Attachments - Table of Contents

State of Hawaii
"QUEST Integration" Section 1115 Demonstration

Section 1115(a) Renewal Application
December 28, 2012

Hawaii is pleased to submit this five-year, Section 1115(a) renewal application to align its current demonstration with provisions in the Affordable Care Act (ACA). In an effort to provide the Centers for Medicare & Medicaid Services (CMS) with the information in a helpful format, this application generally follows the Section 1115 Demonstration Program Template recently published by CMS. Because the template is designed for new demonstration applications, not renewals or extensions, Hawaii modified the template and added content to comply with the extension application requirements in 42 C.F.R. § 431.412(c). Hawaii has not listed the template's specific questions in this application, but has included content that addresses each question in the corresponding template section, to the extent the questions are applicable to this application or renewals generally. The State looks forward to working with CMS to renew this longstanding Section 1115 demonstration.

Table of Contents

Attachments

C. Hawaii Med-QUEST Division Quality Strategy

D. CMS-416 Forms

E. Benefit Specifications and Provider Qualifications Forms; Long Term Services Benefit Specifications and Provider Qualifications Forms

F. Behavioral Health Protocol

G. Budget Neutrality Charts

H. E-mail Notice

I. Abbreviated Public Notice

J. Full Public Notice Document

K. Tribal Notice

I. Introduction

Pursuant to Section 1115(a) of the Social Security Act, and as authorized by Section 1915(h)(2), the State of Hawaii, Department of Human Services (the State), is seeking a five-year renewal of the QUEST Expanded Section 1115 demonstration project from CMS. Absent a renewal, the demonstration will expire on December 31, 2013.

For nearly two decades, Hawaii's demonstration has efficiently and effectively delivered comprehensive benefits to a large number of beneficiaries, including expansion populations, through competitive managed care delivery systems. Under the renewal, "QUEST Integration" (QI) seeks to build on this success by continuing to deliver services through managed care, while also integrating the demonstration's programs and benefits to have a more patient-centered care delivery system and to align the demonstration with ACA's new requirements. The State will eliminate all eligibility caps, and streamline its programs by consolidating current programs under QUEST Integration. All eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be determined by clinical criteria and medical necessity. The renewal will also incorporate the simplified Medicaid eligibility structure and other changes in ACA into Hawaii's demonstration. Finally, QUEST Integration will offer new specialized behavioral health services to beneficiaries and new access to home- and community-based services (HCBS) for individuals who are assessed to be at risk of deteriorating to the institutional level of care (the "at risk" population), as well as certain other benefits.

II. The Current Demonstration - QUEST Expanded

A. Historical Narrative

Originally implemented as the QUEST program in 1994, QUEST Expanded is the current version of Hawaii's demonstration project to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. QUEST stands for:

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

The QUEST program was designed to increase access to health care and control the rate of growth in health care costs. The State combined its Medicaid program with its then General Medical Assistance Program and its State Children's Health Insurance Program. Low-income women, children, and adults who had been covered by the two programs were enrolled into fully capitated managed care plans throughout the State. The demonstration helped substantially close the coverage gap in the State for low-income individuals.

Since its implementation, the State has made many changes to the demonstration:

1. The first amendment, approved July 11, 1995, 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.

2. The second amendment, approved on September 14, 1995, allowed the State to cap QUEST enrollment at 125,000 expansion eligibles.

3. The third amendment, approved on May 10, 1996, allowed the State to reinstate the asset test, establish the QUEST-Net program, and require participants to pay a premium.

4. The fourth amendment, approved on March 14, 1997, lowered the income thresholds to the mandatory coverage groups and allowed the State to implement its medically needy option for the AFDC-related coverage groups for individuals who become ineligible for QUEST and QUEST-Net.

5. The fifth amendment, approved on July 29, 2001, allowed the State to expand the QUEST-Net program to children who were previously enrolled in SCHIP, when their family income exceeds the Title XXI income eligibility limit of 200% of the federal poverty level (FPL).

6. In January 2006, the federal government approved an extension (with a retroactive start date of July 1, 2005) of the Section 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% of the FPL who meet Medicaid asset limits through QUEST-ACE;
    - Elimination of premium contributions for children with income at or below 250% 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% of the FPL to 300% of the FPL.

7. In February 2008, the demonstration was renewed, and as part of the renewal the State implemented the QUEST Expanded Access (QExA) program and increased the eligibility level for QUEST-ACE from 100% to 200% of the FPL.

8. In April 2012, CMS approved the State's request to limit eligibility for non-pregnant, nondisabled adults not otherwise Medicaid eligible at 133% of the FPL.

9. In 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.

10. In June 2012, Hawaii requested an extension of the demonstration, under the same terms and conditions as were in effect at the time.

11. In December 2012, the State submitted an amendment to expand coverage to certain former foster children in advance of 2014, when that group becomes Medicaid eligible under changes in ACA.

B. Overview of QUEST Expanded Today

Today, QUEST Expanded includes four main programs: QUEST, QUEST-Net, QUEST-ACE, and QExA.

QUEST Expanded delivers most benefits through capitated managed care. The State does, however, utilize FFS for long-term supports and services for individuals with developmental or intellectual disabilities, applicants eligible for retroactive coverage only, medically needy non-ABD individuals, and medical services under the State of Hawaii Organ and Tissue Transplant (SHOTT) program, as well as for certain other benefits described in Section VI of this application.

Currently, Hawaii residents may become eligible for QUEST Expanded through one of its four programs. QUEST covers families with dependent children up to 300% of the FPL for children and up to 100% for adults; pregnant women with family income up to 185% of the FPL; adults who are Temporary Assistance for Needy Families (TANF) cash recipients but are otherwise not eligible for Medicaid; low-income adults covered under Section 1931 of the Social Security Act; individuals qualifying for transitional medical assistance under Section 1925 of the Social Security Act; participants in the State General Assistance Program; and childless adults with income up to 100% of the FPL subject to an eligibility cap. QUEST-Net covers adults not eligible for QUEST with income up to 133% of the FPL who were previously enrolled in QUEST, QExA or Medicaid FFS. QUEST-ACE covers adults not eligible for QUEST with income up to 133% FPL who have not previously been enrolled in QUEST, QExA, or Medicaid FFS. QExA covers various groups within the ABD population, including institutionalized individuals who meet the eligibility requirements in the State plan; non-institutionalized individuals would meet the State plan eligibility requirements if they were living in an institution; ABD individuals who meet the SSI standards; and medically needy ABD individuals who meet the medically needy household income standards using SSI methodology.

QUEST Expanded currently offers two packages of benefits:

1. Individuals enrolled in QUEST, QUEST-Net, or QUEST-ACE receive State plan benefits.

2. Individuals enrolled in QExA receive State plan benefits and waiver HCBS.

During the last demonstration waiver period, February 1, 2008 through June 30, 2013, QUEST Expanded successfully implemented managed care for its ABD population with increased service coordination, and the Medicaid program rebalanced its long-term care services with a significant increase in the receipt of HCBS. In addition, to align with implementation of ACA, Hawaii increased benefits in the QUEST-ACE and QUEST-Net programs to be the same as

benefits covered in the QUEST program, reduced income eligibility for the expansion programs QUEST-ACE and QUEST-Net to 133% of the FPL, and sought expanded eligibility for former foster youth.

C. QUEST Expanded Evaluation Report, Summaries of EQRO Reports, MCO and State Quality Assurance Monitoring, and Other Information About Quality of Care and Access to Care Provided Under the Demonstration

On September 5, 2012, the State published the interim QUEST Expanded evaluation, which is available for viewing at http://www.med-quest.us/PDFs/CMS%20Reports/Interim%20Evaluation%20Report%20DYE%2020120630-%20FINAL.pdf.

The State contracted with Health Services Advisory Group, Inc. (HSAG) as its external quality review organization (EQRO). In 2012, HSAG performed the three federally mandated activities as set forth in 42 C.F.R. § 438.358, and one optional activity (a survey of adult members using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)). Other quality assurance activities undertaken during the demonstration period included: finalizing a new Quality Strategy in compliance with 42 C.F.R. § 438.202; implementing CMS's Quality Framework for HCBS; and compiling data for the CMS-Form 416 - Annual EPSDT Participation Report.

Information about the 2012 External Quality Review Report for the QUEST and QExA Health Plans, as well as the State's other quality assurance monitoring information, is provided in Attachment A, "Summaries of EQRO Reports and Quality Assurance Monitoring, and Other Information and Documentation Regarding Quality of and Access to Care." The QUEST Expanded evaluation, the Quality Strategy, and the CMS-Form 416s are attached as Attachment B, Attachment C, and Attachment D, respectively.

III. Program Description - QUEST Integration

A. QUEST Integration Summary and Objectives

Hawaii seeks a five-year renewal of its Section 1115 demonstration waiver for the period January 1, 2014 through December 31, 2018. The waiver will continue to operate statewide. However, Hawaii would be amenable to implementing all the changes in this renewal application effective October 1, 2013, when it will be required to begin accepting new applications under ACA.

This renewal seeks to integrate the demonstration's programs and benefits within the context of ACA alignment under QUEST Integration. QUEST-ACE and QUEST-Net will no longer be needed as the populations previously served in these expansion programs become eligible under the State plan as part of the mandatory ACA adult group or the aging out Former Foster Children group. Where required by ACA, the demonstration will employ the modified adjusted gross income (MAGI) methodology to determine eligibility, and it will incorporate the eligibility and other changes made by ACA. Hawaii intends to integrate its health plan contracting in its next procurement to facilitate care along the continuum, which would effectively combine QUEST and QExA, and it will pursue integrating care for its "dual eligible" enrollees. Lastly, QUEST

Integration will offer new behavioral health services, including a set of HCBS for individuals who are assessed to be "at risk" of deteriorating to the institutional level of care and certain other benefits.

The goals of QUEST Integration will be to:

- Improve the health care status of the member population.
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits.
- Align the demonstration with ACA.
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP).
- Expand access to HCBS and allow individuals to have a choice between institutional services and HCBS.
- Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations.
- Establish contractual accountability among the contracted health plans and health care providers.
- Continue the predictable and slower rate of expenditure growth associated with managed care.
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

B. Renewal Initiatives - Description of Changes from Existing Demonstration and Goals of those Changes

1. Integrate QUEST Programs and Streamline Eligibility

QUEST Integration will consolidate the current programs and provide all beneficiaries enrolled under the demonstration with access to a single benefit package, of which access to certain services will be based on clinical criteria and medical necessity. As part of this integration, the State will also eliminate all program eligibility caps.

Integrating the current programs will ease administrative burdens, streamline the enrollment process, and facilitate access to care for enrollees with changing health status. It will also allow QI's eligibility groups to more closely parallel the simplified Medicaid eligibility structure effective January 1, 2014.

2. Utilize Capitated Managed Care to Deliver High-Quality, Cost-Effective Care

Since 1994, the foundation of the QUEST programs has been a capitated managed care system. Over the history of the QUEST and QUEST Expanded 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.

The State plans to continue to provide most benefits through capitated managed care and mandate managed care enrollment for most beneficiaries, which will require waiver authority. The State will use a FFS system for long-term care services for individuals with developmental or intellectual disabilities, applicants eligible for retroactive coverage only, medically needy non-ABD individuals, and medical services under the SHOTT program, among other services.

3. Health Plan Enrollment and Selection

In an effort to balance beneficiary choice with service coordination and continuity, QI will include some changes to the enrollment and health plan selection process.

Eligible individuals will choose from among participating QI health plans. This choice will be available to any individual who receives a choice notification. If an eligible individual does not make a selection at the time of eligibility notification, the individual will be automatically assigned to a health plan that operates on the island of residence. If auto-assigned to a health plan, the individual will have 15 calendar days from the date of auto-assignment to select a new health plan.

All individuals will have a single 60-day period from their initial enrollment action to change their health plan. That is, an individual who chooses a health plan either at the time of eligibility notification or during the 15-day choice period, or switches health plans during the annual open enrollment, will have an additional 60-day period from the enrollment action to change plans. Similarly, an individual who is auto-assigned for not selecting a health plan upon eligibility notification and during the 15-day choice period will also have 60 days from the auto-enrollment action to change health plans. An individual enrolled in a health plan who chooses to remain in that plan during the annual open enrollment will not be given a 60-day change period. Individuals will be able to change health plans for cause at any time.

These rules apply to all enrollees, including ABD enrollees. The change period described above will be a reduction from 90 days to 60 days for ABD beneficiaries. However, the State found that very few ABD beneficiaries use such a long period of time. Shortening the period to 60 days should not negatively impact choice for ABD beneficiaries and at the same time expands the change period for non-ABD beneficiaries.

After a beneficiary selects a health plan, he or she will receive a survey or a welcome call from the health plan, which will identify if the beneficiary has any special health needs. A welcome call will be required for those who do not respond to the survey if applicable. If special health needs are identified, the health plan will assign a licensed or qualified professional as the beneficiary's service coordinator and perform a face-to-face assessment. In addition, health plans will still be required to perform a face-to-face assessment on individuals with identified special health care needs, such as those receiving long-term services and supports (LTSS). In the current demonstration, health plans are required to perform face-to-face assessments on initial enrollment for certain populations. Hawaii found that this requirement results in unnecessary assessments of individuals who do not have special health needs, and it is implementing the

survey/welcome call process in an effort to identify enrollees' special health needs more efficiently.

4. Encourage Timely Enrollment By Limiting Retroactive Eligibility

Hawaii proposes to continue its policy of encouraging timely enrollment in Medicaid through a shortened retroactive eligibility period. Both Hawaii and the federal government have taken significant steps to simplify and streamline the Medicaid eligibility and enrollment process. Retaining a limited retroactive eligibility period will encourage individuals to apply when eligible, will allow them to benefit more quickly from the programs, and will help alleviate the administrative burden on the managed care plans and the State.

The current demonstration limits retroactive eligibility to a five-day period prior to application, except for those beneficiaries requesting LTSS. Hawaii seeks to modify this retroactive eligibility period from five days to ten calendar days, and to deem applicants eligible for any portion of the ten-day period that extends into a month prior to the month for which the individual was determined eligible. Modestly increasing the retroactive eligibility period in this manner will provide additional coverage for individuals, while also continuing to encourage prompt enrollment and reduce potential uncompensated care costs.

For individuals applying for LTSS, Hawaii will continue to provide retroactive eligibility for up to three months. The State believes that there are unique issues implicated for individuals receiving LTSS that warrant continuing the more lenient retroactive eligibility rules.

5. Integrate Benefit Packages, Expand Home and Community-based Services (HCBS), and Offer Needs-Based HCBS to "At Risk" Enrollees

The QI demonstration will merge the two benefit packages available under QUEST Expanded into one comprehensive set of benefits available to all demonstration populations. The QI benefit package will include benefits consisting of full State plan benefits and will offer certain additional benefits based on medical necessity and clinical criteria. Structuring the benefits in this manner will help ensure that beneficiaries have access to all the services they need, even when their needs change, and will ease the administrative burden on the State.

The State will continue its robust and successful HCBS program, providing access to a comprehensive package of benefits for individuals who meet institutional level of care and are able and choose to receive care at home or in the community. In addition, the State will continue its efforts to expand access to HCBS by providing a set of HCBS to individuals who are assessed to be at risk of deteriorating to the institutional level of care (the "at risk" population).

The State also intends to offer the following new benefits, subject to clinical criteria and medical necessity:

- Cognitive rehabilitation therapy (either through the demonstration or the State plan).
- Covered substance abuse treatment services provided by a certified (as opposed to licensed) substance abuse counselor.

- Specialized behavioral health services (Clubhouse, Peer Specialist, Representative Payee, Supportive Employment, and Supportive Housing) for qualified individuals with a Serious and Persistent Mental Illness (SPMI), Severe Mental Illness (SMI), or requiring Support for Emotional and Behavioral Development (SEBD).

6. Eliminate QUEST-ACE Enrollment Benchmarks for Uncompensated Care Costs

Under the current demonstration, Hawaii is entitled to federal participation in uncompensated care costs up to a specified amount subject to meeting certain QUEST-ACE enrollment benchmarks. With the integration of the QUEST programs and the elimination of QUEST-ACE, these benchmarks will no longer be relevant. The State therefore is proposing to delete the benchmark provisions. At the same time, the State is seeking federal participation in the total of actual uncompensated care costs of private and public hospitals (including uncompensated long-term care costs of public hospitals for serving QI enrollees) incurred in any given year, subject to the overall budget neutrality limitation.

7. Continue Coverage of Certain Non-Medicaid Beneficiaries

With the passage of ACA, Title XIX now authorizes coverage of adults who have long been eligible for medical assistance through QUEST Expanded. Most notably, QUEST Expanded already covers childless adults with income up to and including 133% of the FPL. These adults, covered under what is currently a demonstration group, will be considered to fall into a State plan eligibility category under this Section 1115(a) renewal.

There are still a few groups of individuals Hawaii is requesting waiver or expenditure authority to cover, including individuals who would be eligible under 42 C.F.R. § 435.217 if Hawaii offered its HCBS through a Section 1915(c) waiver, medically needy individuals receiving HCBS through the demonstration, and young adults formerly receiving adoption assistance or kinship guardianship assistance.

C. QUEST Integration Hypotheses, Evaluation Plans, and Evaluation Design

The State's continuing goal is to ensure that our beneficiaries receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. The State has adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. An initial set of ambulatory care measures based on this framework was identified. Healthcare Effectiveness Data and Information Set (HEDIS) measures reported by the health plans are reviewed and updated each year. As the State evaluates the demonstration, the Quality Strategy is used as the framework for the evaluation.

Many of the State's quality activities will be completed in partnership with the EQRO. The EQRO will compile and validate HEDIS measures annually, and administer both the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and provider surveys for the State. The State will then analyze these data for the annual components of the demonstration evaluation.

Finally, the EQRO will submit an annual report to the State in November of each year, and the State will post this report on our website (www. med-quest.us) under the Managed Care/Consumer Guides section for public awareness.

In QUEST Integration, MQD will continue to work in concert with the EQRO on collection and analysis of information from health plans. For QUEST Integration, the State plans the following evaluation activities:

1. CAHPS surveys for children every year and adults every other year
2. Provider surveys every other year
3. Compliance reviews to assure health plans are complying with 42 C.F.R. Part 438
4. Validation of HEDIS data from health plans
5. Validation of at least two Performance Improvement Projects annually
6. Testing hypotheses related to changes implemented in QUEST Integration

Hypotheses

The State will continue to test two overarching hypotheses about its demonstration:

- Capitated managed care delivers high quality care, while also slowing the rate of health care expenditure growth.

- Capitated managed care provides access to HCBS and facilitates rebalancing of provided long-term care services.

The State will test the following hypotheses about the changes implemented in QUEST Integration:

- Consolidating the current programs decreases administrative burdens for the health plans and the State.

- Consolidating the current programs improves access to appropriate care, such as HCBS, and ensures continuity of care when an enrollee's health status changes.

- Extending HCBS to the "at risk" population will decrease the percentage of at-risk enrollees whose health status deteriorates to the institutional level of care.

The State will measure the outcomes in QUEST Integration based on validated measures. We understand that these goals are ambitious and will be all the more challenging should the denominators for measurement be the combined population of non-ABD and ABD beneficiaries. When comparing health plan performance under this waiver to other Medicaid health plans nationally, applying the measures to comparable populations will be important. The following are the State Quality Improvement Strategy targets:

- Childhood Immunizations (CIS): Increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the Medicaid 75th percentile.

- Chlamydia Screening (CHL): Increase performance on the state aggregate HEDIS Chlamydia Screening measure to meet/exceed the Medicaid 75th percentile.

- Breast Cancer Screening (BCS): Increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the Medicaid 75th percentile.

- Comprehensive Diabetes Care (CDC):

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the HEDIS 75th percentile.

    - Improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c poor control (>9) to meet/fall below the HEDIS 25th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<7) to meet/exceed below the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL screening to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL control (<100) to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<140/90) to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for eye exams to meet/exceed the HEDIS 75th percentile.

- Cholesterol Management in Patients with Cardiovascular Conditions (CMC): Increase performance on the state aggregate HEDIS Cholesterol Screening measure to meet/exceed the HEDIS 75th percentile.

- Controlling High Blood Pressure (CBP): Increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the HEDIS 75th percentile.

- Use of Appropriate Medications for People with Asthma (ASM): Increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the HEDIS 75th percentile.

- Emergency Department Visits (AMB): Maintain performance on the state aggregate HEDIS Emergency Department Visits/1000 rate to fall below the HEDIS 10th percentile.

- Plan All-Cause Readmissions: Increase performance on the state aggregate HEDIS to meet/exceed the HEDIS 75th percentile.

- Getting Needed Care: Increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Rating of Health Plan: Increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- How well doctors communicate: Increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Home and Community Based Service (HCBS) beneficiaries: Increase the proportion of clients receiving HCBS to at least 70% of the population receiving long-term supports and services.

Data Collection and Analysis

The results of the data collection and analysis will be various values for the given period. These results will be displayed in graphical format. For most measures, a longitudinal comparison will be made among the various years for Hawaii's statewide scores. Where applicable, comparison to State Quality Improvement Strategy targets will also be reviewed.

A determination will be made if unexpected or expected factors are influencing the findings. These factors could be internal to DHS, specific to a health plan's operations, or external at a state or national level. Either way, there will be a discussion on how the State believes these factors are exerting influence on the values and the need for and feasibility of interventions to improve health care and health status.

IV. Demonstration Eligibility

A. Affected Populations

Hawaii plans to cover the following groups in QUEST Integration:

Mandatory State Plan Groups		
Eligibility Group Name	**Social Security Act and Code of Federal Regulations Citations**	**Income Level and Other Qualifying Criteria**
Parents or caretaker relatives	§ 1902(a)(10)(A)(i)(I), (IV), (V) § 1931(b), (d) 42 C.F.R.§ 435.110 (eff. Jan. 1, 2014)	Up to and including 100% FPL

Pregnant Women	§ 1902(a)(10)(A)(i)(III)-(IV) 42 C.F.R. § 435.116 (eff. Jan. 1, 2014)	Up to and including 185% FPL
Poverty Related Infants	§ 1902(a)(10)(A)(i)(IV) § 1902(l)(1)(B) 42 C.F.R. § 435.118(c) (eff. Jan. 1, 2014)	Infants up to age 1, up to and including 185% FPL
Poverty Related Children	§ 1902(a)(10)(A)(i)(VI)-(VII) § 1902(l)(1)(C)-(D) 42 C.F.R. § 435.118(a) (eff. Jan. 1, 2014)	Children ages 1 through 18, up to and including 133% FPL
ACA Mandatory Adults Age 19 Through 64 Group	§ 1902(a)(10)(A)(i)(VIII) 42 C.F.R. § 435.119(b) (eff. Jan. 1, 2014)	Up to and including 133% FPL
Former Foster Children under age 26	§ 1902(a)(10)(A)(i)(IX)	No income limit
SSI Aged, Blind, or Disabled	§ 1902(a)(10)(A)(i)(II)(aa), as qualified by Section 1902(f) 42 C.F.R. § 435.121	SSI-related using SSI payment standard
Section 1925 Transitional Medicaid, Subject to Continued Congressional Authorization	§ 1925 § 1931(c)(2)	Coverage for two six-month periods due to increased earnings, or for four months due to receipt of child support, that would otherwise make the individual ineligible under Section 1931 - In the second six-month period, family income may not exceed 185% FPL

Optional State Plan Groups		
Eligibility Group Name	**Social Security Act and Code of Federal Regulations Citations**	**Income Level and Other Qualifying Criteria**
Aged or Disabled	§ 1902(a)(10)(ii)(X) § 1902(m) 42 C.F.R. § 435.230(c)(vi)	SSI-related net income up to and including 100% FPL
Independent Foster Care Adolescents (Age 19 and 20)	§ 1902(a)(10)(A)(ii)(XVII) § 1905(w)	No income limit
Optional targeted low-income children	§ 1902(a)(10)(A)(ii)(XIV) Title XXI 42 C.F.R. § 435.229	Up to and including 300% FPL including for children for whom the State is claiming Title XXI funding
Certain Women Needing Treatment for Breast or Cervical Cancer	§ 1902(a)(10)(A)(ii)(XVIII) § 1902(aa)	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non-Aged, Blind, or Disabled Children and Adults	§ 1902(a)(10)(C) 42 C.F.R. § 435.301(b)(1) 42 C.F.R. § 435.308 42 C.F.R. § 435.310	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	§ 1902(a)(10)(C) 42 C.F.R. §§ 435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology
Expansion Population		
Eligibility Group Name	**Federal Poverty Level and/or Other Qualifying**	
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 group receiving HCBS	Income up to and including 100% FPL using the institutional income rules
Medically needy individuals receiving HCBS	Receiving HCBS and meet medically needy income standard using institutional rules for income, assets, and post-eligibility treatment of income
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

B. Methodologies for Determining Eligibility, Changes In Eligibility Procedures, And Transition To New Methodologies And Standards

QUEST Integration will utilize MAGI to the extent required by applicable law and regulations, which will include not having an asset test. Other than the use of MAGI methodology, there will be no changes in eligibility methodology. Eligibility for the ABD groups will continue to be determined using current income and resource methodologies.

Effective January 1, 2014, MAGI will be applied to new non-ABD applicants and annual eligibility re-determinations (no Medicaid child enrolled on January 1, 2014 will lose his or her eligibility prior to March 31, 2014 because of the implementation of MAGI).

Because QUEST Expanded currently provides coverage to individuals up to and including 133% FPL, Hawaii does not expect a difficult transition to cover the newly Medicaid-eligible adult population as of January 1, 2014.

C. Eligibility and Enrollment Limits

There will be no eligibility limits for QUEST Integration. However, there may be health plan enrollment limits. The State seeks to retain its authority to impose enrollment limits 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.

D. Projected Eligibility

From July 1, 2011 to June 30, 2012, there was an average of 236,964 individuals enrolled in the current demonstration (and covered in part by a federal match). During the five-year renewal period, the annual increase in enrollment is expected to be 3% per year for non-ABD recipients and 1.2% for ABD recipients, or approximately 6,317 recipients per year for the existing population. In addition, 24,000 recipients may become eligible under the new ACA eligibility guidelines.

E. Post-Eligibility Treatment of Income

There will be no changes in the demonstration's treatment of post-eligibility income. All 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 or individuals who would be eligible for Medicaid if institutionalized as set forth in 42 C.F.R § 435.217.

V. Demonstration Benefits and Cost Sharing Requirements

A. QUEST Integration Benefits

Under QUEST Integration, Hawaii will combine the two benefit packages available under the current demonstration into one comprehensive set of benefits available to all demonstration populations. Instead of offering different benefit packages to different eligibility groups, Hawaii will offer one primary and acute care services package consisting of full State plan benefits to all demonstration populations, with certain additional benefits available based on clinical criteria and medical necessity. This benefit structure will be easier for beneficiaries to navigate, better equipped to serve patients with changing needs, and less burdensome for the State to administer.

Individuals who meet institutional level of care ("1147 certified") will have access to a wide variety of LTSS, including specialized case management, home maintenance, personal assistance, adult day health, respite care, and adult day care, among others. Moreover, Hawaii will provide HCBS to certain individuals who are assessed to be at risk of deteriorating to institutional level of care, in order to prevent a decline in health status and maintain individuals safely in their homes and communities. These individuals (the "at risk" population) will have access to a set of HCBS that includes personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS) and skilled nursing, subject to limits on the number of hours of HCBS or the budget for such services.

Hawaii also plans to include in the QUEST Integration benefit package the following new benefits, subject to clinical criteria and medical necessity:

- Cognitive rehabilitation therapy (either through the demonstration or the State plan).
- Covered substance abuse treatment services provided by a certified (as opposed to licensed) substance abuse counselor.
- Specialized behavioral health services (Clubhouse, Peer Specialist, Representative Payee, Supportive Employment, and Supportive Housing) for qualified individuals with an SPMI, SMI, or SEBD (either through the demonstration or the state plan).

The following chart specifies the benefit package that all QI eligibility groups will receive:

QUEST Integration Benefit Package Chart

Benchmark Benefit Plan	
Full State Plan Benefits	
Additional Benefits Based on Level of Need	
Level of Need	**Benefits**
If medically necessary	• Cognitive rehabilitation therapy (either through 1115 or State plan) • Covered substance abuse treatment services provided by a certified substance abuse counselor • Specialized behavioral health services (Clubhouse, Peer Specialist, Representative Payee, Supportive Employment, and Supportive Housing) for qualified individuals with an SPMI, SMI, or SEBD (either through the demonstration or the State plan).
Individuals who are assessed to be at risk of deteriorating to institutional level of care ("at risk" population)	HCBS: • Personal assistance • Adult day care • Adult day health • Home delivered meals • Personal emergency response system (PERS) • Skilled nursing
Individuals who meet institutional level of care ("1147 certified")	HCBS:* • Adult day care • Adult day health • Assisted living facility • Community care foster family homes • Counseling and training • Environmental accessibility adaptations • Home delivered meals • Home maintenance • Moving assistance

	• Non-medical transportation • Personal assistance • Personal emergency response system (PERS) • Residential care • Respite care • Skilled nursing • Specialized case management • Specialized medical equipment and supplies *Room and board is not a covered HCBS.

The State has attached the Benefit Specifications and Provider Qualifications forms, as well as Long Term Services and Supports forms, for each applicable benefit as Attachment E.

B. Access to Long Term Services and Supports (LTSS)

1. Choice of Institutional Services or HCBS

Under QUEST Integration, the State will continue its policy of allowing beneficiaries who meet an institutional level of care to choose between institutional services or HCBS. Access to both institutional and HCBS LTSS will be 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, or who requests or receives LTSS, will receive a functional assessment at least every twelve months, or more frequently when there has been a significant change in the beneficiary's condition or circumstances. In addition, each member who requests a functional assessment will receive one.

The State's delegated contractor will review the assessments and make a determination as to whether the beneficiary meets an institutional (hospital or nursing facility) level of care. Individuals who meet the institutional level of care may access institutional care or HCBS through their health plan. Certain individuals who are assessed to be "at risk" of deteriorating to the institutional level of care (the "at risk" population) will have access to defined HCBS services described above. The State requests authority to limit the number of hours of HCBS provided to "at risk" individuals or the budget for such services.

2. Election of HCBS

A beneficiary who elects to receive HCBS will, following the functional LOC assessment, receive an individualized service plan that must be sufficient to meet the beneficiary's needs, taking into account family and other supports available to the beneficiary. The amount, duration, and scope of all covered services may vary to reflect the unique needs of the individual.

If the estimated costs of providing necessary HCBS to the beneficiary are less than the estimated costs of providing necessary care in an institution (hospital or nursing facility), the health plan must provide the HCBS to an individual who so chooses, subject to certain limitations. Health plans will be required to document good-faith efforts to establish a cost-effective, person-centered plan of care in the community using industry best practices and guidelines.

If the estimated costs of providing necessary HCBS to the beneficiary exceed the estimated costs of providing necessary care in an institution (hospital or nursing facility), a health plan may refuse to offer HCBS if the State or its independent oversight contractor so approves. In reviewing such a request by a health plan, the State will take into account the health plan's aggregate HCBS costs as compared to the aggregate costs that it would have paid for institutional care. Although the intent of HCBS is to utilize social supports, the State recognizes and seeks to accommodate temporary medical or social conditions that require additional services. Accordingly, adults will be able to receive up to 90 days per benefit period of 24 hours of HCBS per day.

3. 1915(c) DD/ID Waiver Enrollees

Individuals enrolled in Hawaii's Section 1915(c) DD/ID waiver will receive 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. (The only exception to this is children who have access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.) 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. Waiting list policies will be based on objective criteria and applied consistently in all geographic areas served.

4. Waiting List for HCBS

The State requests authority to allow the QI health plans to establish waiting lists, upon approval by the State, for the provision of HCBS. Waiting list policies will be 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 health plans on a quarterly basis to discuss any issues associated with management of the waiting lists. Members 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.

C. Access to Behavioral Health Benefits

QUEST Integration will continue to provide a full array of standard behavioral health services through managed care. It will also continue to offer additional, specialized behavioral health services covered under this demonstration as described above or under the State plan. Children requiring SEBD will receive specialized behavioral health services through the Hawaii Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD). Qualified adults with a SPMI or SMI will receive specialized behavioral health services through either the DOH Adult Mental Health Division (AMHD), health plan, or behavioral health organization also referred to as the Community Care Services (CCS) program. Regardless of how adults access the specialized behavioral health services, all adults will have access to the same services. The State assures there will be no duplication of specialized behavioral health services. The State intends to transition all adults to receive specialized behavioral health services through the CCS program by the completion of the waiver period. More details about the provision of specialized behavioral health services are provided in the Behavioral Health Services Protocol (Attachment F).

D. Premium Assistance, Premiums, and Cost Sharing

The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan.

VI. Delivery System and Payment Rates for Services

A. Delivery System for Demonstration Benefits

The delivery system used to provide benefits for the QI demonstration will differ from Hawaii's State plan in that the vast majority of benefits will be provided through managed care, as opposed to FFS. A statewide managed care delivery system will help Hawaii ensure access to high-quality, cost-effective care; establish contractual accountability among the health plans and health care providers; and continue the predictable and slower rate of expenditure growth associated with managed care. Savings generated from the managed care delivery system allows coverage of expansion populations.

Although most QI benefits will be provided through managed care organizations (MCOs), the State will utilize FFS for the following services, for the following reasons:

- LTSS for individuals with developmental disabilities or intellectual disabilities, under the State's Section 1915(c) waiver.
- Intermediate Care Facilities for the Intellectually Disabled (ICF-ID), because this is a specialized program administered by another State department.
- Medical services to applicants eligible for retroactive coverage only, because there is no opportunity to manage care and it is for a very small population.
- Medical services under the SHOTT program, because this is a specialized program serving a small population that incurs very high costs.
- Medical services to medically needy individuals who are not ABD, because of the actuarial difficulty associated with a small volume of people that negatively affects capitation rates.
- Dental services, because these are specialized services.
- Targeted Case Management, School-based services, and Early Intervention Services, because those programs are administered by another State department.

The FFS payments will not deviate from State plan provider rates.

The following table depicts the delivery system for each benefit offered through QUEST Integration.

Benefit(s)	Delivery System	Authority
State plan services	Managed Care - MCO	1115
QUEST Integration LTSS	Managed Care - MCO	1115
Cognitive rehabilitation therapy	Managed Care - MCO	1115 or State plan
Medical services to medically needy	Managed Care - MCO	1115

individuals who are ABD		
Medical services to medically needy individuals who are non-ABD	Fee-for-service	1115
LTSS for individuals with developmental disabilities or intellectual disabilities	Fee-for-service	1915(c)
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID)	Fee-for-service	State plan
Medical services to applicants eligible for retroactive coverage only	Fee-for-service	State plan
Medical services under the SHOTT program	Fee-for-service	State plan
Dental services	Fee-for-service	State plan
Targeted Care Management	Fee-for-service	State plan
School-based services	Fee-for-service	State plan
Early Intervention Services	Fee-for-service	State plan
Covered substance abuse treatment services provided by a certified substance abuse counselor	As described in the behavioral health protocol	1115
Specialized behavioral health services for qualified individuals with a SPMI, SMI, or SEBD	As described in the behavioral health protocol	1115 or State plan

B. QUEST Integration Health Plan Enrollment and Selection

For information about health plan enrollment and selection, please see Section III.B.3.

C. Limitation on Retroactive Eligibility

For information about retroactive eligibility, please see Section III.B.4.

D. Contracting Policies with the QUEST Integration Health Plans

Under the QI demonstration, all contracts and modifications of existing contracts between the State and the health plans will be approved by CMS. Hawaii will provide CMS with at least 45 days to review any changes. The contracts may contain financial incentives, as allowed by title XIX and CMS regulations, which expand capacity for HCBS beyond the annual thresholds established by the State, and include other goals defined by the State and sanctions for non-performance. Should the health plans be awarded financial incentives for meeting State goals, the health plans will be required, as determined appropriate by federal and state law, to share a portion of any bonuses with providers.

Hawaii will procure the QUEST Integration program under Section 103F of the Hawaii Revised Statutes. The procurement process includes the issuance of a Request for Information (RFI) to provide an opportunity for stakeholders and other interested parties to provide input into the

development of the Request for Proposals (RFP). Proposals submitted in response to the RFP are evaluated in compliance with State procurement requirements.

E. Medically Needy Non-ABD Individuals

Medically needy non-ABD individuals will not be enrolled in a QI health plan and will be subject to the medically needy spend-down. They will receive services on a FFS basis. This category might include, for example, persons who become medically needy for a short-term period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically. This unpredictability (which is different than for ABDs, who typically become medically needy due to long-term care needs) can skew health plan capitation rates if included.

F. Medically Needy ABD Individuals

Medically needy ABD individuals will be enrolled in a QI health plan. If their spend-down liability is expected to exceed the health plans' monthly capitation payment, they will be subject to 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.

G. Dual Eligible Beneficiaries

Dual eligible individuals may be enrolled in a CMS-approved demonstration to integrate care for Medicare and Medicaid enrollees (MME), and may be subject to the terms of that demonstration. The State seeks to nest the MME demonstration within this 1115 demonstration and utilize the QI health plans to provide the Medicare benefits to their MME members.

H. Self-Direction Opportunities

Self-direction opportunities will be available under the QI demonstration for the following long-term services and supports (LTSS):

- Personal assistance- Level I (also known as Chore)
- Personal assistance- Level II
- Respite care

Beneficiaries who are assessed to receive personal assistance or respite care will be offered self-direction as a choice of provider. Those who are unable to make their own health care decisions, but still express an interest in the self-direction option, may appoint a surrogate to assume the self-direction responsibilities on their behalf.

Beneficiaries will have the ability to hire family members (including spouses, children, and parents for beneficiaries over eighteen years of age), neighbors, and friends, as service providers. Beneficiaries may not hire their surrogate as their service provider. For family members to be paid as providers of self-directed services, the services cannot be an activity that the service provider would ordinarily perform as a family member.

Self-direction service providers are not required to be part of the health plans' provider network. However, service providers will sign an agreement that specifies their responsibilities in provision of services to the beneficiary.

Service providers will be required to submit to the beneficiary/surrogate their time sheets on a monthly basis. The beneficiary/surrogate must approve the time sheet and send it to the health plan for processing. The health plan will then pay the service provider for the hours worked in the previous month. Health plans will withhold from payments applicable Federal, State, and employment taxes. Moreover, the health plans are responsible for establishing a payment structure for the self-direction program, and must train beneficiaries/surrogates on their responsibilities in the self-direction program.

I. Additional Hospice Payment for Nursing Facility Residents

Consistent with federal law, when hospice care is furnished to an individual residing in a nursing facility, the State pays the hospice provider an additional amount to take into account the room and board furnished by the facility. This amount is at least 95 percent of the per diem rate that the State would have paid to the nursing facility under the State plan. Under QUEST Integration, the State requests authority to allow the nursing facilities to seek reimbursement for that amount directly from the health plans, instead of seeking reimbursement from the hospice providers. This will facilitate the nursing facilities' cash flow and promote administrative simplification for the hospice providers.

J. Payment Rates

Rates will be developed in accordance with the Code of Federal Regulations, 42 C.F.R. § 438.6(c), and CMS's Appendix A, PAHP, PIHP and MCO contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting. Rate development is based on recent experience data and is consistent with guidelines as set forth by the American Academy of Actuaries.

1. Quality-Based Supplemental Payments

Value-driven health care is a payment methodology to providers that incorporates both quality and efficiency. Hawaii will require the QI health plans to implement value-driven health care in their contracts with providers. This payment reform may include, but not be limited to, different reimbursement strategies such as FFS with incentives for performance, capitation payment to providers with assigned responsibility for patient care, or a hybrid. Measures used must be evidence-based and validated.

Primary Care Provider

For primary care providers (PCP), the medical home is a model to facilitate the provision of outpatient high quality and highly efficient care. Under the QI demonstration, health plans must implement a medical home model that is based on the domains of patient-centered, accessible, comprehensive, coordinated, evidence-based, and performance measurement. Incentivizing increased quality and efficiency of care, including proactive population management, must be based on outcomes. Payment reform is a quintessential component of

enabling the medical home. The QI health plans may utilize a monthly patient management reimbursement to the provider that is reconciled with earned financial incentives based on performance or gain-sharing, or other payment strategies approved by the State. A medical home may receive increased reimbursement compared to a practice that does not meet the criteria to be a medical home.

Hospitals

The QI health plans are expected to utilize value-based purchasing with hospitals as well. Health plans will have flexibility in their payment methodologies, which should be based on validated measures that preferably hospitals are already required to report.

Integrated Service Models

QI health plans will be encouraged to pursue a shared risk and shared savings program with accountable care organizations if available. Such a health care delivery model may be physician, hospital, or other provider led with appropriate measurement and accountability. An additional delivery model for this is the Patient Centered Health Organization that expands on the network supported patient-centered medical home. However, a shared risk and shared savings program can occur with any provider if agreed upon by the provider and health plan. The contractual arrangement would be expected to include an element of management/capitation payment and may also include performance-based adjustments and gain/loss sharing.

VII. Implementation of Demonstration

Because QUEST Integration builds on a preexisting demonstration, the State does not believe a phase-in approach is necessary.

The changes in QI will become effective on January 1, 2014. That said, pending prospective CMS guidance, Hawaii would be amenable to implementing all the changes in this renewal application effective October 1, 2013, when it will be required to begin accepting new applications. Alternatively, if not possible, Hawaii may seek an amendment to its current demonstration or State plan as applicable to implement MAGI on October 1, 2013.

The renewal process itself and accompanying public input procedures have helped provide notice to beneficiaries of the future changes. In addition, demonstration beneficiaries will receive notice about the changes at various points of contact with the Med-QUEST Division and the health plans. Beneficiaries will also be informed of any changes that directly impact their eligibility or benefits.

For information about the contracting and procurement policies in QUEST Integration please see Section VI.D.

Beneficiaries will be enrolled pursuant to the enrollment and health plan selection process described in Section III.B.3. Upon a change in the number of health plans in which a beneficiary can choose to enroll, beneficiaries will be afforded the opportunity to change health plan and choose among all available health plans. For those who do not make a choice, every effort will be made to retain beneficiaries to the extent possible in the health plan with which they have an existing relationship.

VIII. Demonstration Financing and Budget Neutrality

From July 1, 2011 to June 30, 2012, there was an average of 236,964 individuals enrolled in the demonstration (and covered in part by a federal match). During the five-year renewal period, the annual increase in enrollment is expected to be 3% per year for non-ABD recipients and 1.2% for ABD recipients, or approximately 6,317 recipients per year for the existing population. In addition, 24,000 recipients may become eligible under the new ACA eligibility guidelines.

Total aggregate expenditures for each renewal year are anticipated to be $2.0 billion in both State and federal funding. That is, the State expects the changes required by ACA, coupled with other State-requested changes to the demonstration, to result in approximately $700 million in increased State and federal annual expenditures during the renewal period. Attachment G includes the budget neutrality charts, with details about historical financial data, projected expenditure data for the life of the extension request, and a financial analysis of the changes to the demonstration.

The demonstration will be financed by a combination of State dollars and federal matching funds.

IX. List of Proposed Waivers and Expenditure Authorities

A. Waiver Authority

The State believes the following waiver authorities will be necessary to authorize the demonstration.

1. Medically Needy - Section 1902(a)(10)(C); Section 1902(a)(l7)

   To enable the State to limit medically needy spend-down eligibility to those non-ABD individuals whose gross incomes, before any spend-down calculation, are at or below 300% of the Federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which has 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.

   To enable the State to maintain waiting lists, through a health plan, for home and community-based services. No waiting list is permissible for other services for health plan enrollees.

   To enable the State to impose an hour or budget limit on the home and community-based services provided to the "at risk" population.

3. Retroactive Eligibility - Section 1902(a)(34)

To enable the State to limit retroactive eligibility to a ten (10) day period prior to application, or up to three months for individuals requesting long-term care services. Individuals will be considered eligible for any portion of the 10-day retroactive period that extends into a month prior to the month for which determined eligible.

4. Freedom of Choice - Section 1902(a)(23)

To enable Hawaii to restrict the freedom of choice of providers to groups that could not otherwise be mandated into managed care under Section 1932.

5. Hospice Care Payment - Section 1902(a)(13)(B)

To enable the State (through the health plans), when hospice care is furnished to an individual residing in a nursing facility, to make payments directly to the nursing facility rather than the hospice providers for the room and board furnished by the facility.

B. Expenditure Authorities

The State believes the following expenditure authorities will be necessary to authorize 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):

   a) Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to disenroll without cause to within 60 days of initial enrollment in an MCO, as opposed to the 90 days designated under Section 1903(m)(2)(A)(vi) and Section 1932(a)(4)(A)(ii)(I) of the Social Security 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 health plan in the absence of a choice of health plan on that particular island.

   b) Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more health plans, as required under Section 1903(m)(2)(A)(xii), Section 1932(a)(3) and Federal regulations at 42 C.F.R. § 438.52.

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 Eligibility. Expenditures to provide coverage to the following populations:

   a) Parents or caretaker relatives who would otherwise be eligible if the dependent child was under 18 years of age.

   b) Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

   c) Individuals 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 estimated to exceed the amount of the health plan capitation payment, subject to an enrollment fee equal to the spend-down liability.

   d) Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance.

   e) Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program, are not eligible under any other eligibility group, and were enrolled in the State plan or waiver while receiving assistance.

4. Uncompensated Care Costs. Expenditures to reimburse certain hospital and nursing facility providers for provider costs of inpatient and outpatient hospital services and long-term care services to the uninsured and/or underinsured, subject to certain restrictions placed on hospital and nursing facility uncompensated care costs. The State is seeking federal participation in the total of actual uncompensated care costs of private and public hospitals (including uncompensated long-term care costs of public hospitals for serving QI enrollees) incurred in any given year, subject to the overall budget neutrality limitation.

5. Home and Community-Based Services (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 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 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.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable, will apply to the demonstration beginning January 1, 2014, through December 31, 2018, except those waived or listed below as not applicable.

C. Title XIX Requirements Not Applicable to Demonstration Populations

The State believes the following Medicaid requirement will need to be deemed not applicable to demonstration populations.

1. Cost Sharing - Section 1902(a)(14)

   To enable the State to charge cost sharing with limits on cost-sharing amounts but no aggregate limit. To enable the State to charge an enrollment fee to Medically Needy Aged, Blind and Disabled health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate, in the amount equal to the estimated spend-down or cost share amount or, where applicable, the amount of patient income applied to the cost of long-term care.

X. Public Notice

A. The State's Public Notice and Input Efforts

The State has taken multiple steps to inform the public and solicit public input about its Demonstration extension application. These public notice and public input procedures comply with 42 C.F.R. § 431.408.

The State certifies that it undertook the following public notice and comment activities:

- The State solicited and conducted informational sessions with various organizations and stakeholder groups seeking input for the submission of the Section 1115(a) waiver submittal.

- The State's public notice and comment period began on November 20, 2012 and ran for 30 days, until December 21, 2012. During that time, the State accepted public comments sent to Noreen Moon-Ng by mail to P.O. Box 700190, Kapolei, HI 96709-0190 or by email to nmoon-ng@medicaid.dhs.state.hi.us.

- On November 20, 2012, the State notified, via e-mail, a list of potentially interested parties. *See* Attachment H. This e-mail list was gathered from individuals who attended public hearings, community forums, or provided comments as part of the public input process for the recent amendments to the demonstration or the recent Section 1115(e) extension application.

- On November 20, 2012, the State published an abbreviated public notice in the newspapers of widest circulation in each city with a population of 100,000 or more, which included a description of the demonstration extension; the location and internet address where copies of the renewal application were available for review and comment, the locations, dates, and times of two public hearings convened to seek public input about the extension application; and an active link to the full public notice document on the State's web page. *See* Attachment I.

- On November 20, 2012, the State issued a full public notice document with a comprehensive description of the proposed renewal. *See* Attachment J. Consistent with 42 C.F.R. § 431.408, the notice included the location and internet address where copies of the renewal application were available for review and comment; the dates of the public comment period; postal and e-mail addresses where written comments could be sent; and the locations, dates, and times of the two public hearings convened by the State to seek public input about the extension application. This public notice document described the public notice and input processes, included a link to the relevant Medicaid demonstration page on the CMS web site, and was maintained for the entire public comment period in a prominent location at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/

- On November 20, 2012, the State posted the following for viewing at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/: the Draft 1115 Application; Quality Assurance Monitoring Information - "Summaries of EQRO Reports and Quality Assurance Monitoring, and Other Information and Documentation Regarding Quality of and Access to Care"; the Behavior Health Protocol and addenda; and the budget neutrality charts.

- The State held two public hearings to solicit public input and comment about the Demonstration extension application:

  1. December 3, 2012 from 8:00 a.m.-12:00 p.m.:

Oahu	Keoni Ana Videoconference Center Keoni Ana Building 1177 Alakea Street, Room 302 Honolulu, Hawaii
Hawaii	Hilo Videoconference Center Hilo State Office Building 75 Aupuni Street, Basement

Hilo, Hawaii

Kauai — Lihue Videoconference Center
Lihue State Office Building
3060 Eiwa Street, Basement
Lihue, Hawaii

Maui — Wailuku Videoconference Center
Wailuku Judiciary Building
2145 Main Street, First Floor
Wailuku, Hawaii

2. December 7, 2012 from 9:00 a.m.-12:00 p.m.:

Department of Human Services
1390 Miller Street, Conference Rooms 1 & 2
Honolulu, Hawaii

In its public notice, the State provided contact information for State staff to assist individuals who require special assistance or auxiliary aids and/or services to participate in the public hearings (*e.g.*, sign or foreign language or wheelchair accessibility).

Below is a chart detailing the State's public notice and input procedures:

Date	**Public Notice and/or Public Input Opportunity**
November 19	Tribal notice issued
November 20	Email to potentially interested parties
November 20	Abbreviated public notice published in newspapers
November 20	Public comment period began
November 20	Full public notice posted on the Department of Human Services and Med-QUEST Division websites.
November 20	Section 1115(a) application posted on the Department of Human Services and the Med-QUEST Division websites and available for public distribution.
December 3	Public meeting via videoconference
December 7	Public meeting at the Department of Human Services with teleconference availability
November 20 - December 21	Public input was accepted by the State.

B. Issues Raised by the Public and the State's Consideration of Those Issues

The State received fifteen public comments on the draft Section 1115(a) application (eleven written comments, two oral comments, and two comments provided both orally and in writing). Out of the fifteen comments, ten expressed support for aspects of the State's proposal. For example, several applauded the State's proposal to consolidate the current programs into one program and improve coordination with the Medicare program. Others expressed strong support for the State's proposal to offer new specialized behavioral health benefits. Six commenters expressed concerns about various aspects of the proposal, which are summarized below. One commenter provided testimony against a particular health plan, which did not relate to the waiver.

Commenters raised the following issues regarding the draft application:

1. Behavioral Health Services. One commenter expressed concern that individuals diagnosed with anxiety or personality disorders, such as post-traumatic stress disorder (PTSD), would not have access to specialized behavioral health services, and asked the State to expand the list of eligible diagnoses to include those disorders. Another commenter advocated against the separation of medical and behavioral services for the SPMI membership through a carve-out.
2. Identification of Special Health Needs. One commenter recommended that, in addition to making welcome phone calls, health plans should have the option of mailing surveys to new enrollees so they can self-report any special health needs.
3. Quality Measures. One commenter suggested that the State collect and report quality measures and surveys by sub-population cohort (for example, comparing QUEST vs. QExA children); otherwise, the results may not be accurate and the plan-to-plan comparisons may not be appropriate. Another commenter urged the State to base quality incentives on improved performance by a particular plan, rather than a comparison of plans.
4. Enrollment Limits. One commenter recommended that the State clarify that it seeks to retain its authority to impose enrollment limits on health plans, to enable the State to better balance membership among the health plans when in the best interest of the State and the beneficiaries.
5. Health Plan Enrollment and Selection. One commenter asked for clarification on whether the plan selection and auto-enrollment process applies only to newly eligible enrollees.
6. Managed Care. One commenter questioned the effectiveness of managed care as a health care delivery system, and urged the State to switch to the Primary Care Case Management (PCCM) model.
7. Safety Net Care Plans. One commenter asked the State to actively encourage safety net care plans to contract with the State.
8. Auto-Assignment Process. One commenter encouraged the State to use the auto-assignment process to reduce the overall cost of the QI program by encouraging lower health plan administrative costs.

9. Other Issues. Commenters also asked for clarification and expressed concerns regarding other aspects of the proposal, including the implementation date; retroactive eligibility; operationalization of the wait lists for HCBS; services for dual eligible beneficiaries, medically fragile children, and 1915(c) DD/ID waiver enrollees; the rate structure; and use of an administrative enrollment cap.

After considering all of the comments, the State elected to make the following changes to the application:

1. The State added two diagnoses to the list of eligible diagnoses in the Behavioral Health Protocol: PTSD and substance-induced psychosis.
2. The State amended the application to allow health plans to identify new enrollees with special health needs through a survey or a welcome phone call, with a phone call required for those who do not respond to a survey.
3. The State clarified the intent of its quality goals and emphasized the importance of applying the measures to comparable populations.
4. The State amended the description of enrollment limits to clarify that it seeks to retain its authority to impose enrollment limits on health plans.
5. The State revised the description of the health plan selection and enrollment process to clarify that the process applies to individuals who receive a choice notification.

The State determined that the remaining issues did not warrant any changes to the application because:

1. A number of the concerns lack support, relate to operational or procurement issues, or are informational in nature and do not require action on the part of the State.
2. Efforts are underway to transform the delivery of behavioral health services by unifying in a single program for the entire Medicaid population, and potentially with other populations for which the DOH/AMHD purchases services.
3. The State intends to continue using a managed care delivery system, as it allows the State to make the most efficient use of taxpayer dollars and provide high-quality care to the maximum number of individuals. The current managed care program allows for doctors, hospitals, and other providers to be organized to provide coordinated care, including use of health information exchange and provider-directed quality improvement programs. Hawaii does not have the infrastructure to be an effective PCCM program at this time, and conversion to PCCM could result in the loss of the significant amount of accumulated budget neutrality.
4. Because all health plans that meet minimum technical requirements will be awarded a contract, there is no need for a preference for safety net care plans.
5. The application waiver does not include the specific algorithm that will be used for auto-assignment. This will be addressed in the health plan contract.

C. Tribal Consultation

Consistent with 42 C.F.R. § 431.408(b) and Hawaii's State plan, the State notified its sole urban Indian Organization, Ke Ola Mamo, to seek its consultation, feedback and recommendation on behalf of designees of its health organization through written correspondence on November 20, 2012. *See* Attachment K. The State received no comments from Ke Ola Mamo in response to the notification.

The State continues to have an amicable and productive relationship with Ke Ola Mamo through written correspondence, email, and face-to-face meetings, as requested.

D. The Post-Award Public Input Process

The State will comply with the post-award public notice and input procedures in 42 C.F.R. § 431.420(c). Within six months of implementation of the renewal, and annually thereafter, the State will hold a public forum to solicit public comments on the progress of QUEST Integration, at which the public will have an opportunity to comment. The State will publish the date, time, and location of the public forum in a prominent location on its web site at least 30 days prior to the date of the public forum. The State will hold the forum at such time as to enable it to include a summary of the forum in the quarterly report associated with the quarter in which the forum will be held, as well as in its annual report to CMS.

XI. Demonstration Administration

Name: Noreen Moon-Ng, Medical Assistance Program Officer
Med-QUEST Division, PPDO
Telephone: (808) 692-8134
Email: nmoon-ng@medicaid.dhs.state.hi.us.

Attachment A

Summaries of EQRO Reports and Quality Assurance Monitoring, and Other Information and Documentation Regarding Quality of and Access to Care

DHS contracted with the Health Services Advisory Group, Inc. (HSAG) as its external quality review organization (EQRO) to monitor QUEST Expanded's managed care health plans. The 2012, 2011, and 2010 External Quality Review Reports of Results for the QUEST and QExA Health Plans (hereafter "EQR Reports"), which provide detail about the EQRO's activities, are available at http://www.med-quest.us/ManagedCare/consumerguides.html.

In 2012, HSAG performed the three federally mandated activities as set forth in 42 C.F.R. § 438.358—a follow-up review and evaluation of compliance with select federal managed care standards and associated State contract requirements, validation of performance measures/Healthcare Effectiveness Data and Information Set (HEDIS®) compliance audits, and validation of performance improvement projects (PIP). One optional EQR activity was also performed this year: a survey of adult members using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®).

External Quality Review Activity	Description	Findings, Conclusions, and/or Recommendations
Follow-up Review and Evaluation of Compliance with Federal Managed Care Standards and State Contract Requirements	In 2011, the plans received individual scores for each of the five areas reviewed for compliance. These five areas were related to the health plans' structure and operations, as described in the managed care regulations at 42 C.F.R. §§ 438.214-230. These scores can be viewed in the 2011 EQR Report at the link cited above. Following issuance of the final reports, the health plans were required by the MQD to submit corrective action plans ("CAP") for any standards scored "Partially Met" or "Not Met." For the 2012 re-evaluation of health plan compliance, HSAG used a monitoring tool to assess and document the health plans' implementation of CAPs in any standards where deficiencies had been identified during the 2011 review.	Following completion of their CAPs, each plan submitted documentation for HSAG's desk review and participated in an onsite and/or telephonic re-evaluation to ensure that the deficiencies were resolved and that compliance was attained. As needed, health plans were provided additional technical assistance and monitoring until demonstrating compliance with each standard. The results of each re-evaluation were provided to the plan and the MQD as a record of how the deficiencies were addressed. In the end, all health plans achieved full compliance with the standards during this calendar year: all 136 CAPS required as a result of the 2011 scores were "closed" and found compliant during the follow up review this year. More detail about these CAP closures can be found in the 2012 EQR Report at the link cited above.

Validation of Performance Measures/HEDIS®	HSAG performed independent audits of the HEDIS data for the QUEST and QExA health plans. Each HEDIS Compliance Audit incorporated a detailed assessment of the health plans' information systems capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. During the HEDIS audits, HSAG reviewed the performance of the health plans on State-selected HEDIS performance measures. The six measures reviewed for the QUEST health plans were: Childhood Immunization Status, Well-Child Visits in the First 15 Months of Life, Controlling High Blood Pressure, Comprehensive Diabetes Care, Ambulatory Care, and Chlamydia Screening in Women. The six measures reviewed for the QExA health plans were: Cholesterol Management for Patients with Cardiovascular Conditions, Comprehensive Diabetes Care, Adults' Access to Preventive/Ambulatory Health Services, Ambulatory Care, Inpatient Utilization—General Hospital/Acute Care, and Plan All-Cause Readmissions. The measurement period was calendar year 2011 and the audit activities were conducted concurrently with HEDIS 2012 reporting.	All plans were compliant with the National Committee for Quality Assurance's (NCQA) information systems standards. Plans varied in how they compared to the HEDIS 2011 national Medicaid percentiles. Those comparisons can be viewed in the 2012 EQR Report at the link cited above. Recommendations varied across the indicators. HSAG recommended that each plan target the lower-performing measures for improvement.
Validation of Performance Improvement Projects	Performance Improvement Projects (PIP) are designed to assess health care processes, implement process improvements, and improve outcomes of care. In 2012, HSAG validated two PIPs for each of the QUEST and QExA health plans. The QUEST plans were required to conduct PIPs on Access to Care and a second topic to improve a HEDIS measure. The plans' selected topics included childhood immunizations and controlling blood pressure. The QExA plans were required to conduct one PIP on improving the results of a HEDIS measure and a second PIP on a topic of the plan's choice, approved by the MQD. Both QExA plans conducted PIPs related to the HEDIS measure on diabetes care. For their second PIP topic, both QExA plans focused on an aspect of obesity care.	HSAG validated each QUEST and QExA health plans' PIPs by following standardized validation procedures, assessing the degree to which the projects were designed, conducted, and reported in a methodologically sound manner. This process facilitates improvements in care and generates confidence that reported improvement has, in fact, been accomplished. Following the review and validation of the health plans' 2012 projects, HSAG arrived at a handful of specific conclusions, which can be viewed in the 2012 EQR Report at the link cited above.

CAHPS®	The CAHPS health plan surveys are standardized survey instruments that measure members' satisfaction levels with their health care. For 2012, HSAG administered the CAHPS 4.0H Adult Medicaid Health Plan Survey to members of the QUEST and QExA health plans over 18 years of age.	The results of nine measures of satisfaction were reported. These measures included four global ratings (*Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often*) and five composite measures (*Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making*). The QUEST health plans' aggregate score was above the NCQA national adult Medicaid average on six measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, How Well Doctors Communicate, and Shared Decision Making. The QExA health plans' aggregate score was above the NCQA national adult Medicaid average on one measure, Rating of Personal Doctor, and was within two percentage points of the national average on three other measures: How Well Doctor's Communicate, Rating of Specialist Seen Most Often, and Rating of All Health Care. More details about the CAHPS findings can be found in the 2012 EQR Report at the link cited above.

In 2010, the Med-QUEST Division finalized a new Quality Strategy in compliance with 42 C.F.R. § 438.202, which was approved by CMS. A copy of the Quality Strategy is available at http://www.med-quest.us/ManagedCare/qualitystrategy.html and is attached to this application as Attachment C.

Under the Quality Strategy, the Med-Quest Division receives and reviews all monitoring and quality reports from the health plans, the Developmentally Disabled/ Intellectually Disabled 1915(c) waiver, the State of Hawaii Organ and Tissue Transplant program, and the EQRO. Findings from the reports are presented to various Quality Strategy Committees on a monthly rotation. The Committees are composed of representatives from the Quality Strategy Leadership Team, technical experts from the programs being reviewed, and other staff involved in contractual oversight and monitoring. The Committee meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The Committees recommend feedback to the health plans and programs, and corrective action is requested if needed.

The Med-QUEST Division also began implementing CMS's Quality Framework for home and community-based services (HCBS) in state fiscal year 2011. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. The State will use this template for HCBS monitoring.

Like all States, Hawaii compiles data for the CMS-Form 416, Annual EPSDT Participation Report. Form 416 includes the number of individuals eligible for EPSDT, the number receiving screening, the number referred for medical treatment, and the number provided dental services. Hawaii's 2011 Form 416 shows a screening ratio of 98%, and a participation ratio of 78%. The Form 416s from 2010 and from 2011 are included in this application in Attachment D.

Attachment B