and (b) provide services consistent with the benefit. Types of additional metrics required may include percent of CIS enrolled beneficiaries who have completed a functional needs assessment, and percent of CIS Program enrolled beneficiaries who have an individualized service plan.

iv. Year 4: By the fourth year of the CIS Program, the state must require MCOs to demonstrate short and intermediate outcomes from the program, including appropriate healthcare utilization and use of community-based social supports. Withhold and/or incentive arrangements may be used to incentivize MCO efforts to increase the percentage of CIS beneficiaries who are stably housed, as well as demonstrating re-engagement in the receipt of healthcare services. Indicators selected may include percent of CIS Program beneficiaries with one or more primary care visits since enrollment; enhanced receipt of specialty treatment and behavioral health services among beneficiaries, based on specific needs, may also be tracked.

v. Year 5: By the fifth year, the state anticipates improvement in health outcomes among beneficiaries enrolled in the program, including decreased ER and inpatient utilization. Withholds may be used to continue enrollment, engagement, and ongoing service utilization; while withholds and withhold and incentive arrangements may be provided for decreases in use of emergency departments and inpatient hospitalizations among beneficiaries enrolled in the program. Other types of quality measures that indicate greater control of conditions may also be included.

j. **Evaluation of the CIS Program**. The state must incorporate the CIS Program into the demonstration evaluation design. The evaluation design must meet the requirements of section XII of these STCs. In addition to the evaluation design requirements, the state must include the following in the evaluation design:

1. The state must develop a pilot services evaluation strategy that will incorporate rapid cycle assessments (RCAs) into the process to obtain timely information on the effectiveness of pilot services. These evaluations will allow the state to discontinue services determined to have minimal effectiveness and redeploy resources to more valuable strategies, serving as another mechanism for promoting value within the program. RCAs must be conducted by an independent entity identified by the state. The state, in collaboration with stakeholders, must develop process-based and outcome-based metrics, which must be submitted for review and approval by CMS in the evaluation design, and the state must report annually to CMS on these metrics.
2. The state, in consultation with stakeholders, must develop process-based and outcome-based metrics, many of which would be relevant for evaluating

demonstration implementation and demonstration impact, and must be submitted for review and approval by CMS in the evaluation design. Some of these same and a few other process and outcome measures may also be appropriate for routine annual monitoring. The state must finalize any such metrics in discussion with CMS, and report annually to CMS in the monitoring reports or in the RCAs, as appropriate. The state must develop metrics for pre-tenancy supports, housing stability, tenancy sustaining services, and health needs based criteria that are quantifiable, and for which data sources can be identified. Outcome measures of housing stability, health status, utilization, and cost of care should be identified – as applicable – for the short, medium and long-term assessment of the pilot program.

23. **Community Transition Services Pilot Program.** The state will be authorized to establish Community Transition Services under the CIS program throughout the state from August 1, 2019 through July 31, 2024. The state must provide services to beneficiaries who meet the eligibility criteria in STC 22 on a voluntary basis.
    a. Community Transition Services Pilot Program Benefits:

Service Category	**Community Transition Services**
Transitional Case Management Services	Services that will assist the individual with moving into stable housing, including assisting the individual in arranging the move, assessing the unit's and individual's readiness for move-in, assisting the individual) (excluding financial assistance) in obtaining furniture and commodities. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. Funding related to one-time utility set-up and moving costs provided that such funding is not available through any other program.
Housing Quality and Safety Improvement Services	Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing occupant's health condition, as documented by a health care professional, and remediation is not covered under any other program. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure occupant's health and modification is not covered under any other provision such as the Americans with Disabilities Act.
Legal Assistance	Assisting the individual by connecting the enrollee to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. This pilot service does not include legal representation or payment for legal representation.

Service Category	Community Transition Services
Securing House Payments	Provide a one-time payment for security deposit and/or first month's rent provided that such funding is not available through any other program. This payment may only be made once for each enrollee during the life of the demonstration, except for state determined extraordinary circumstances such as a natural disaster. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through beneficiary's individualized care and the beneficiary is unable to meet such expense or when the services cannot be obtained from other sources.

24. **HCBS Standards.** The state must assure compliance with CMS standards for HCBS settings as articulated in current section 1915(c) and 1915(i) policy and as modified by subsequent regulatory changes. HCBS requirements include the following:
    a. **HCBS Electronic Visit Verification System**. The state must demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.
    b. **HCBS Quality Systems and Strategy**. The state must is expected to implement systems that measure and improve its performance to meet the waiver assurances set forth in 42 CFR 441.301 and 441.302. The Quality Review provides a comprehensive assessment of the state's capacity to ensure adequate program oversight, detect and remediate compliance issues and evaluate the effectiveness of implemented quality improvement activities.
    c. **For 1915(c)-Approvable HCBS**, for services that could have been authorized to individuals served under a 1915(c) waiver, the state must have an approved Quality Improvement Strategy and is required to develop and measure performance indicators for the following waiver assurances:
        i. **Administrative Authority**: A performance measure should must be developed and tracked identifying any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.
        ii. **Level of Care**: Performance measures are required for the following two sub-assurances: applicants with reasonable likelihood of needing services receive a level of care determination and the processes for determining level of care are followed as documented. While a performance measure for annual levels of care is not required to be reported, the state is expected to must be sure that annual levels of care are determined.
        iii. **Qualified Providers**: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.

iv. **Service Plan**: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

v. **Health and Welfare**: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

vi. **Financial Accountability**: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. The state must have performance measures that track that it provides evidence that claims are coded and paid for in accordance for services rendered, and that it provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

vii. Medicaid Authorities Transition. During the demonstration period, the state must evaluate which portions of the demonstration could be transitioned to 1915(c) and 1915(i) authorities. There will be a five year transition plan as follows:

1. January 2019 through December 2021 – CMS and the state conduct joint transition planning activities in order to identify which portions can be transferred.
2. January 2022 through December 2022 – The state must develop and submit 1915(c) and 1915(i) authorities for the portions to be transitioned for CMS review and approval.
3. January 2022 through December 2023 – The state and CMS will work to approve any 1915(c) waivers or 1915(i) SPAs no later than December 31, 2023.

25. The state must submit a report to CMS following receipt of an Evidence Request letter and report template from the Regional Office no later than 21 months prior to the end of the approved demonstration period which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. (1915(c) and 1915(i) HCBS). The Regional Office will send a DRAFT report to the state which will have 90 days to respond to the DRAFT report. The Regional Office will issue a FINAL report to the state 60 days following receipt of the state's response.

26. The CMS Regional Office will evaluate each evidentiary report to determine whether the assurances have been met and will issue a final report to the state 12 months prior to expiration to the demonstration.

27. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS waiver assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year.

28. For 1915(i)-Approvable HCBS, for services that could have been authorized to individuals served under a 1915(i) waiver, the state must have an approved Quality Improvement Strategy and is required to develop performance measures to address the following requirements:

a. Service plans that:
   i. address assessed needs of 1915(i) participants;
   ii. are updated annually; and
   iii. document choice of services and providers.

b. Eligibility Requirements: The state will must ensure that:
   i. an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future;
   ii. the processes and instruments described in the approved program for determining 1915(i) eligibility are applied appropriately; and
   iii. the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually (end of demonstration year) or if more frequent, as specified in the approved program.

c. Providers meet required qualifications.

d. Settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1) and (2).

e. The SMA retains authority and responsibility for program operations and oversight.

f. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

g. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

h. The state must also describe the process for systems improvement as a result of aggregated discovery and remediation activities.

29. Person-centered planning. The state must assure there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan must be developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(c) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

30. **Conflict of Interest**: The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

31. Each beneficiary eligible for long term services and supports must have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options. (MLTSS with self-direction)

32. The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant. (MLTSS)

33. The state must assure compliance with the characteristics of HCBS settings as described in 1915(c) and 1915(i) regulations in accordance with implementation/effective dates as published in the Federal Register.

34. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan. (MLTSS).
    a. Any revisions to the QUEST Integration delivery system for Behavioral Health Services as defined in this STC requires a revision to Attachment E.
    b. **Cost of Room and Board Excluded from Capitation Rate Calculations**. For purposes of determining capitation rates, the cost of room and board is not included in noninstitutional care costs.

VIII. DELIVERY SYSTEM

35. **Forms of Managed Care.** The state is authorized to contract with Managed Care Organizations (MCOs) and Prepaid inpatient health plans (PIHPs) all of which are defined under 42 CFR 438.2. The state must comply with 42 CFR 438 in connection with managed care offered under this demonstration unless specified otherwise herein.

36. **QUEST Integration Plans**. QUEST Integration (QI) plans are MCOs as defined under 42 CFR 438.2. Eligible individuals will be enrolled in a QI plan upon initial eligibility consistent with 42 CFR 438.54 and as outlined here. Eligible individuals will choose among participating QI plans offered to provide the full range of primary, acute, home and community based services and standard behavioral health benefits (including substance abuse treatment). Eligible individuals must be provided with information on the available health plans by the state. The state must ask each applicant to select a health plan upon determination of eligibility. If an eligible individual does not make a selection at the time of the approval of eligibility, the individual is automatically assigned to a plan that operates on

the island of residence, consistent with 42 CFR 438.54, and will have 15 days from the date of auto assignment to select a different health plan from the list provided. The state must send a notice of enrollment upon auto assigning the individual. The state may place an enrollment limit on health plans in order to assure adequate capacity and sufficient enrollment in all participating health plans, as long as at least two QI health plans operating on an island do not have an enrollment limit.

37. **Specialized Behavioral Health plan**. Acting as a PIHP as defined under 42 CFR 438.2, the Community Care Services (CCS) provides standard behavioral health services to all beneficiaries, and specialized behavioral health services to beneficiaries 18 and older with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral disorder (SEBD).

38. **Physical and Behavior Health Integration.** If the state chooses to integrate the specialized behavioral health services provided to any beneficiaries or subset of beneficiaries with SMI, SPMI, or SEBD into the QI Plans, the state must assess readiness pursuant to § 438.66(d). Assignment of any beneficiaries or subset of beneficiaries with SMI, SPMI, or requiring SEBD into the QI Plans must comply with § 438.54 and may only begin when each QI Plan has been determined by the state and CMS to meet certain readiness and network requirements. The state must notify CMS of the intended integration at least 9 months prior to the assignment of beneficiaries. Any beneficiaries or subset of beneficiaries with SMI, SPMI, or SEBD, may be mandatorily enrolled into a QI Plan providing fully integrated services pursuant to the state's expenditure and waiver authorities that provide for plan choice.

39. **Enrollment and Disenrollment Processes.**
    a. **Enrollment process.** The state must maintain a managed care enrollment and disenrollment process that complies with 42 CFR Part 438, except that disenrollment without cause from a MCO will be more limited in cases where the enrollee was not passively enrolled to the MCO. If the enrollee was not passively enrolled to the MCO, the state must maintain a process by which the enrollee may change MCOs (consistent with STC 36) only if both MCOs agree to the change. The state must track and report to CMS these requests on an annual basis;
    b. **Disenrollment With and Without Cause**. The provisions of 42 CFR section 438.56(c), relating to disenrollment with and without cause, must apply to individuals enrolled in QUEST Integration health plans, except that the without cause change period after enrollment in a plan will be 60 days, rather than 90 days. The state must accommodate and grant all reasonable plan change requests from aged, blind and disabled beneficiaries that occur days 61-90. The state must track the number of plan change requests from aged, blind and disabled beneficiaries that occur during that timeframe and include this data in quarterly reports described in STC 51.
        i. Individuals who have been enrolled in a plan within the last 6 months will be reassigned to the prior plan unless the beneficiary exercises his/her option to disenroll for cause.

40. **Member Services**. Following the selection of a health plan, the plan will call the individual or send the individual a survey to identify special health needs (such as the need for long-term services and supports). If the individual is sent a survey and does not respond, the health plan shall be required to call the individual.

41. **Service Coordination Model.** After a beneficiary selects a health plan and completes the function described in STC 36, the health plan will assign a licensed or qualified professional as the beneficiaries' service coordinator. The following are required to ensure QUEST Integration program integrity.
    a. Service Coordinator Responsibilities.
        i. Assuring that the health plan promptly conducts a face-to-face health and functionality assessment (HFA) for each individual who is identified as having special health needs as described in STC 40. Members who are identified as having special health needs will receive a face-to-face HFA within 15 days of the documentation of special health needs through STC 40;
        ii. Referring any member appearing to meet a nursing facility level of care to the state's Contractor for a functional eligibility review;
        iii. Providing options counseling regarding institutional placement and HCBS alternatives;
        iv. Coordinating services with other providers such as physician specialists, Medicare fee-for-service and/or Medicare Advantage health plans and their providers, mental health providers and DD/ID case managers;
        v. Facilitating and arranging access to services;
        vi. Seeking to resolve any concerns about care delivery or providers;
        vii. Leading a team of decision-makers to develop a care plan for those members meeting functional eligibility. The care planning team may include the primary care provider (who may be a specialist); the beneficiary, family members, and significant others (when appropriate); legal guardians, an Ombudsman if so requested by the beneficiary; and other medical care providers relevant to the beneficiary needs; and
        viii. For those members meeting functional eligibility, leading the care planning team in the development of a case-specific, person-centered, cost-effective plan of care in the community, using industry best practices and guidelines established in STC 41(b) below.
    b. **Written Comprehensive Care Plans.** For each enrollee who meets the functional Level of Care (LOC) or "At Risk" assessment for long-term care, the state must require that the MCOs develop and implement a person-centered written care plan that analyzes and describes the medical, social, HCBS, and/or long-term care institutional services that the member will receive. In developing the care plan, the state must that require the MCOs consider appropriate options for the beneficiary related to his/her medical, behavioral health, psychosocial, case-specific needs at a specific point in time, as well as for longer term strategic planning and must emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. Service plans must be updated annually or more frequently in conjunction with the health and functional assessment.
    c. **Ombudsman Program.** The state must require that the Ombudsman Program must be available to all beneficiaries under the demonstration. The purpose of the program is to

ensure access to care, to promote quality of care, and to strive to achieve recipient satisfaction with QUEST Integration. The Department of Human Services (DHS) must seek a qualified independent organization to assist and represent members in the resolution of problems and conflicts between the health plan and its members regarding QUEST Integration services to act as the Ombudsman prior to the initial date for delivery of services.

i. **Delivery of Ombudsman Services.** The Ombudsman must assist in the resolution of issues/concerns about access to, quality of, or limitations to, services. The contracting organization must not be affiliated with any of the QUEST Integration health plans contracted by DHS and operate independently of the Med-QUEST Division.
ii. **Services Offered by Ombudsman Program.** Ombudsman services must be available to QUEST Integration members to navigate and access covered health care services and supports to include choice counseling, general program-related information, access point for complaints, concerns related to health plan enrollment, and access to services.
iii. **Scope of the Ombudsman Program.** The Ombudsman Program must not replace the grievance and appeals process that all health plans that contract with the state must have in place, nor replace the right of a recipient to an administrative hearing. The Ombudsman may assist and represent members up to the point of an Administrative Hearing under state law. They may also assist a member during the hearing process but must not represent the member in an Administrative Hearing. The QUEST Integration member shall file a grievance or appeal with the contracted health plan. An Administrative Hearing may be filed once the health plan's appeal process has been exhausted.

42. **Contracts.** All contracts and contract modifications of existing contracts between the state and Managed care entities must be prior approved by CMS in accordance with 42 C.F.R. 438.3. The state must provide CMS with a minimum of 90 days to review changes for consideration of approval.

43. **Statewideness.** For rural and non-rural Islands on which only one health plan is available, the state must require the health plan assure that members have a choice of primary care providers (PCPs).

44. **Dual-eligible Beneficiaries.** Dual eligible beneficiaries may select a PCP and will be assigned a service coordinator to assure coordination of Medicare and Medicaid services.

45. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**. The MCOs must fulfill the state's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

46. **Monitoring Activities by State and/or External Quality Review Organization (EQRO).** The state's EQRO process must meet all the requirements of 42 CFR §438 Subpart E. In addition, the state, or its EQRO having sufficient experience and expertise and oversight by

the State Medicaid Agency (SMA), must monitor and annually evaluate the MCOs' and/or contracting providers performance on the HCBS requirements under QUEST Integration. These include but are not limited to the following:

a. Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with the Community Benefit have been assessed to meet the required level of care for those services.
b. Service plans – to ensure that MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.
c. MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.
d. Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

IX. COST SHARING

47. **Cost sharing.** Cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447(b) applies to the demonstration.

48. **Enrollment fee.** Notwithstanding subparagraph (a), the following enrollment fee is permitted under QUEST Integration:

Population	Amount
Medically Needy with Spend-down	An enrollment fee equal to the spend-down obligation or, where applicable, the amount of patient income applied to the cost of long-term care.

X. GENERAL REPORTING REQUIREMENTS

49. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.
    a. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.
        1. The follow process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the

requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

  i. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
  ii. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
  iii. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
  iv. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

b. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

50. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state must work with CMS to:
  a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
  b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
  c. Submit deliverables to the appropriate system as directed by CMS.

XI. MONITORING

51. **Monitoring Reports.** The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The fourth quarter information that would ordinarily be provided in a separate report must be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) calendar days following the end of the DY. The reports must include all required elements as per 42 CFR 431.428, and must not direct readers to links outside the report.

Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion must also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report must also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This must also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and must follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements- Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements (Section XIII) of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration must be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state must include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The discussion must also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant recruitment, if applicable.

52. **Corrective Action.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

53. **Close-Out Report**. Within 120 calendar days after to the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

a. The draft report must comply with the most current guidance from CMS.

   b. The state must present to and participate in a discussion with CMS on the close-out report.
   c. The state must take into consideration CMS' comments for incorporation into the final close-out report.
   d. The final close-out report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
   e. A delay in submitting the draft or final version of the c-out report may subject the state to penalties described in STC 49.

54. **Monitoring Calls**. CMS will convene periodic conference calls with the state.
    a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
    b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
    c. The state and CMS will jointly develop the agenda for the calls.

55. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XII. EVALUATION OF THE DEMONSTRATION

56. **Independent Evaluator.** Upon approval of the demonstration, the state must begin arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party must conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

57. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

58. **Draft Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) calendar days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design must not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

59. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state must publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

60. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component must have at least one hypothesis and pertinent research question(s) to test each hypothesis. In addition, the state must include a hypothesis and evaluation questions focusing specifically on CIS programs. The state must also include additional hypotheses and evaluation questions that measure progress in any areas identified as needing improvement during the previous demonstration period. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

61. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report must be posted to the state's website with the application for public comment.
    a. The interim evaluation report must discuss evaluation progress and present findings to date as per the approved evaluation design.
    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and

hypotheses, and how the design was adapted must be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment B of these STCs.

62. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period August 1, 2019 – June 30, 2024, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.
    a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
    b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

63. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

64. **Public Access**. The state must post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

65. **Additional Publications and Presentations.** For a period of twelve (12) months following CMS approval of the final reports, CMS must be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS must be provided a copy including any associated press materials. CMS must be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

66. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and

record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 50.

XIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

67. **Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[1]

68. **Unallowable Expenditures.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:
    a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
    b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
    c. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
    d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the “inpatient psychiatric services for individuals under age 21” benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

69. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used for this demonstration. The state must provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

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[1] For a description of CMS’s current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

70. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XIV:
    a. Administrative costs, including those associated with the administration of the demonstration;
    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
    c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

71. **Sources of Non-Federal Share.** The state certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
    a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
    b. The state acknowledges that any amendments that impact the financial status of the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

72. **State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:
    a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
    b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
    c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

73. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

74. **Medicaid Expenditure Groups (MEG).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Master MEG Chart

EG subject to BN	Hypothetical (Yes/No)
EG 1 – Children	No
EG 2 – Adults	No
EG 3 – Aged	No
EG 4 – Blind/Disabled	No
EG 5 – Group VIII	Yes
EG 6 - CIS	Yes
EG 7 – CIS Community Transition Pilot	Yes

75. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00001/9). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year

(identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. Cost Settlements. The state must report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments must be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. Premiums and Cost Sharing Collected by the State. The state must report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) must also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year must be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. Pharmacy Rebates. Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. Administrative Costs. The state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in section XI, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. Budget Neutrality Specifications Manual. The state must create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

76. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Demonstration Years	
Demonstration Year 26	August 1, 2019- July 31, 2020
Demonstration Year 27	August 1, 2020- July 31, 2021
Demonstration Year 28	August 1, 2021- July 31, 2022
Demonstration Year 29	August 1, 2022- July 31, 2023
Demonstration Year 30	August 1, 2023- July 31, 2024

77. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XIV. CMS will provide technical assistance, upon request.[2]

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[2] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

78. **Claiming Period.** The state must report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

79. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
    a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets must reflect the phase out of impermissible provider payments by law or regulation, where applicable.
    b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement must be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
    c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, must result in a modified budget neutrality expenditure limit.

XIV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

80. **Limit on Title XIX Funding.** The state must be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

81. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

82. **Calculation of Budget Neutrality Limit and How it is Applied**. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

83. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that demonstration waivers granted have not resulted in increased costs to Medicaid, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Main Budget Neutrality Test Table

MEG	TREND	DY 26 PMPM	DY 27 PMPM	DY 28 PMPM	DY 29 PMPM	DY 30 PMPM
Children	1.0%	$448.48	$452.96	$457.49	$462.07	$466.69
Adults	3.7%	$925.47	$959.72	$995.23	$1,032.05	$1,070.24
Aged	3.4%	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66
Blind/Disabled	4.4%	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25

84. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

85. **Hypothetical Budget Neutrality Tests**
    a. **Hypothetical Budget Neutrality Test 1: Group VIII.** Low income adults with FPL up to 133%.
    b. **Hypothetical Budget Neutrality Test 2: CIS.** Expenditures related to the CIS benefits of pre-tenancy supports and tenancy supports; excludes expenditures related to the Community Transition Services Pilot Program.
    c. **Hypothetical Budget Neutrality Test 3: CIS Community Transition Pilot.** Expenditures related to the Community Transition Services Pilot Program.

Hypothetical Budget Neutrality Test Table

MEG	TREND	DY 26 PMPM	DY 27 PMPM	DY 28 PMPM	DY 29 PMPM	DY 30 PMPM
Group VIII	4.8%	$899.37	$942.54	$987.78	$1,035.20	$1,084.89
CIS	4.8%%	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15
CIS Community Transition Pilot	4.8%	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67

    d. The Hypothetical Group VIII and CIS expenditures caps consist of the total computable dollar limits presented in the above table, summed across all DYs. The federal share of the caps is obtained by multiplying the total computable by the federal share rate for that DY.

e. If total FFP for a hypothetical group should exceed the federal share of cap, the difference must be reported as a cost against the budget neutrality limit described in STC 88.

86. **Composite Federal Share**. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

87. **Transitional Phase-Down of Newly Accrued Savings**. Beginning with DY 26, the net variance between the without-waiver cost and actual with-waiver cost will be reduced for selected Medical population based MEGs. The reduced variance, calculated as an applicable percentage times the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The applicable percentages have been determined in accordance with the policy for Transitional Phase-Down of Newly Accrued Savings described in State Medicaid Director Letter # 18-009. This provision only applies to the Main Budget Neutrality Test, and to the MEGs that are designated "Both" without-waiver and with-waiver. The MEGs affected by this provision and the applicable percentages are shown in the table below. If the total variance for an MEG in a DY is negative, the applicable percentage is 100 percent.

Savings Phase Down Table

MEG					
Children	25%	25%	25%	25%	25%
Adults	25%	25%	25%	25%	25%
Aged	25%	25%	25%	25%	25%
Blind/Disabled	25%	25%	25%	25%	25%

88. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from August 1, 2019 to July 31, 2023. The Main Budget Neutrality Test may incorporate net savings from the immediately prior demonstration period of January 1, 2013 through December 31, 2018 (but not from any earlier approval period). If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget

neutrality test will be based on the time period through the termination date.

89. **Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Demonstration Year	Cumulative Target Definition	Percentage
DY 1 through DY 26	Cumulative budget neutrality limit	2.0 percent
DY 1 through DY 27	Cumulative budget neutrality limit	1.5 percent
DY 1 through DY 28	Cumulative budget neutrality limit	1.0 percent
DY 1 through DY 29	Cumulative budget neutrality limit	0.5 percent
DY 1 through DY 30	Cumulative budget neutrality limit	0 percent

XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION PERIOD

Due Date	**Deliverable**
30 calendar days from approval letter date	State Acceptance of Demonstration Extension, STCs, Waivers, and Expenditure Authorities.
120 calendar days from approval letter date	Ensure that all prior MSIS reports are timely and accurate (STC 50)
180 calendar days from approval letter date	Submit Draft Evaluation Design (STC 58)
60 calendar days after receipt of CMS comments	Submit Final Evaluation Design (STC 59)
30 calendar days after CMS Approval	Approved Evaluation Design published to state's website (STC 59)
Quarterly Deliverables Due 60 calendar days after end of each quarter, except 4th quarter	Quarterly Progress Reports (STC 51)
	Quarterly Expenditure Reports (STC 69)
Annual Deliverables – Due 90 calendar days after end of each 4th quarter	Annual Report (STC 51)
150 calendar days after the approval of the demonstration extension	Submit Behavioral Health Services Protocol (STC 21)

ATTACHMENT A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration must be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

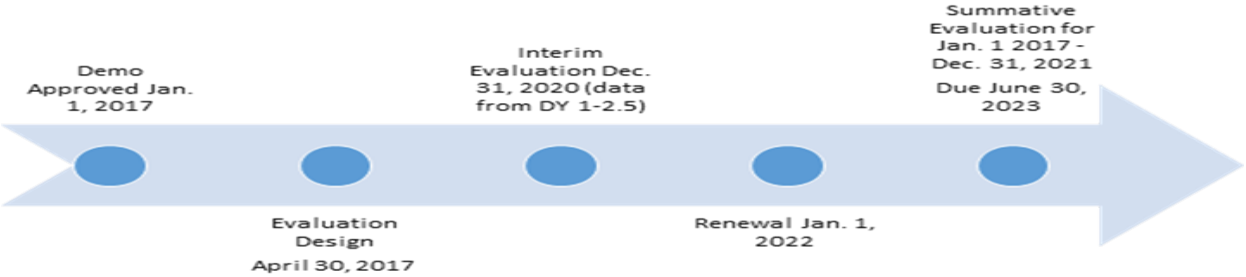
Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in B2 below) must be included with an explanation of the depicted information.

A. **General Background Information** – In this section, the state must include basic information about the demonstration, such as:

   1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

   2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

   3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

   4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

   5) Describe the population groups impacted by the demonstration.

B. **Evaluation Questions and Hypotheses** – In this section, the state must:

   1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:

4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section must provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

   a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.

   b. Qualitative analysis methods may be used, and must be described in detail.

   c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.

   d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

   e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).

   f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section must:

   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state must also identify any efforts to minimize the limitations. Additionally, this section must include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design must include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design must incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline must also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States must have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report must be posted on the state’s website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

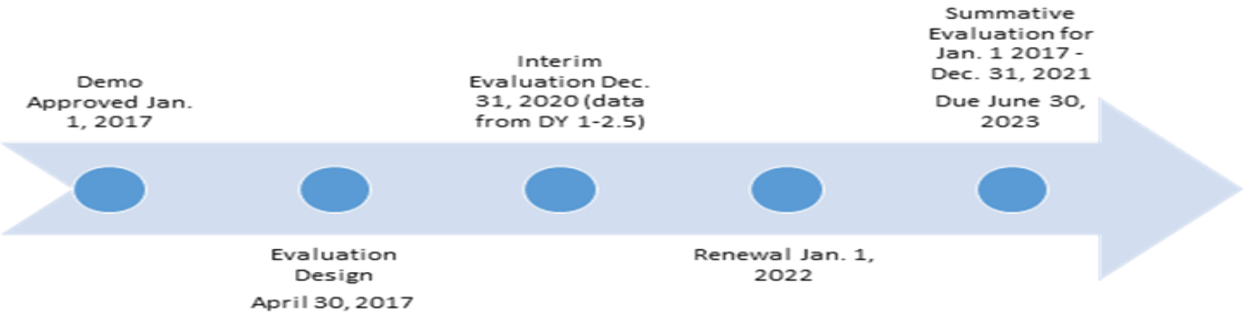
Intent of this Guidance

The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state’s submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report must present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
B. **General Background Information about the Demonstration** – In this section, the state must include basic information about the demonstration, such as:
    1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
    2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
    3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
    4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
    5) Describe the population groups impacted by the demonstration.
C. **Evaluation Questions and Hypotheses** – In this section, the state must:
    1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
    2) Identify the state's hypotheses about the outcomes of the demonstration;
        a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
        b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
        c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design must also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report must provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design must assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section must provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?

2. *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected

4. *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?

5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.

6. *Analytic methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

    A. **Methodological Limitations** - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

    B. **Results** – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings must visually depict the demonstration results (tables, charts, graphs). This section must include information on the statistical tests conducted.

C. **Conclusions –** In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. **Interpretations, Policy Implications and Interactions with Other State Initiatives –** In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This must include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section must also include a discussion of the implications of the findings at both the state and national levels.

E. **Lessons Learned and Recommendations –** This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

E. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C: Reserved for Evaluation Design

Attachment D: Home and Community-Based Services (HCBS) and Long-Term Care Provider Guidelines and Service Definitions

The following are the provider guidelines and service definitions for HCBS provided by section 1915(c) waivers, as well as the QUEST integration program.

Service/Provider Term	Service Definition
Adult Day Care Center	Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants in accordance with HAR§17-1417. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services. Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency. Adult Day Care Centers are licensed by the Department of Human Services and maintained and operated by an individual, organization, or agency. Included in the sub-set of services for the "At Risk" population.
Adult Day Health Center	Adult Day Health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96 and HAR §11-94-5. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community. Each program must have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services must be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse. In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, meals which do not constitute a full nutritional program, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services. Adult Day Health Centers are licensed by the Department of Health. Included in the sub-set of services for the "At Risk" population.
Assisted Living Facility	Assisted living services include personal care and supportive care services (homemaker, chore, attendant services, and meal preparation) that are furnished to members who reside in an assisted living facility. Assisted living facilities are home-like, non-institutional settings. Payment for room and board is prohibited. Section 30.200 describes Assisted Living Facilities as a facility, as defined in HRS 321-15.1, that is licensed by the Department of Health. This facility must consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility must be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.
Community Care Management Agency (CCMA)	CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. A health plan may, at its option, demonstrate the ability to provide CCMA services by contracting with an entity licensed under HAR subchapters 1 and 2. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services,

Service/Provider Term	Service Definition
	supplies, and equipment needs of members; ongoing face-to-face monitoring and implementation of the member's care plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. CCMAs shall (1) communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders, (2) work with families regarding service needs of member and serve as an advocate for their members, and (3) be accessible to the member's caregiver twenty-four (24) hours a day, seven (7) days a week. CCMA's are agencies licensed by the DHS or its designee under HAR chapter 17-1454, subchapters 1 and 2, to engage in locating, coordinating and monitoring comprehensive services to residents in community care foster family homes or members in E-ARCHS and assisted living facilities. A health plan may be a community care management agency.
Community Care Foster Family Home (CCFFH)	CCFFH services is personal care and supportive services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted under state law) provided in a <u>certified</u> private home by a principal care provider who lives in the home. The number of adults receiving services in CCFFH is determined by HAR, Title 17, Department of Human Services, SubTitle 9, Chapter 1454-43. CCFFH services are currently furnished to up to three (3) adults who receive these services in conjunction with residing in the home. All providers must provide individuals with their own bedroom. Each individual bedroom shall be limited to two (2) residents. Both occupants must consent to the arrangement. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four (4). In accordance with HAR, Title 17, Department of Human Services, SubTitle 9, Chapter 1454-42, members receiving CCFFH services must be receiving ongoing CCMA services. A CCFFH is a home issued a certificate of approval by the DHS to provide, for a fee, twenty-four (24) hour living accommodations, including personal care and homemaker services. The home must meet all applicable requirements of HAR §17-1454-37 through HAR §17-1454-56.
Counseling and Training	Counseling and training activities include the following: member care training for members, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling. Counseling and training is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member.
Environmental Accessibility Adaptations	Environmental accessibility adaptations are those physical adaptations to the home, required by the individual's care plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be provided in accordance with applicable state or local building codes.
Expanded Adult	Residential care services are personal care services, homemaker, chore, attendant care and

Service/Provider Term	Service Definition
Residential Care Home (E-ARCH) or Residential Care Services	companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principal care provider who lives in the home. Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH), allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the DHS to live in a Type I home with no more than two (2) of whom may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. An E-ARCH's is a facility, as defined in HAR §11-100.1.2 and licensed by the Department of Health, that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of expanded care ARCHs in accordance with HRS § 321-1562 as described above.
Home Delivered Meals	Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization. Included in the sub-set of services for the "At Risk" population
Home Maintenance	Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.
Moving Assistance	Moving assistance is provided in rare instances when it is determined through an assessment by the care coordinator that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.
Non-Medical Transportation	Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.
Personal Assistance Services (Level I)	Personal assistance services Level I are provided to individuals requiring assistance with instrumental activities of daily living (IADLs) in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I may be self-directed and consist of companion services and homemaker services. Homemaker services include:

Service/Provider Term	Service Definition
	• Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish; • Care of clothing and linen by washing, drying, ironing, mending; • Marketing and shopping for household supplies and personal essentials (not including cost of supplies); • Light yard work, such as mowing the lawn; • Simple home repairs, such as replacing light bulbs; • Preparing meals; • Running errands, such as paying bills, picking up medication; • Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available; • Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer; • Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate; and • Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service. Included in the sub-set of services for the "At Risk" population
Personal Assistance Services (Level II)	Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform activities of daily living (ADLs) and health maintenance activities. Personal assistance services Level II must be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. The following activities may be included as a part of personal assistance services Level II: • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing; • Assistance with bowel and bladder care; • Assistance with ambulation and mobility; • Assistance with transfers; • Assistance with medications, which are ordinarily self-administered when ordered by member's physician; • Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician; • Assistance with feeding, nutrition, meal preparation and other dietary activities; • Assistance with exercise, positioning, and range of motion; • Taking and recording vital signs, including blood pressure; • Measuring and recording intake and output, when ordered; • Collecting and testing specimens as directed; • Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, Hawaii Administrative Rules; • Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished; • Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and • Maintaining documentation of observations and services provided.

Service/Provider Term	Service Definition
	When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the care plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may also be provided. Personal assistance services Level II may be self-directed. Personal Assistance is care provided when a member, member's parent, guardian, family member or legal representative employs and supervises a personal assistant who is certified by the health plan as able to provide the designated services whose decision is based on direct observation of the member and the personal assistant during the actual provision of care. Documentation of this certification will be maintained in the member's individual plan of care. Included in the sub-set of services for the "At Risk" population
Personal Emergency Response Systems	PERS is a twenty-four (24) hour emergency assistance service which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items: • 24-hour answering/paging; • Beepers; • Med-alert bracelets; • Intercoms; • Life-lines; • Fire/safety devices, such as fire extinguishers and rope ladders; • Monitoring services; • Light fixture adaptations (blinking lights, etc.); • Telephone adaptive devices not available from the telephone company; and • Other electronic devices/services designed for emergency assistance. All types of PERS, described above, must meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting. Included in the sub-set of services for the "At Risk" population
Private Duty Nursing	Private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses (as defined in HAR § 16-89) within the scope of state law. Included in the sub-set of services for the "At Risk" population
Respite Care	Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally

Service/Provider Term	Service Definition
	providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; foster home/expanded-care adult residential care home; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the state. Respite care services are authorized by the member's PCP as part of the member's care plan. Respite services may be self-directed.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items must meet applicable standards of manufacture, design and installation and may include: • Specialized infant car seats; • Modification of parent-owned motor vehicle to accommodate the child (i.e., wheelchair lifts); • Intercoms for monitoring the child's room; • Shower seat; • Portable humidifiers; • Electric bills specific to electrical life support devices (ventilator, oxygen concentrator); • Medical supplies; • Heavy duty items including, but not limited to, patient lifts or beds that exceed $1,000 per month; • Rental of equipment that exceeds $1,000 per month such as ventilators; and • Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month. Items reimbursed shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies shall be recommended by the member's PCP.

Attachment E: Reserved for the Behavioral Health Services Protocol

Attachment E

Attachment E
Main Budget Neutrality Test, October 2023

Without Waiver Projections										
MEG	**PC or Agg**	**WOW, WW, or Both**	**Projected Historical DY30**	**Trend Rate**	**DY31**	**DY32**	**DY33**	**DY34**	**DY35**	**Total**
PMPMs										
Children	PC	Both	$308.77	5.0%	$324.20	$340.42	$357.44	$375.31	$394.07	$359.15
Adults	PC	Both	$603.22	5.0%	$633.38	$665.05	$698.30	$733.21	$769.87	$701.65
Aged	PC	Both	$1,668.85	5.0%	$1,752.29	$1,839.91	$1,931.90	$2,028.50	$2,129.92	$1,938.38
Blind/Disabled	PC	Both	$2,349.80	5.0%	$2,467.29	$2,590.66	$2,720.19	$2,856.20	$2,999.01	$2,729.32
BH Contingency Management	Agg	WW Only								
Traditional Healing	PC	WW Only								
Member Months										
Children	PC	Both	1,692,802	2.5%	1,735,122	1,778,500	1,822,962	1,868,536	1,915,250	9,120,370
Adults	PC	Both	744,160	2.5%	762,764	781,833	801,379	821,414	841,949	4,009,339
Aged	PC	Both	339,250	1.0%	342,643	346,069	349,530	353,025	356,555	1,747,823
Blind/Disabled	PC	Both	304,229	1.0%	307,272	310,344	313,448	316,582	319,748	1,567,394
BH Contingency Management	Agg	WW Only								
Traditional Healing	PC	WW Only								
Total Expenditures										
Children	PC	Both	$522,680,672		$562,535,074	$605,428,373	$651,592,286	$701,276,198	$754,748,508	$3,275,580,440
Adults	PC	Both	$448,889,908		$483,117,763	$519,955,493	$559,602,099	$602,271,759	$648,194,981	$2,813,142,094
Aged	PC	Both	$566,158,420		$600,411,004	$636,735,870	$675,258,390	$716,111,523	$759,436,270	$3,387,953,058
Blind/Disabled	PC	Both	$714,879,040		$758,129,222	$803,996,040	$852,637,801	$904,222,387	$958,927,842	$4,277,913,292
BH Contingency Management	Agg	WW Only								
Traditional Healing	PC	WW Only								
DSHP	Agg	WW Only								
Total			$2,252,608,040		$2,404,193,063	$2,566,115,776	$2,739,090,576	$2,923,881,868	$3,121,307,601	$13,754,588,884

With Waiver Projections

MEG	PC or Agg	WOW, WW, or Both	Projected Historical DY30	Trend Rate	DY31	DY32	DY33	DY34	DY35	Total
PMPMs										
Children	PC	Both	$269.29	5.0%	$282.75	$296.89	$311.73	$327.32	$343.68	$313.23
Adults	PC	Both	$486.46	5.0%	$510.78	$536.32	$563.14	$591.30	$620.86	$565.84
Aged	PC	Both	$1,531.90	5.0%	$1,608.49	$1,688.92	$1,773.37	$1,862.03	$1,955.13	$1,779.31
Blind/Disabled	PC	Both	$2,151.19	5.0%	$2,258.75	$2,371.69	$2,490.27	$2,614.79	$2,745.53	$2,498.63
BH Contingency Management	Agg	WW Only								
Traditional Healing	PC	WW Only		5.0%	$2.51	$2.63	$2.76	$2.90	$3.05	$2.78
Member Months										
Children	PC	Both	1,692,802	2.5%	1,735,122	1,778,500	1,822,962	1,868,536	1,915,250	9,120,370
Adults	PC	Both	744,160	2.5%	762,764	781,833	801,379	821,414	841,949	4,009,339
Aged	PC	Both	339,250	1.0%	342,643	346,069	349,530	353,025	356,555	1,747,823
Blind/Disabled	PC	Both	304,229	1.0%	307,272	310,344	313,448	316,582	319,748	1,567,394
BH Contingency Management	Agg	WW Only								
Traditional Healing	PC	WW Only			4,704,950	4,812,825	4,923,299	5,036,437	5,152,304	24,629,815
Total Expenditures										
Children	PC	Both	$455,847,433		$490,605,800	$528,014,492	$568,275,597	$611,606,612	$658,241,616	$2,856,744,117
Adults	PC	Both	$362,004,870		$389,607,742	$419,315,332	$451,288,126	$485,698,845	$522,733,382	$2,268,643,427
Aged	PC	Both	$519,697,370		$551,139,061	$584,482,974	$619,844,194	$657,344,768	$697,114,126	$3,109,925,124
Blind/Disabled	PC	Both	$654,455,501		$694,050,059	$736,040,087	$780,570,512	$827,795,028	$877,876,628	$3,916,332,314
BH Contingency Management	Agg	WW Only			$4,713,072	$4,713,072	$4,713,072	$4,713,072	$4,713,072	$23,565,360
Traditional Healing	PC	WW Only			$11,791,246	$12,668,306	$13,610,909	$14,623,972	$15,712,783	$68,407,216
DSHP	Agg	WW Only			$49,172,927	$53,473,288	$57,990,953	$62,055,147	$66,492,078	$289,184,393
Total			$1,992,005,174		$2,191,079,906	$2,338,707,552	$2,496,293,364	$2,663,837,444	$2,842,883,685	$12,532,801,951
DY BN Savings (TC)			$260,602,866		$213,113,157	$227,408,224	$242,797,212	$260,044,424	$278,423,916	$1,221,786,933
Prior CY Capped Carryover Savings										$1,586,324,001

Hypotheticals Including HRSN

MEG	PC or Agg	WOW, WW, or Both	Projected Historical DY30	Trend Rate	DY31	DY32	DY33	DY34	DY35	Total
PMPMs										
VIII Group Combined	PC	Both	$626.62	5.0%	$657.95	$690.85	$725.39	$761.66	$799.75	$728.87
CIS Pre-Tenancy and Tenancy Support	PC	Both	$1,390.61	5.0%	$1,460.14	$1,533.15	$1,609.81	$1,690.30	$1,774.81	$1,617.53
CIS Community Transition	PC	Both	$3,792.58	5.0%	$3,982.21	$4,181.32	$4,390.39	$4,609.91	$4,840.40	$4,411.44
Pre-Release Services	PC	Both	NA	5.0%	$939.20	$986.16	$1,035.47	$1,087.24	$1,141.60	$1,037.93
CE 1:0-6 Coverage	PC	Both	NA	5.0%	$390.99	$410.54	$431.07	$452.62	$475.25	$441.84
CE 2:6-18 Coverage	PC	Both	NA	5.0%	$144.25	$151.47	$159.04	$166.99	$175.34	$162.63
Nutrition Supports MTM	PC	Both	NA	3.0%	$3.60	$7.42	$11.13	$11.13	$11.13	$8.97
Assisted Living - At Risk Population	PC	Both	NA	5.0%	$13.54	$14.22	$16.42	$19.59	$20.57	$16.87
HRSN Services	PC	Both	NA	varies	$7.98	$15.21	$23.01	$24.98	$27.10	$19.87
Member Months										
VIII Group Combined	PC	Both	1,519,170	2.5%	1,557,149	1,596,078	1,635,980	1,676,880	1,718,802	8,184,889
CIS Pre-Tenancy and Tenancy Support	PC	Both	4,073	2.5%	4,175	4,279	4,386	4,496	4,608	21,944
CIS Community Transition	PC	Both	4,073	2.5%	4,175	4,279	4,386	4,496	4,608	21,944
Pre-Release Services	PC	Both	NA	0.0%	3,308	3,308	3,308	3,308	3,308	16,540
CE 1:0-6 Coverage	PC	Both	NA	varies	10,589	21,179	25,414	31,768	33,886	122,835
CE 2:6-18 Coverage	PC	Both	NA	varies	25,704	51,409	56,267	61,691	77,113	272,184
Nutrition Supports MTM	PC	Both	NA	varies	4,704,950	4,812,825	4,923,299	5,036,437	5,152,304	24,629,815
Assisted Living - At Risk Pop.	PC	Both	NA	0.0%	51,222	51,222	51,222	51,222	51,222	256,112
HRSN Services	PC	Both	NA	varies	4,704,950	4,812,825	4,923,299	5,036,437	5,152,304	24,629,815

Total Expenditures										
VIII Group Combined	PC	Both	$951,944,775		$1,024,530,564	$1,102,651,020	$1,186,728,160	$1,277,216,182	$1,374,603,916	$5,965,729,841
CIS Pre-Tenancy and Tenancy Support	PC	Both	$5,663,970		$6,095,848	$6,560,656	$7,060,906	$7,599,300	$8,178,747	$35,495,457
CIS Community Transition	PC	Both	$15,447,190		$16,625,038	$17,892,697	$19,257,016	$20,725,363	$22,305,672	$96,805,786
Pre-Release Services	PC	Both	NA		$3,106,866	$3,262,209	$3,425,320	$3,596,586	$3,776,415	$17,167,396
CE 1:0-6 Coverage	PC	Both	NA		$4,140,330	$8,694,692	$10,955,312	$14,378,847	$16,104,309	$54,273,491
CE 2:6-18 Coverage	PC	Both	NA		$3,707,928	$7,786,649	$8,948,612	$10,301,737	$13,521,029	$44,265,955
Nutrition Supports MTM	PC	Both	NA		$16,954,238	$35,726,508	$54,819,870	$56,079,635	$57,369,787	$220,950,038
Assisted Living - At Risk Pop.	PC	Both	NA		$693,582	$728,261	$841,142	$1,003,635	$1,053,817	$4,320,438
HRSN Services	PC	Both	NA		$37,525,618	$73,184,292	$113,266,510	$125,793,039	$139,641,660	$489,411,118
Pre-Release Non-Services	Agg	Both	NA		$8,222,318	$7,194,528	$5,138,949	$0	$0	$20,555,794
HRSN Infrastructure	Agg	Both	NA		$14,685,792	$15,970,121	$17,319,349	$18,533,145	$19,858,261	$86,366,668
Total					$1,136,288,122	$1,279,651,633	$1,427,761,144	$1,535,227,469	$1,656,413,613	$7,035,341,982
Total Waiver Budget Expenditures Including Hypotheticals					$3,327,368,028	$3,618,359,185	$3,924,054,508	$4,199,064,913	$4,499,297,299	$19,568,143,933

Attachment E

Budget Neutrality Summary Enrollment and Expenditures, October 2023

Budget Neutrality Reporting Start DY	**31**
Budget Neutrality Reporting End DY	**35**

Without-Waiver Total Expenditures

			31	**32**	**33**	**34**	**35**	**Total**
Medicaid Per Capita								
EG 1 - Children	1	**Total**	$ 562,535,074	$ 605,428,373	$ 651,592,286	$ 701,276,198	$ 754,748,508	
		PMPM	$324.20	$340.42	$357.44	$375.31	$394.07	
		Mem-Mon	1,735,122	1,778,500	1,822,962	1,868,536	1,915,250	
EG 2 - Adults	2	**Total**	$ 483,117,763	$ 519,955,493	$ 559,602,099	$ 602,271,759	$ 648,194,981	
		PMPM	$633.38	$665.05	$698.30	$733.21	$769.87	
		Mem-Mon	762,764	781,833	801,379	821,414	841,949	
EG 3 - Aged	3	**Total**	$ 595,242,015	$ 631,254,157	$ 669,445,034	$ 709,946,458	$ 752,898,219	
		PMPM	$1,737.21	$1,824.07	$1,915.27	$2,011.04	$2,111.59	
		Mem-Mon	342,643	346,069	349,530	353,025	356,555	
EG 4 – Blind/Disabled	4	**Total**	$ 764,715,753	$ 810,981,056	$ 860,045,410	$ 912,078,157	$ 967,258,885	
		PMPM	$2,488.73	$2,613.16	$2,743.82	$2,881.01	$3,025.07	
		Mem-Mon	307,272	310,344	313,448	316,582	319,748	
TOTAL			**$ 2,405,610,605**	**$ 2,567,619,079**	**$ 2,740,684,829**	**$ 2,925,572,573**	**$ 3,123,100,594**	**$ 13,762,587,679**

With-Waiver Total Expenditures

			31	**32**	**33**	**34**	**35**	**TOTAL**
EG 1 - Children	1		$ 490,605,800	$ 528,014,492	$ 568,275,597	$ 611,606,612	$ 658,241,616	$ 2,856,744,117.45
EG 2 - Adults	2		$ 389,607,742	$ 419,315,332	$ 451,288,126	$ 485,698,845	$ 522,733,382	$ 2,268,643,427.27
EG 3 - Aged	3		$ 544,677,825	$ 577,630,833	$ 612,577,499	$ 649,638,437	$ 688,941,563	$ 3,073,466,156.12
EG 4 – Blind/Disabled	4		$ 702,283,222	$ 744,771,357	$ 789,830,024	$ 837,614,740	$ 888,290,432	$ 3,962,789,774.18
BH Contingency Management			$ 4,713,072	$ 4,713,072	$ 4,713,072	$ 4,713,072	$ 4,713,072	$ 23,565,360
Traditional Healing			$ 11,791,246	$ 12,668,306	$ 13,610,909	$ 14,623,972	$ 15,712,783	$ 68,407,216
DSHP			$ 49,170,513	$ 53,440,180	$ 57,993,879	$ 62,130,881	$ 66,642,373	$ 289,377,827
TOTAL			**$ 2,192,849,420**	**$ 2,340,553,572**	**$ 2,498,289,106**	**$ 2,666,026,559**	**$ 2,845,275,221**	**$ 12,542,993,878**

BASE VARIANCE			**$ 212,761,185**	**$ 227,065,507**	**$ 242,395,723**	**$ 259,546,013**	**$ 277,825,373**	**$ 1,219,593,801**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								$ 1,586,324,001
NET VARIANCE (subject to cap)								**$ 2,805,917,801**

Cumulative Target Limit

			31	**32**	**33**	**34**	**35**	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%	0.0%	
Cumulative Budget Neutrality Limit (CBNL)			$ 12,403,133,442	$ 14,970,752,521	$ 17,711,437,350	$ 20,637,009,923	$ 23,760,110,516	
Allowed Cumulative Variance (= CTP X CBNL)			$ 248,062,669	$ 224,561,288	$ 177,114,374	$ 103,185,050	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (1,799,085,186)	$ (2,026,150,692)	$ (2,268,546,415)	$ (2,528,092,429)	$ (2,805,917,801)	
Is a Corrective Action Plan needed?								

Attachment E

Budget Neutrality Summary Enrollment and Expenditures, October 2023

Budget Neutrality Reporting Start DY	**31**
Budget Neutrality Reporting End DY	**35**

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 1 Per Capita EG 5 – Group VIII	1	**Total**	$ 1,174,384,970	$ 1,263,931,824	$ 1,360,306,626	$ 1,464,030,006	$ 1,575,662,294	
		PMPM	$754.19	$791.90	$831.49	$873.07	$916.72	
		Mem-Mon	1,557,149	1,596,078	1,635,980	1,676,880	1,718,802	
TOTAL			**$ 1,174,384,970**	**$1,263,931,824**	**$1,360,306,626**	**$1,464,030,006**	**$1,575,662,294**	**$ 6,838,315,720**

With-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 1 Per Capita EG 5 – Group VIII	1		$1,024,530,564	$1,102,651,020	$1,186,728,160	$1,277,216,182	$1,374,603,916	
TOTAL			**$1,024,530,564**	**$ 1,102,651,020**	**$ 1,186,728,160**	**$ 1,277,216,182**	**$ 1,374,603,916**	**$ 5,965,729,841.06**

HYPOTHETICALS VARIANCE 1			**$ 149,854,406**	**$ 161,280,805**	**$ 173,578,466**	**$ 186,813,824**	**$ 201,058,378**	**$ 872,585,879**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 2 Per Capita EG 6 - CIS	1	**Total**	$ 6,129,633	$ 6,597,017	$ 7,100,040	$ 7,641,418	$ 8,224,076	
		PMPM	$1,468.24	$1,541.65	$1,618.73	$1,699.67	$1,784.65	
		Mem-Mon	4,175	4,279	4,386	4,496	4,608	
TOTAL			**$ 6,129,633**	**$ 6,597,017**	**$ 7,100,040**	**$ 7,641,418**	**$ 8,224,076**	**$ 35,692,185**

With-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 2 Per Capita EG 6 - CIS	1		$ 6,095,848	$ 6,560,656	$ 7,060,906	$ 7,599,300	$ 8,178,747	
TOTAL			**$ 6,095,848**	**$ 6,560,656**	**$ 7,060,906**	**$ 7,599,300**	**$ 8,178,747**	**$ 35,495,457.02**

HYPOTHETICALS VARIANCE 2			**$ 33,785**	**$ 36,361**	**$ 39,134**	**$ 42,118**	**$ 45,329**	**$ 196,728**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 3 Per Capita EG 7 – CIS Community Transition Pilot	1	**Total**	$ 16,717,170	$ 17,991,854	$ 19,363,733	$ 20,840,217	$ 22,429,284	
		PMPM	$4,004.28	$4,204.49	$4,414.72	$4,635.45	$4,867.23	
		Mem-Mon	4,175	4,279	4,386	4,496	4,608	
TOTAL			**$ 16,717,170**	**$ 17,991,854**	**$ 19,363,733**	**$ 20,840,217**	**$ 22,429,284**	**$ 97,342,257**

With-Waiver Total Expenditures

			31	32	33	34	35	TOTAL

Attachment E

Budget Neutrality Summary Enrollment and Expenditures, October 2023

Budget Neutrality Reporting Start DY	**31**
Budget Neutrality Reporting End DY	**35**

Hypothetical 3 Per Capita EG 7 – CIS Community Transition Pilot	1		$ 16,625,038	$ 17,892,697	$ 19,257,016	$ 20,725,363	$ 22,305,672	
TOTAL			**$ 16,625,038**	**$ 17,892,697**	**$ 19,257,016**	**$ 20,725,363**	**$ 22,305,672**	**$ 96,805,786.19**

HYPOTHETICALS VARIANCE 3			**$ 92,131**	**$ 99,156**	**$ 106,717**	**$ 114,854**	**$ 123,612**	**$ 536,470**

HYPOTHETICALS TEST 4

Without-Waiver Total Expenditures

			31	**32**	**33**	**34**	**35**	**TOTAL**
Hypothetical 4 Per Capita EG 8 – Pre-Release Medicaid Services for Justice-Involved Individuals	1	**Total**	$ 3,106,865.99	$ 3,262,209	$ 3,425,320	$ 3,596,586	$ 3,776,415	
		PMPM	$939.20	$986.16	$1,035.47	$1,087.24	$1,141.60	
		Mem-Mon	3,308	3,308	3,308	3,308	3,308	
Hypothetical 4 Aggregate		**Same as WW Total?** **Yes**						
EG 9 – Pre-Release Medicaid Infrastructure for Justice-Involved Individuals	2		$ 8,222,317.73	$ 7,194,528	$ 5,138,949	$ -	$ -	
TOTAL			**$ 11,329,183.72**	**$ 10,456,737**	**$ 8,564,268**	**$ 3,596,586**	**$ 3,776,415**	**$ 37,723,190**

With-Waiver Total Expenditures

			31	**32**	**33**	**34**	**35**	**TOTAL**
Hypothetical 4 Per Capita EG 8 – Pre-Release Medicaid Services for Justice-Involved Individuals	1		$ 3,106,865.99	$ 3,262,209	$ 3,425,320	$ 3,596,586	$ 3,776,415	
Hypothetical 4 Aggregate EG 9 – Pre-Release Medicaid Infrastructure for Justice-Involved Individuals	2		$ 8,222,317.73	$ 7,194,528	$ 5,138,949	$ -	$ -	
TOTAL			**$ 11,329,183.72**	**$ 10,456,737**	**$ 8,564,268**	**$ 3,596,586**	**$ 3,776,415**	**$ 37,723,190.13**

HYPOTHETICALS VARIANCE 4			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Attachment E

Budget Neutrality Summary Enrollment and Expenditures, October 2023

Budget Neutrality Reporting Start DY	**31**
Budget Neutrality Reporting End DY	**35**

HYPOTHETICALS TEST 5

Without-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 5 Per Capita								
EG 10 – Continuous eligibility for children ages 0 to 6	1	**Total**	$ 4,140,329.67	$ 8,694,692	$ 10,955,312	$ 14,378,847	$ 16,104,309	
		PMPM	$390.99	$410.54	$431.07	$452.62	$475.25	
		Mem-Mon	10,589	21,179	25,414	31,768	33,886	
EG 11 - Two-year continuous eligibility for children ages 6 to 19	2	**Total**	$ 3,707,928.13	$ 7,786,649	$ 8,948,612	$ 10,301,737	$ 13,521,029	
		PMPM	$144.25	$151.47	$159.04	$166.99	$175.34	
		Mem-Mon	25,704	51,409	56,267	61,691	77,113	
TOTAL			**$ 7,848,257.79**	**$ 16,481,341**	**$ 19,903,924**	**$ 24,680,584**	**$ 29,625,339**	**$ 98,539,446**

With-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 5 Per Capita								
EG 10 – Continuous eligibility for children ages 0 to 6	1		$ 4,140,329.67	$ 8,694,692	$ 10,955,312	$ 14,378,847	$ 16,104,309	
EG 11 - Two-year continuous eligibility for children ages 6 to 19	2		$ 3,707,928.13	$ 7,786,649	$ 8,948,612	$ 10,301,737	$ 13,521,029	
TOTAL			**$ 7,848,257.79**	**$ 16,481,341**	**$ 19,903,924**	**$ 24,680,584**	**$ 29,625,339**	**$ 98,539,445.83**

HYPOTHETICALS VARIANCE 5			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

HYPOTHETICALS TEST 6

Without-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 6 Per Capita								
EG 12 - Nutrition Supports: Medically Tailored Meals	1	**Total**	$ 16,193,515.22	$ 34,123,488	$ 53,930,951	$ 56,825,397	$ 59,876,687	
		PMPM	$3.44	$7.09	$10.95	$11.28	$11.62	
		Mem-Mon	4,704,950	4,812,825	4,923,299	5,036,437	5,152,304	
TOTAL			**$ 16,193,515.22**	**$ 34,123,488**	**$ 53,930,951**	**$ 56,825,397**	**$ 59,876,687**	**$ 220,950,038**

With-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 6 Per Capita								
EG 12 - Nutrition Supports: Medically Tailored Meals	1		$ 16,193,515.22	$ 34,123,488	$ 53,930,951	$ 56,825,397	$ 59,876,687	
TOTAL			**$ 16,193,515.22**	**$ 34,123,488**	**$ 53,930,951**	**$ 56,825,397**	**$ 59,876,687**	**$ 220,950,038.01**

HYPOTHETICALS VARIANCE 6			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

HYPOTHETICALS TEST 7

Without-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 7 Per Capita								
EG 13 - Assisted Living for At-Risk Population	1	**Total**	$ 693,582.24	$ 728,261	$ 841,142	$ 1,003,635	$ 1,053,817	
		PMPM	$13.54	$14.22	$16.42	$19.59	$20.57	
		Mem-Mon	51,222	51,222	51,222	51,222	51,222	

Attachment E

Budget Neutrality Summary Enrollment and Expenditures, October 2023

Budget Neutrality Reporting Start DY	31
Budget Neutrality Reporting End DY	35

TOTAL			**$ 693,582.24**	**$ 728,261**	**$ 841,142**	**$ 1,003,635**	**$ 1,053,817**	**$ 4,320,437.56**

With-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 7 Per Capita								
EG 13 - Assisted Living for At-Risk Population	1		$ 693,582.24	$ 728,261	$ 841,142	$ 1,003,635	$ 1,053,817	
TOTAL			**$ 693,582.24**	**$ 728,261**	**$ 841,142**	**$ 1,003,635**	**$ 1,053,817**	**$4,320,438**

HYPOTHETICALS VARIANCE 7			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

HYPOTHETICALS TEST 8

Without-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 8 Per Capita								
EG 14 - HRSN Services	1	**Total**	$36,354,261	$ 70,710,863	$ 112,356,807	$ 127,960,221	$ 144,868,290	
		PMPM	$7.73	$14.69	$22.82	$25.41	$28.12	
		Mem-Mon	4,704,950	4,812,825	4,923,299	5,036,437	5,152,304	
Hypothetical 8 Aggregate		**Same as WW Total?**						
		Yes						
EG 15 - HRSN Infrastructure	2		$ 14,685,071.20	$ 15,960,233	$ 17,320,223	$ 18,555,763	$ 19,903,148	
TOTAL			**$ 51,039,332.07**	**$ 86,671,096**	**$ 129,677,030**	**$ 146,515,984**	**$ 164,771,438**	**$ 578,674,880.76**

With-Waiver Total Expenditures

			31	32	33	34	35	TOTAL
Hypothetical 8 Per Capita								
EG 14 - HRSN Services	1		$ 36,354,261	$ 70,710,863	$ 112,356,807	$ 127,960,221	$ 144,868,290	
Hypothetical 8 Aggregate								
EG 15 - HRSN Infrastructure	2		$ 14,685,071.20	$ 15,960,233	$ 17,320,223	$ 18,555,763	$ 19,903,148	
TOTAL			**$ 51,039,332.07**	**$ 86,671,096**	**$ 129,677,030**	**$ 146,515,984**	**$ 164,771,438**	**$ 578,674,880.76**

HYPOTHETICALS VARIANCE 8			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Attachment E

Budget Neutrality Summary Enrollment and Expenditures, October 2023

Budget Neutrality Reporting Start DY	**31**
Budget Neutrality Reporting End DY	**35**

With-Waiver Total Expenditures Including Hypotheticals

			31	**32**	**33**	**34**	**35**	**TOTAL**
EG 1 - Children			$ 490,605,800	$ 528,014,492	$ 568,275,597	$ 611,606,612	$ 658,241,616	$ 2,856,744,117.45
EG 2 - Adults			$ 389,607,742	$ 419,315,332	$ 451,288,126	$ 485,698,845	$ 522,733,382	$ 2,268,643,427.27
EG 3 - Aged			$ 544,677,825	$ 577,630,833	$ 612,577,499	$ 649,638,437	$ 688,941,563	$ 3,073,466,156.12
EG 4 – Blind/Disabled			$ 702,283,222	$ 744,771,357	$ 789,830,024	$ 837,614,740	$ 888,290,432	$ 3,962,789,774.18
BH Contingency Management			$ 4,713,072	$ 4,713,072	$ 4,713,072	$ 4,713,072	$ 4,713,072	$ 23,565,360
Traditional Healing			$ 11,791,246	$ 12,668,306	$ 13,610,909	$ 14,623,972	$ 15,712,783	$ 68,407,216
DSHP			$ 49,170,513	$ 53,440,180	$ 57,993,879	$ 62,130,881	$ 66,642,373	$ 289,377,826.92
Hypotheticals								
EG 5 – Group VIII			$ 1,024,530,564	$ 1,102,651,020	$ 1,186,728,160	$ 1,277,216,182	$ 1,374,603,916	$ 5,965,729,841.06
EG 6 - CIS			$ 6,095,848	$ 6,560,656	$ 7,060,906	$ 7,599,300	$ 8,178,747	$ 35,495,457.02
EG 7 – CIS Community Transition Pilot			$ 16,625,038	$ 17,892,697	$ 19,257,016	$ 20,725,363	$ 22,305,672	$ 96,805,786
EG 8 – Pre-Release Medicaid Services for Justice-Involved Individuals			$ 3,106,866	$ 3,262,209	$ 3,425,320	$ 3,596,586	$ 3,776,415	$ 17,167,396
EG 9 – Pre-Release Medicaid Infrastructure for Justice-Involved Individuals			$ 8,222,318	$ 7,194,528	$ 5,138,949	$ -	$ -	$ 20,555,794.32
EG 10 – Continuous eligibility for children ages 0 to 6			$ 4,140,330	$ 8,694,692	$ 10,955,312	$ 14,378,847	$ 16,104,309	$ 54,273,490.73
EG 11 - Two-year continuous eligibility for children ages 6 to 19			$ 3,707,928	$ 7,786,649	$ 8,948,612	$ 10,301,737	$ 13,521,029	$ 44,265,955.10
EG 12 - Nutrition Supports: Medically Tailored Meals			$ 16,193,515	$ 34,123,488	$ 53,930,951	$ 56,825,397	$ 59,876,687	$ 220,950,038.01
EG 13 - Assisted Living for At-Risk Population			$ 693,582	$ 728,261	$ 841,142	$ 1,003,635	$ 1,053,817	$ 4,320,437.56
EG 14 - HRSN Services			$ 36,354,261	$ 70,710,863	$ 112,356,807	$ 127,960,221	$ 144,868,290	$ 492,250,442.65
EG 15 - HRSN Infrastructure			$ 14,685,071	$ 15,960,233	$ 17,320,223	$ 18,555,763	$ 19,903,148	$ 86,424,438.10
TOTAL			**$ 3,327,204,741**	**$ 3,616,118,870**	**$ 3,924,252,502**	**$ 4,204,189,591**	**$ 4,509,467,251**	**$ 19,581,232,955**

Attachment F

Stakeholder Email Notification
Section 1115 Demonstration Renewal

October 16, 2023

The Hawaii Med-QUEST Division (MQD) in the Department of Human Services is excited to announce the draft of our program's Section 1115 Demonstration renewal is complete, and open for public comment. We have greatly appreciated the community energy and engagement this past summer on the new initiatives being requested, and the commitment over the years to continually work to improve QUEST. Our current demonstration is approved through July 31, 2024, and this application will request approval of a five-year renewal beginning August 1, 2024 and continuing through July 31, 2029. Before submitting to the Centers for Medicare and Medicaid Services (CMS), we must have a 30-day public comment period. The "short" Public Notice has detailed information related to our program, its objectives, details regarding eligibility and the care delivery system; proposed hypotheses and evaluation approaches; proposed waiver and expenditure authorities, impact to eligibility and budget neutrality (attached). For further details on the demonstration renewal, please refer to our full public notice and the draft renewal application available at: https://medquest.hawaii.gov/en/about/state-plan-1115.html#tabs-8ee927caf9-item-99d6f14a00.

We will also hold two public hearings to solicit public input and comment about the demonstration application. You and all interested parties are invited to join the public forum and to state their views regarding progress on the Section 1115 Demonstration. Attendees may participate in the meetings either in-person or via teleconference.

Registration is required to participate. If you plan to attend in person for either meeting date, please RSVP your attendance by calling 808-692-8058 or emailing PPDO@dhs.hawaii.gov. If you plan to attend via teleconference, you must register for the meeting using the links listed below—participants will receive a confirmation email containing Zoom login information needed to join the meeting virtually.

- **Wednesday, October 18, 2023 at 6:00PM HST**
    - *(In-Person)* Kakuhihewa Building, Conference Rooms 111 A&B, 601 Kamokila Boulevard, Kapolei HI 96707
    - *(Teleconference)* https://medquest-hawaii-gov.zoom.us/meeting/register/tZcqd-Gspz0vGNOASTxnI_u1k9bo8QOXTkX-
    - Note: If you need auxiliary aid/service or other accommodation due to disability or limited English proficiency, please contact: the Med-QUEST Division at (808) 692-8151 (voice); or 711 (TTY) or by email at MHACcomments@dhs.hawaii.gov by 4:00 pm on Monday, October 16, 2023. Requests made as early as possible

    have a greater chance of being fulfilled due to a limited number of communication access providers.

- **Tuesday, October 24, 2023 at 6:00PM HST**
    - *(In-Person)* Queen Lili’uokalani Building, 2nd Floor Conference Room, 1390 Miller Street, Honolulu, HI 96813
    - *(Teleconference)* https://medquest-hawaii-gov.zoom.us/meeting/register/tZwtd--opj8jGdHX86gdWXGW_WwoMgqbIlha
    - Note: If you need auxiliary aid/service or other accommodation due to disability or limited English proficiency, please contact: the Med-QUEST Division at (808) 692-8151 (voice); or 711 (TTY) or by email at MHACcomments@dhs.hawaii.gov by 4:00 pm on Friday, October 20, 2023. Requests made as early as possible have a greater chance of being fulfilled due to a limited number of communication access providers.

Written comments may be submitted by email to PPDO@dhs.hawaii.gov using “Section 1115 Demonstration Feedback” in the subject line, or mailed to Med-QUEST Division, Attn: PPDO, P.O. Box 700190, Kapolei, HI, 96709. Comments for the Quest Integration Section 1115 Demonstration Project must be received by **November 16, 2023**.

Attachment G

ABBREVIATED NOTICE OF REQUEST FOR SECTION 1115(a) RENEWAL OF HAWAII’S SECTION 1115 DEMONSTRATION (11-W-00001/9)

QUEST Integration Renewal Application

The State of Hawaiʻi, Department of Human Services (the State) is requesting approval from the federal Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) to renew and amend the “QUEST Integration” (Project Number 11-W-00001/9) demonstration under Section 1115(a) of the Social Security Act for an additional five years. The State’s existing Section 1115 Demonstration is approved through July 31, 2024, and this application will request approval of a five-year renewal beginning August 1, 2024 and continuing through July 31, 2029.

Pursuant to 42 CFR 431.408, Med-QUEST Division (MQD), Hawaii’s Medicaid Agency, gives notice of the State’s intent to file this Section 1115 Demonstration renewal and amendment. This abbreviated public notice, issued October 16, 2023, provides information on this demonstration, opportunities for public comment, and dates of public hearings.

The State is soliciting public comments on the draft Section 1115 Demonstration application from October 16, 2023 through November 16, 2023. For further details, please go to: https://medquest.hawaii.gov/en/about/state-plan-1115.html#tabs-8ee927caf9-item-99d6f14a00.

Demonstration Background, Objectives, and Renewal Request

Demonstration Background

Originally implemented as the QUEST program in 1994, QUEST Integration is the current version of Hawaii’s Section 1115 Demonstration project to provide comprehensive benefits to its Medicaid enrollees through a competitive managed care delivery system. Since its implementation, CMS has renewed the QUEST demonstration six times. Over the years, the State has made significant changes to the demonstration.

The program was designed to increase access to health care and control the rate of annual increases in health care expenditures. It has also served as a mechanism for delivery system innovation, enabling Hawaiʻi to advance its policy goals and improve the health and well-being of Hawaiʻi residents.

Demonstration Objectives

This renewal introduces new strategies to execute on the same overarching objectives as the current demonstration. As such, the State’s objectives are to:

- Improve health outcomes for Medicaid enrolled individuals covered under the demonstration;
- 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
- Address health determinants to improve health outcomes and lower healthcare costs.

Demonstration Renewal Request

Hawaiʻi is requesting a five-year renewal of most of the waiver and expenditure authorities contained in the QUEST Integration 2019 Section 1115 Demonstration and is proposing new authorities to enable the State to continue its whole-person approach to care. The proposed authorities reflect the State's commitment to identifying and addressing social drivers of health. In concert with this Section 1115 Demonstration amendment and renewal, the State will separately seek new or exercise existing authorities via the State Plan, Section 1915(c) Waiver, and managed care contracts to expand or modify certain benefits or eligibility criteria for select Medicaid beneficiaries. Together, these authorities will enable MQD to continue championing its mission of empowering Hawaiʻi residents to improve and sustain wellbeing.

Current authorities that will be renewed and may be amended include:

- QUEST Integration Mandatory Managed Care
- Behavioral Health
- Home- and Community-Based Services (HCBS)
- Housing-Related Services through Community Integration Services (CIS)

New requests include federal matching funds related to:

- Continuous Eligibility for Children
- Pre-Release Services for Justice-Involved Individuals
- Nutritional Supports
- Native Hawaiian Traditional Healing Practices
- Contingency Management
- Infrastructure Funding
- Designated State Health Programs (DSHP)

For further details on the renewal request descriptions, goals, and objectives, please refer to the full public notice, the draft Section 1115 Demonstration Renewal application, and other relevant documents located at: https://medquest.hawaii.gov/en/about/state-plan-1115.html#tabs-8ee927caf9-item-99d6f14a00.

Public Comment Period

Public Hearings

In concert with 42 C.F.R. 431.408(a)(3), the State will hold two public hearings to solicit public input and comment about the demonstration renewal application. Interested parties are invited to join the public forum and to state their views regarding progress on the Section 1115 Demonstration. Attendees may participate in the meetings in-person or via teleconference.

Registration is required to participate. If you plan to attend in person, please RSVP your attendance by calling 808-692-8058 or emailing PPDO@dhs.hawaii.gov. If you plan to attend via teleconference, you must register for the meeting using the links listed below—participants will receive a confirmation email containing login information needed to join the meeting virtually.

- **Wednesday, October 18, 2023 at 6:00PM HST**
    - *(In-Person)* Kakuhihewa Building, Conference Rooms 111 A&B, 601 Kamokila Boulevard, Kapolei HI 96707
    - *(Teleconference)* https://medquest-hawaii-gov.zoom.us/meeting/register/tZcqd-Gspz0vGNOASTxnI_u1k9bo8QOXTkX-
    - Note: If you need auxiliary aid/service or other accommodation due to disability or limited English proficiency, please contact: the Med-QUEST Division at (808) 692-8151 (voice); or 711 (TTY) or by email at MHACcomments@dhs.hawaii.gov by 4:00 pm on Monday, October 16, 2023. Requests made early have a greater chance of being fulfilled due to a limited number of communication access providers.
- **Tuesday, October 24, 2023 at 6:00PM HST**
    - *(In-Person)* Queen Lili'uokalani Building, 2nd Floor Conference Room, 1390 Miller Street, Honolulu, HI 96813
    - *(Teleconference)* https://medquest-hawaii-gov.zoom.us/meeting/register/tZwtd--opj8jGdHX86gdWXGW_WwoMgqbIIha
    - Note: If you need auxiliary aid/service or other accommodation due to disability or limited English proficiency, please contact: the Med-QUEST Division at (808) 692-8151 (voice); or 711 (TTY) or by email at MHACcomments@dhs.hawaii.gov by 4:00 pm on Friday, October 20, 2023. Requests made early have a greater chance of being fulfilled due to a limited number of communication access providers.

Public Comment

The State invites the public to comment on the draft Section 1115 Demonstration renewal application, which is available online at https://medquest.hawaii.gov/en/about/state-plan-1115.html#tabs-8ee927caf9-item-99d6f14a00.

A printed copy of the proposed changes and special accommodations (e.g., interpreter, large print or taped materials, etc.) can be arranged if requested by contacting the Policy and Program Development Office at (808) 692-8058 or via email at PPDO@dhs.hawaii.gov no later than seven (7) working days before the comment period ends.

Written comments may be submitted by email to PPDO@dhs.hawaii.gov using “Section 1115 Demonstration Feedback” in the subject line, or mailed to Med-QUEST Division, Attn: PPDO, P.O. Box 700190, Kapolei, HI, 96709. Comments for the Quest Integration Section 1115 Demonstration Project must be received by **November 16, 2023**.

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR

Attachment H

NOTICE OF REQUEST FOR SECTION 1115(a) RENEWAL OF HAWAII'S SECTION 1115 DEMONSTRATION (11-W-00001/9)

QUEST Integration Renewal Application

The State of Hawaiʻi, Department of Human Services (the State) is requesting approval from the federal Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) to renew and amend the "QUEST Integration" (Project Number 11-W-00001/9) demonstration under Section 1115(a) of the Social Security Act for an additional five years. The State's existing Section 1115 Demonstration is approved through July 31, 2024, and this application will request approval of a five-year renewal beginning August 1, 2024 and continuing through July 31, 2029.

Pursuant to 42 C.F.R. § 431.408, Med-QUEST Division (MQD), Hawaii's Medicaid Agency, gives notice of the State's intent to file this Section 1115 Demonstration renewal and amendment. This public notice, issued October 16, 2023, provides information on this demonstration, including an overview of the program and its objectives; details regarding eligibility and the care delivery system; proposed hypotheses and evaluation approaches; proposed waiver and expenditure authorities; impact to eligibility and budget neutrality; and opportunities for public comment and dates of public hearings.

The State invites the public to comment on the draft Section 1115 Demonstration renewal application, available online at https://medquest.hawaii.gov/en/about/state-plan-1115.html#tabs-8ee927caf9-item-99d6f14a00. Written comments may be submitted by email to PPDO@dhs.hawaii.gov using "Section 1115 Demonstration Feedback" in the subject line, or mailed to Med-QUEST Division, Attn: PPDO, P.O. Box 700190, Kapolei, HI, 96709. Comments for the Quest Integration Section 1115 Demonstration Project must be received by **November 16, 2023**.

Hawaiʻi ʻOhana Nui Project Expansion (HOPE) Strategic Framework

The State is committed to supporting and creating healthy families and healthy communities by empowering Hawaiʻi residents to improve and sustain their wellbeing. Developed as a roadmap to achieve this vision, the HOPE program provides a "north star" to guide the development of Hawaii's delivery system reform initiatives, including this Section 1115 Demonstration renewal application.

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

- Assuring continued access to health insurance and health care;
- Emphasis on whole person and whole family care over their life course;

- Address the social drivers of health and health-related social needs;
- Emphasis on health promotion, prevention and primary care;
- Emphasis on investing in system-wide changes; and
- Leverage and support community initiatives.

HOPE activities—including those reflected in the renewal application—focus on four strategic areas:

- Invest in primary care, prevention, and health promotion;
- Improve outcomes for high-need, high-cost individuals;
- Implement payment reform and alignment; and
- Support community driven initiatives to improve population health.

Demonstration Background, Objectives, and Renewal Request

Demonstration Background

Originally implemented as the QUEST program in 1994, QUEST Integration is the current version of Hawaii's Section 1115 Demonstration project to provide comprehensive benefits to its Medicaid enrollees through a competitive managed care delivery system. Since its implementation, CMS has renewed the QUEST demonstration six times. Over the years, the State has made significant changes to the demonstration.

The program was designed to increase access to health care and control the rate of annual increases in health care expenditures. It has also served as a mechanism for delivery system innovation, enabling Hawaiʻi to advance its policy goals and improve the health and well-being of Hawaiʻi residents. QUEST stands for:

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

Demonstration Objectives

Building on the HOPE vision and accomplishments of the existing Section 1115 Demonstration, this renewal introduces new strategies to execute on the same overarching objectives as the current demonstration. As such, the State's objectives are to:

- Improve health outcomes for Medicaid enrolled individuals covered under the demonstration;
- 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
- Address health determinants to improve health outcomes and lower healthcare costs.

Demonstration Renewal Request

Hawaiʻi is requesting a five-year renewal of most of the waiver and expenditure authorities contained in the QUEST Integration 2019 Section 1115 Demonstration and is proposing new authorities to enable the State to continue its whole-person approach to care. The proposed authorities reflect the State's commitment to identifying and addressing social drivers of health. In concert with this Section 1115 Demonstration amendment and renewal, the State will separately seek new or exercise existing authorities via the State Plan, Section 1915(c) Waiver, and managed care contracts to expand or modify certain benefits or eligibility criteria for select Medicaid beneficiaries. Together, these authorities will enable MQD to continue championing its mission of empowering Hawaiʻi residents to improve and sustain wellbeing.

Current authorities that will be renewed and may be amended include:

- **QUEST Integration Mandatory Managed Care:** Renew authority to continue providing services through a mandatory managed care delivery system. Hawaiʻi seeks a technical correction related to reporting and a minor waiver authority to expand out-of-state former foster youth eligibility.
- **Behavioral Health:** Renew authority to continue providing behavioral health benefits as approved and described in the behavioral health protocol.
- **Home- and Community-Based Services (HCBS):** Renew authority to continue providing HCBS, with several proposed amendments. Major amendments include: (1) the addition of assisted living facility services as a new benefit for individuals who are assessed to be at risk of deteriorating to institutional level of care, and (2) continuing select Attachment K flexibilities, including telehealth and e-signature authorities, enacted as a result of the COVID-19 pandemic.
- **Community Integration Services (CIS)**: Renew authority to continue providing housing-related services to eligible beneficiaries; this program will be renamed "Community Integration Services Plus (CIS+)." Services under the current program include outreach, pre-tenancy supports, tenancy sustaining supports, and limited rental assistance. Under the renewal, MQD seeks to include expanded rental assistance and new medical respite benefits.

New requests include federal matching funds related to:

- **Continuous Eligibility for Children:** Provide continuous eligibility for children ages 0 to 6 and continuous two-year eligibility for children ages 6 to 19.
- **Pre-Release Services for Justice-Involved Individuals:** Provide targeted services to eligible justice-involved populations 90-days pre-release from incarceration. Pre-release services include, as clinically appropriate, case management and care coordination, physical and behavioral health clinical consultation services, lab and radiology services,

and, for use post-release into the community, durable medical equipment (DME) and a minimum 30-day supply of medications.

- **Nutritional Supports:** Provide nutritional supports for eligible beneficiaries including nutrition education, fruit and vegetable prescriptions and/or protein boxes, meals or pantry restocking, and medically tailored meals or groceries.
- **Native Hawaiian Traditional Healing Practices:** Provide Native Hawaiian Traditional Healing Practices for eligible beneficiaries, not limited to those identifying as Native Hawaiian. Native Hawaiian Traditional Healing Practices include:
  - ***Lomilomi**:* Native Hawaiian Traditional Healing Practice of physiotherapy and massage;
  - ***Hula**:* Native Hawaiian form of dance, offering physical movement classes that seek to improve health through physical activity, mindfulness practices, and social interaction;
  - ***Hoʻoponopono**:* Native Hawaiian Traditional Healing Practice of peacemaking, intended to restore and maintain healthy relationships;
  - ***ʻAi pono**:* Native Hawaiian Traditional Healing Practice of holistic nutrition therapy;
  - ***Lā'au lapa'au**:* Native Hawaiian Traditional herbalist healing practice; and,
  - ***Hāpai hānau***: Native Hawaiian Traditional midwifery practices.
- **Contingency Management:** Pilot Contingency Management (CM) for beneficiaries with a qualifying substance use disorder (SUD), including stimulant use disorders (StimUDs) and opioid use disorders (OUDs). CM will consist of a complementary course of SUD treatment and a series of motivational incentives to advance SUD treatment goals.
- **Infrastructure Funding:** Claim federal matching funds on infrastructure spending to support capacity building for and implementation of health-related social need (HRSN) services requested in this renewal.
- **Designated State Health Programs (DSHP):** Claim federal matching funds for State expenditures on DSHP and leverage those matching funds to support the development and implementation of 1115 Demonstration initiatives that address HRSN.

Eligibility and Care Delivery System

Eligibility

The State provides coverage to children and adults who are eligible under the Medicaid state plan as well as additional children and adults (including former adoption assistance children, certain parents, and certain individuals who receive home and community based (HCBS) services). The groups currently eligible for Medicaid are described in Table 1; this table does not reflect the proposed eligibility changes requested in the demonstration application, such as continuous eligibility policies for children.

Table 1. Summary of Section 1115 Demonstration Requests.

Mandatory State Plan Groups

Mandatory State Plan Groups		
Eligibility Group Name	Authority	Qualifying Criteria
Parents or Caretaker Relatives	Sections 1902(a)(10)(A)(i)(I), (IV), (V) and 1931(b), (d) of the Social Security Act 42 CFR 435.110	Up to and including 100% FPL
Pregnant Women	Section 1902(a)(10)(A)(i)(III)-(IV) of the Social Security Act 42 CFR 435.116	Up to and including 191% FPL
	Section 1902(e)(5)-(6) of the Social Security Act 42 CFR 435.170	Extended and continuous eligibility for pregnant women
Infants	Sections 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(B) of the Social Security Act 42 CFR 435.118(c)(2)(iii)	Infants up to age 1, up to and including 191% FPL
	Section 1902(e)(4) of the Social Security Act 42 CFR 435.117	Deemed newborn children
	Section 1902(e)(7) of the Social Security Act 42 CFR 435.172	Continuous eligibility for hospitalized children
Children	Sections 1902(a)(10)(A)(i)(VI)-(VII) and 1902(l)(1)(C)-(D) of the Social Security Act 42 CFR 435.118	Children ages 1 through 18, up to and including 133% FPL
	Section 1902(e)(7) of the Social Security Act 42 CFR 435.172	Continuous eligibility for hospitalized children
Low-Income Adults aged 19 through 64	Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act	Up to and including 133% FPL

	42 CFR 435.119	
Children with Adoption Assistance, Foster Care, or Guardianship Care under Title IV-E	Sections 1902(a)(10)(A)(i)(I) and 473(b)(3) of the Social Security Act 42 CFR 435.145	An adoption assistance agreement is in effect under title IV-E of the Act; or foster care or kinship guardianship assistance maintenance payments are being made by a State under title IV-E
Former Foster Care Children to age 26	Section 1902(a)(10)(A)(i)(IX) of the Social Security Act 42 CFR 435.150	No income limit
State Plan Mandatory Aged, Blind, or Disabled Groups	Section 1902(a)(10)(A)(i)(II) of the Social Security Act 42 CFR 435.120	ABD individuals who meet more restrictive requirements for Medicaid than the SSI requirements; uses SSI payment standard
	Sections 1902(a)(10)(A)(i)(II) and 1905(q) of the Social Security Act 42 CFR 435.120	Qualified severely impaired blind and disabled individuals under age 65
	Sections 1634, 1634(a), 1634(b), 1634(c), 1634(d), and 1634(e) of the Social Security Act 42 CFR 435.121-122, 130-135, 138	Other ABD groups as described in the State Plan
Transitional Medical Assistance	Section 1925 of the Social Security Act 42 CFR 435.112	Coverage for one 12-month period due to increased earnings that would otherwise make the individual ineligible under Section 1931

1931 Extension	Section 1931(c)(1)-(2) of the Social Security Act 42 CFR 435.115	Coverage for four months due to receipt of child or spousal support, that would otherwise make the individual ineligible under Section 1931
Qualified Medicare Beneficiaries*	Sections 1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Social Security Act	Standard eligibility provisions for this population as described in the State Plan
Specified Low-Income Medicare Beneficiaries*	Sections 1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Social Security Act	Standard eligibility provisions for this population as described in the State Plan

**Dual eligibles are included as those with full Medicaid benefits are served under QI health plans, and QI health plans pay Part B co-payments and coordinate Medicare services.*

Optional State Plan Groups

Optional State Plan Groups		
Eligibility Group Name	Authority	Qualifying Criteria
Optional Coverage of Families and Children and the Aged, Blind, or Disabled	Sections 1902(a)(10)(ii) and 1905(a) of the Social Security Act 42 CFR 435.210	ABD individuals who do not receive cash assistance but meet income and resource requirements
	42 CFR 435.211	Individuals eligible for assistance but for being in a medical institution
	Section 1902(a)(10)(ii)(VII) of the Social Security Act	Individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care

	Section 1902(a)(10)(ii)(XI) of the Social Security Act 42 CFR 435.121, 435.230	ABD individuals in domiciliary facilities or other group living arrangements
	Sections 1902(a)(10)(ii)(X) and 1902(m) of the Social Security Act	Aged or disabled individuals with income up to and including 100% FPL
Optional Targeted Low-Income Children	Section 1902(a)(10)(A)(ii)(XIV) Title XXI of the Social Security Act 42 C.F.R. § 435.229	Up to and including 308% FPL, including for children for whom the State is claiming Title XXI funding
Certain Women Needing Treatment for Breast or Cervical Cancer	Sections 1902(a)(10)(A) and 1920 of the Social Security Act	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non- Aged, Blind, or Disabled Children and Adults	Section 1902(a)(10)(C) of the Social Security Act 42 CFR 435.301(b)(1), 435.308	Up to and including 300% FPL, if spenddown to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	Section 1902(a)(10)(C) of the Social Security Act 42 CFR 435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology
Foster Children	Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act 42 CFR 435.227	Children with non-IV-E adoption assistance
Foster Children age 19 and 20	Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act 42 CFR 435.227	Receiving foster care maintenance payments or under an adoption assistance agreement under the state plan

Expansion Populations

Expansion Population

Eligibility Group Name	Qualifying Criteria
Parents or Caretaker Relatives with a Dependent Child age 18	Parents or caretaker relatives who (i) are living with an 18-year-old who would be a dependent child but for the fact that they have reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age
Individuals in the 42 CFR 435.217 like Group Receiving HCBS	Income up to and including 100% FPL
Medically Needy ABD Individuals whose Spenddown Exceeds the Plans' Capitation Payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment
Individuals age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance	Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in a state plan or waiver while receiving assistance payments

Care Delivery System

Most beneficiaries are enrolled in mandated managed care and receive benefits through capitated managed care plans. All beneficiaries are eligible for state plan benefits (or, in the case of the Affordable Care Act childless adult group, approved benefits under the alternative benefit plan) and additional benefits (including HCBS and specialized behavioral health services) based on medical necessity and clinical criteria provided through an integrated managed care delivery system. For certain individuals, specialized and non-specialized behavioral health services are provided through Community Care Services (CCS), a separate behavioral health organization (BHO).

The State also uses a fee-for-service (FFS) delivery system for long-term care services for individuals with developmental or intellectual disabilities (via Section 1915(c) Waiver), Intermediate Care Facilities for the Intellectually Disabled (ICF-ID), services for applicants eligible for retroactive coverage only, services for certain medically needy non-aged, blind, and disabled (ABD) individuals, medical services under the State of Hawaiʻi Organ and Tissue Transplant (SHOTT) program, targeted case management services, school-based services, early intervention services, and dental services.

Under the renewal, the State will continue the same cost-sharing policies. The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan.

Hypotheses and Evaluation Parameters

Table 2 presents a set of hypotheses intended to guide the evaluation of the demonstration renewal. These hypotheses are formulated to provide a framework for the evaluation, and specific evaluation measures and methodologies will be developed iteratively upon implementation of the intended programs. More specific evaluation measures and methodologies will therefore be submitted upon approval of the application via the revised evaluation design.

Table 2. Summary of Renewal Hypotheses and Evaluation Approaches.

Hypotheses	Evaluation Approach	Data Sources
CIS+		
CIS+ beneficiaries will receive different combinations of CIS+ services that match their needs, and tailoring services to fit needs will result in increased housing stability, improved wellbeing, and decreased cost of care.	Quantitative evaluation of the impact of CIS+ on health outcomes and costs; examination of differences in outcomes and cost among CIS+ sub-populations.	Encounter data, specific outcome metrics of interest (e.g., use of specific types of CIS+ services, inpatient utilization, etc.); cost measures where feasible may consider broader system-level costs; and as feasible, beneficiary self-reported data.
Continuous Eligibility		
Continuous eligibility will reduce churn and gaps in coverage for children enrolled in Medicaid, including for racial and ethnic minority populations that experience disproportionately high rates of churn.	Examine enrollment data by age, race, and ethnicity to determine trends in churn over time.	Measure is likely to be a calculated rate, broken out by multiple variables (e.g., age groups, particularly those that align with eligibility policy). Adjustments may be required to account for continuous enrollment during the PHE and PHE unwinding.

Continuous eligibility will reduce the quantity of redeterminations, resulting in lower administrative burden for eligibility workers and associated costs.	Examine case load of eligibility workers and associated personnel costs over time.	Measure is likely to be hours spent on redeterminations by eligibility workers and associated personnel costs, parsed by eligibility groupings to evaluate differences across Medicaid sub-populations.
Continuous eligibility will result in a slower rate of expenditure growth for children enrolled in Medicaid.	Examine differences in rates of growth in managed care capitation payments across actuarial groups.	Per Member Per Month (PMPM) costs during the waiver demonstration period; comparative populations or periods may be utilized to evaluate the impact of continuous eligibility on children.
Contingency Management		
Increasing the availability of Contingency Management will increase the number of Medicaid beneficiaries engaged in treatment for substance use disorders.	Mixed-methods approach that seeks to evaluate the implementation of guidance for Contingency Management services; network capacity for the provision of contingency management services; screening and identification of Medicaid beneficiaries with a qualifying SUD; and uptake of Contingency Management services among qualifying Medicaid beneficiaries.	Review of guidance, workflows and other documents to examine various aspects of implementation; examination of process metrics to assess progress of implementation; and encounter data to assess screening, identification, and uptake of services.
Participation in Contingency Management among Medicaid beneficiaries with substance use disorders will increase adherence to and retention in SUD treatment.	Evaluate utilization of Contingency Management and other concomitantly delivered SUD treatment services among qualifying Medicaid beneficiaries. Evaluate continued engagement in and adherence to treatment. Examine related and proximal health outcomes (e.g., evidence of ongoing sobriety,	Encounter data, specific outcome metrics of interest (e.g., ED visits for substance use), and QI health plan reports to capture utilization metrics and other data.

	Emergency Department (ED) visits/ admissions for relapse).	
Pre-Release Medicaid Services for Justice-Involved Individuals		
Implementation of pre-release services will result in increased collaboration between stakeholders, identification of unaddressed medical and health-related social needs prior to release, gradual expansion of access to pre-release services for justice-involved individuals, and improved insights into healthcare delivery for this population.	Use a mixed-methods process evaluation approach to examine the implementation of pre-release services, including the identification of eligible individuals, unaddressed medical and health-related social needs, and provision of Medicaid-covered services in the pre-release setting.	Qualitative interviews of stakeholders (e.g., QI health plans, MQD, and the State's Public Safety Division); review of guidance, workflows, and other documents to examine various aspects of implementation; and examination of health plan reports to assess progress of implementation.
Access to pre-release services will result in continuity of targeted health services upon release to the community, resulting in positive impacts on health outcomes.	Examine the post-release utilization of specific targeted health services including but not limited to CIS+ housing supports, those that address other identified health related social needs, and medication refills among individuals receiving pre-release services. Examine related and short term physical and behavioral health outcomes (e.g., stable housing, medication adherence).	Encounter data, specific outcome metrics of interest (e.g., medication possession ratio), and QI health plan reports to capture utilization metrics and other data.
Nutrition Supports		
Implementation of nutrition supports will result in increased collaboration between stakeholders, gradual expansion of access to nutrition services for qualifying individuals, and improved infrastructure for the provision of nutrition support services.	Use a mixed-methods process evaluation approach to examine the implementation of nutrition support programs including the identification of individuals with food insecurity, referral mechanisms to existing non-Medicaid nutrition programs, and provision of Medicaid-covered nutrition	Qualitative interviews of stakeholders (e.g., QI health plans, SNAP program, MQD, and providers of nutrition support services); review of guidance, workflows and other documents to examine various aspects of implementation; and examination of QI health plan

	supports to qualifying individuals.	reports to assess progress of implementation.
Nutrition support services will result in reductions in food insecurity and improved disease management for participating individuals.	Assess the impact of each nutrition supports program on targeted outcomes. Examine related and proximal health outcomes (e.g., diabetes control).	Encounter data and QI health plan reports to capture utilization metrics and other qualitative data. Additional data may be collected at target delivery locations as feasible.
Native Hawaiian Traditional Healing Practices		
Integration of Native Hawaiian Traditional Healing Practices within the Medicaid delivery system will result in increased collaboration between stakeholders, gradual expansion of access to these services, and improved infrastructure for the provision of Native Hawaiian Traditional Healing Practices.	Use a mixed-methods process evaluation approach to examine the implementation of Native Hawaiian Traditional Healing Practices, including differences by setting if applicable (e.g., integrated vs. non-integrated settings); evaluate the uptake of Medicaid-covered Native Hawaiian Traditional Healing Practices.	Qualitative interviews of stakeholders (e.g., QI health plans, providers and overseeing bodies of Native Hawaiian Traditional Healing Practices, and MQD); review of guidance, workflows and other documents to examine various aspects of implementation; and examination of QI health plan reports to assess progress of implementation. As feasible, qualitative interviews of beneficiaries receiving services, with the Consumer Assessment of Healthcare Providers & Systems (CAHPS) questions included to provide comparative analytics.
Native Hawaiian Traditional Healing Practices will increase engagement in Hawaii's health care system among Medicaid-enrolled individuals receiving Native Hawaiian Traditional Healing Practices.	Evaluate utilization of Native Hawaiian Traditional Healing Practices and other health care services (e.g., outpatient primary care and specialist visits, prescription medication use and medication refills, receipt of annual wellness visits, etc.) indicative of increased engagement.	Encounter data, specific outcome metrics of interest (e.g., medication possession ratio, receipt of preventive services), and QI health plan reports to capture utilization metrics and other data.

	Examine related and proximal health outcomes (e.g., receipt of preventive health services).	
	VBP	
Value Based Purchasing (VBP) expectations and requirements implemented by MQD will result in expansion of Alternative Payment Models (APMs) implemented by QI health plans.	Qualitative and quantitative methodologies to evaluate implementation and impacts of select APMs on health outcomes and cost of care.	Qualitative data to investigate APM implementation; encounter data, QI health plan reports on beneficiary and provider attribution, financial outcomes, and survey data on APMs to evaluate quantitative impacts.
	Care Coordination	
Increased engagement in Health Coordination Services (HCS) will result in improved chronic disease management and health outcomes for individuals with complex health care needs.	Examine the implementation of HCS for populations with complex health care needs, including but not limited to those in CIS+, long-term services and supports (LTSS), and special health care needs (SHCN)/expanded health care needs (EHCN). Evaluate differences in implementation for specific sub-populations.	Encounter data, specific outcome metrics of interest (e.g., ED visits and inpatient hospitalizations), CMS core set/Healthcare Effectiveness Data and Information Set (HEDIS) metrics, and QI health plan reports to capture utilization metrics and other data. Additional qualitative data collection from QI health plans and/or providers may be conducted.

Waiver and Expenditure Authorities

The State believes the following waiver and expenditure authorities, as outlined in Tables 3-4, respectively, will be necessary to authorize the demonstration. CMS will review the requested waiver and expenditure authorities and approve as necessary to enable the State to conduct the approved 1115 demonstration renewal.

Table 3. Requested Waiver Authorities.

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
Waiver Authority for All Section 1115	**Amount, Duration, and Scope** To enable the state to offer demonstration benefits that may not	Section 1902(a)(10)(B) of the Social Security	Yes

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
Demonstration Benefits	be available to all categorically eligible or other individuals.	Act and 42 CFR 440.230-250	
Waiver Authority for QI Mandatory Managed Care	**Medically Needy** To enable the state to limit medically needy spend-down eligibility in the case of those individuals who are not aged, blind, or disabled to those individuals whose gross incomes, before any spend-down calculation, are at or below 300 percent of the federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, for whom there is no gross income limit.	Section 1902(a)(10)(C); Section 1902(a)(17) of the Social Security Act and 42 CFR 435.831	Yes
	Freedom of Choice To enable Hawaiʻi to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932.	Section 1902(a)(23)(A) of the Social Security Act and 42 CFR 431.51	Yes
	Out of State Former Foster Youth To enable the State to receive federal financial participation and provide coverage for any individual who has aged out of foster care in another state prior to or after January 1, 2023 as eligible for Medicaid, subject to other applicable Medicaid eligibility criteria.	Section 1902(a)(10)(A)(i)(IX) of the Social Security Act and 42 C.F.R. 435.150	No
	Cost Sharing To enable the state to charge cost sharing up to 5 percent of annual family income. To enable the state to charge an enrollment fee to Medically Needy Aged, Blind and Disabled QUEST Integration health plan enrollees (Demonstration Population 3) whose spend-down liability is estimated to exceed the QI health plan capitation rate, in the	Section 1902(a)(14) of the Social Security Act insofar as it incorporates 1916 and 1916A and 42 CFR 4472.52	Yes

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
	amount equal to the estimated spend-down amount or where applicable, the amount of patient income applied to the cost of long-term care.		
Waiver Authority for HCBS	**HCBS Waiver** To enable the State to waive certain requirements under home and community based service programs, including provision of services through QI health plans for individuals assessed to be at risk of deteriorating to the institutional level of care.	Section 1915(c) of the Social Security Act and 42 CFR 441.301	Yes
Waiver Authority for Continuous Eligibility	**Periodic Renewal of Medicaid Eligibility** To allow federal financial participation for the continuous eligibility of children without regard to whether a child's income exceeds eligibility limits; and to enable the State to waive the requirements for individuals to report and for the State act on changes with respect to income eligibility.	Section 1916A(4) of the Social Security Act and 42 C.F.R. 435.916	No
Waiver Authority for Pre-Release Medicaid Services for Justice-Involved Populations	**State Wideness/Uniformity** To permit the state to provide nutrition supports to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No
Waiver Authority for Nutrition Supports	**State Wideness/Uniformity** To permit the state to provide nutrition supports to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No
Waiver Authority for Native Hawaiian Traditional Healing Practices	**State Wideness/Uniformity** To permit the state to provide Native Hawaiian traditional healing practices to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No

Waiver Authority	Use for Waiver Authority	Relevant Statute or Regulation	Currently Approved?
Waiver Authority for Contingency Management	**State Wideness/Uniformity** To permit the state to provide contingency management interventions to eligible individuals on a geographically limited basis.	Section 1902(a)(1) of the Social Security Act and 42 CFR 431.50	No

Table 4. Requested Expenditure Authorities.

Expenditure Authority	Use for Expenditure Authority	Currently Approved
Expenditures for QI Mandatory Managed Care	**Managed Care Payments** Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m): Expenditures for capitation payments provided to managed care organizations (MCOs) in which the state restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island. Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and federal regulations at 42 CFR section 438.52.	Yes
	Quality Review of Eligibility Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.	Yes
	Demonstration Expansion Eligibility Expenditures to provide coverage to the following demonstration expansion populations: <u>Demonstration Population 1</u>: Parents and caretaker relatives who are living with an 18-	Yes

Expenditure Authority	Use for Expenditure Authority	Currently Approved
	year-old who would be a dependent child but for the fact that the 18-year-old has reached the age of 18, if such parents would be eligible if the child was under 18 years of age. Demonstration Population 2: Aged, blind, and disabled individuals in the 42 C.F.R. § 435.217 like group who are receiving home- and community- based services, with income up to and including 100 percent of the federal poverty limit using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules. Demonstration Population 3: Aged, blind, and disabled medically needy individuals receiving home-and community-based services, who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income. Demonstration Population 4: Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance, who would not otherwise be eligible under the state plan, with the same income limit that is applied for Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement under the state plan. Demonstration Population 5: Individuals who are younger than 26, aged out of the adoption	

Expenditure Authority	Use for Expenditure Authority	Currently Approved
	assistance program or the kinship guardianship assistance program (either Title IV-E assistance or non Title IV-E assistance), or would otherwise be eligible under a different eligibility group but for income, and were enrolled in the State plan or waiver while receiving assistance payments.	
Expenditures for HCBS	Expenditures to provide HCBS not included in the Medicaid state plan and furnished to QUEST Integration enrollees, as follows: a. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement; b. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, i.e., the "at risk" population. The state may maintain a waiting list, through a health plan, for home and community-based services (including personal care services). No waiting list is permissible for other services for QUEST Integration enrollees. The state may impose an hour or budget limit on home and community based services provided to individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "at risk" population), as long as such limits are sufficient to meet the assessed needs of the individual.	Yes
Expenditures for CIS+	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for CIS+ services to qualifying individuals.	Yes
Expenditures for Continuous Eligibility	Expenditure authority as necessary to permit the State to implement continuous eligibility	No

Expenditure Authority	Use for Expenditure Authority	Currently Approved
	and receive Medicaid matching funds for associated expenditures.	
Expenditures for CM	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for contingency management through small incentives to qualifying individuals.	No
Expenditures for Pre-Release Medicaid Services	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for costs not otherwise matchable for certain services, as described in this application, rendered to individuals who are incarcerated up to 90 days prior to their release.	No
Expenditures for Administrative Costs Related to Pre-Release Medicaid Services	Expenditure authority as necessary to permit the State to receive Medicaid matching funds for capped pre-release administrative expenditures for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure, and other interventions.	No
Expenditures for Nutrition Supports	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for nutrition supports to qualifying individuals.	No
Expenditures for Native Hawaiian Traditional Healing Practices	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for Native Hawaiian Traditional Healing Practices provided by eligible Native Hawaiian Traditional Healers to eligible individuals.	No
Expenditures for HRSN Infrastructure Funding	Expenditure authority as necessary to permit the State to provide and receive Medicaid matching funds for allowable infrastructure building expenditures related to HRSN services.	No
Expenditures for DSHP	Expenditure authority as necessary to permit the State to claim Medicaid matching funds for designated programs which are otherwise state-funded and not otherwise eligible for Medicaid payment.	No

Impact to Enrollment and Budget Neutrality

Enrollment

The Medicaid pause in redeterminations during the COVID-19 public health emergency (PHE) led to an historic increase in Medicaid enrollment. Between March 2020 and April 2023, enrollment grew more than 40%, from 327,119 to its peak of 468,120 in April 2023. Hawaiʻi began Medicaid redeterminations, also known as unwinding, in May of 2023.

Table 5. Enrollment Growth January 1, 2019 – September 18, 2023.

	2019	2020	2021	2022	2023**
Average Enrollment*	330,758	358,067	417,435	449,541	460,180
Percent Growth Year over Year	-	8%	17%	8%	2%

**Point in time measured weekly.*

***Data available through September 18, 2023*

The State is not proposing any changes that would negatively impact enrollment between Demonstration Year (DY) 31 through DY35. Further, several proposed authorities within this Section 1115 Demonstration, including continuous eligibility and the addition of pre-release services for justice-involved individuals, are expected to increase enrollment.

Table 6. Preliminary Estimates of Enrollment Impacts.

	DY31	DY32	DY33	DY34	DY35
Total Projected Medicaid Enrollment	396,427	408,441	418,405	428,814	439,932
QI Mandatory Managed Care	392,079	401,069	410,275	419,703	429,359
Continuous Eligibility	3,024	6,049	6,807	7,788	9,250
Pre-Release Services	1,323	1,323	1,323	1,323	1,323

Budget Neutrality

For the duration of the existing Section 1115 Demonstration period, the State continued to maintain strong positive variance and met budget neutrality requirements. The tables in the Section 1115 Demonstration amendment and renewal application provide a summary of Hawaii’s projected with-waiver, without-waiver, and hypothetical expenditures for its Section 1115 Demonstration renewal, from DY31-DY35. These tables contain considerable detail regarding cost projections associated with each of the various proposed authorities.

Public Engagement

To produce the draft renewal application, Hawaiʻi developed and refined elements of its Section 1115 Demonstration renewal through a robust stakeholder and public engagement process. Key to Hawaii's stakeholder engagement process has been its high-touch, accessible, and responsive engagement with local communities and organizations. In total, Hawaiʻi engaged dozens of stakeholder organizations and conducted over 30 stakeholder meetings to ideate, iterate, and vet details of the new initiatives proposed in this renewal application. For example, through stakeholder workgroups, Hawaiʻi cooperatively developed and obtained consensus of the details for nutrition supports, Native Hawaiian traditional healing practices, and CIS+ proposals. In addition to this preliminary stakeholder engagement work, Hawaiʻi will meaningfully engage in a public comment period to solicit and incorporate additional stakeholder perspectives, consistent with federal requirements.

Tribal Consultation

Historically, Hawaii's tribal consultation process as required by 42 CFR 431.408(b) was conducted with Ke Ola Mamo, the State's Urban Indian Organization partner. However, as of April 1, 2023 and at the time of this public notice, Ke Ola Mamo's contract with the Indian Health Services expired and MQD has no organization with which to complete the tribal consultation. As such, MQD has confirmed with CMS that there are no tribal consultation requirements to fulfill for this Section 1115 Demonstration renewal.

Public Notice

On October 16, 2023, the State will use an electronic mailing list to notify potentially interested parties of the opportunity to review the public notice and provide comments. On October 16, 2023, the State will issue a full public notice document with a comprehensive description of the proposed QUEST waiver renewal. Consistent with 42 C.F.R. 431.408, the notice will include the location and internet address where copies of the renewal application were available for review and comment; the dates for the public comment period; postal and e-mail addresses where written comments could be sent; and the locations, dates and times of the two (2) public hearing convened by the State to seek public input about the extension application. This public notice document will be available in a prominent location at https://medquest.hawaii.gov/ for the duration of the comment period.

Public Hearings

In concert with 42 C.F.R. 431.408(a)(3), the State will hold two public hearings to solicit public input and comment about the demonstration renewal application. Interested parties are invited to join the public forum and to state their views regarding progress on the Section 1115 Demonstration. Attendees may participate in the meetings in-person or via teleconference.

Registration is required to participate. If you plan to attend in person, please RSVP by calling 808-692-8058 or emailing PPDO@dhs.hawaii.gov. If you plan to attend via teleconference, participants must register for the meeting using the links listed below— participants will receive a confirmation email containing Zoom login information needed to join the meeting virtually.

- **Wednesday, October 18, 2023 at 6:00PM HST**

    - *(In-Person)* Kakuhihewa Building, Conference Rooms 111 A&B, 601 Kamokila Boulevard, Kapolei HI 96707
    - *(Teleconference)* https://medquest-hawaii-gov.zoom.us/meeting/register/tZcqd-Gspz0vGNOASTxnI_u1k9bo8QOXTkX-
    - Note: If you need auxiliary aid/service or other accommodation due to disability or limited English proficiency, please contact: the Med-QUEST Division at (808) 692-8151 (voice); or 711 (TTY) or by email at MHACcomments@dhs.hawaii.gov by 4:00 pm on Monday, October 16, 2023. Requests made early have a greater chance of being fulfilled due to a limited number of communication access providers.
- **Tuesday, October 24, 2023 at 6:00PM HST**
    - *(In-Person)* Queen Lili'uokalani Building, 2nd Floor Conference Room, 1390 Miller Street, Honolulu, HI 96813
    - *(Teleconference)* https://medquest-hawaii-gov.zoom.us/meeting/register/tZwtd--opj8jGdHX86gdWXGW_WwoMgqbIIha
    - Note: If you need auxiliary aid/service or other accommodation due to disability or limited English proficiency, please contact: the Med-QUEST Division at (808) 692-8151 (voice); or 711 (TTY) or by email at MHACcomments@dhs.hawaii.gov by 4:00 pm on Friday, October 20, 2023. Requests made early have a greater chance of being fulfilled due to a limited number of communication access providers.

Public Comment

The State invites the public to comment on the draft Section 1115 Demonstration renewal application, available online at https://medquest.hawaii.gov/en/about/state-plan-1115.html#tabs-8ee927caf9-item-99d6f14a00.

A printed copy of the proposed changes and special accommodations (e.g., interpreter, large print or taped materials, etc.) can be arranged if requested by contacting the Policy and Program Development Office at (808) 692-8058 or via email at PPDO@dhs.hawaii.gov no later than seven (7) working days before the comment period ends.

Written comments may be submitted by email to PPDO@dhs.hawaii.gov using "Section 1115 Demonstration Feedback" in the subject line, or mailed to Med-QUEST Division, Attn: PPDO, P.O. Box 700190, Kapolei, HI, 96709. Comments for the Quest Integration Section 1115 Demonstration Project must be received by **November 16, 2023**.

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR