

**Hawaii QUEST Expanded  
Section 1115 Demonstration Waiver**

**Interim Demonstration Evaluation Report**  
September 5, 2012

**Demonstration Year Ending: June 30, 2012**



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## Executive Summary

The demonstration evaluation period for this report is from January 1, 2008 to June 30, 2012. This concludes the 18<sup>th</sup> demonstration year for the QUEST Expanded Medicaid section 1115 demonstration waiver. The demonstration evaluation period has seen several significant initiatives for the QUEST Expanded program:

- **Development and implementation of the QUEST Expanded Access (QExA) program on February 1, 2009.**

Effective February 1, 2009, the majority of the fee-for-service (FFS) population was transitioned into managed care in the QUEST Expanded Access (QExA) program. The Medicaid population in QExA consists of beneficiaries 65 years or older or with a disability of any age. The QExA program has two health plans: ‘Ohana Health Plan and UnitedHealthcare Community Plan. As of June 30, 2012, the QExA program has approximately 45,000 beneficiaries. The QExA health plans provide a continuum of services to include primary, acute care, standard behavioral health, and long-term care services. The goals of the QExA program are:

- Improve the health status of the member population;
- Establish a “provider home” for members through the use of assigned primary care providers (PCPs);
- Establish contractual accountability among the State, the health plan and healthcare providers;
- Expand and strengthen a sense of member responsibility and promote independence and choice among members;
- Assure access to high quality, cost-effective care that is provided, whenever possible, in a member’s home and/or community;
- Coordinate care for the members across the benefit continuum, including primary, acute and long-term care benefits;
- Provide home and community based services (HCBS) to persons with neurotrauma;
- Develop a program that is fiscally predictable, stable and sustainable over time; and
- Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals.

- **Reprocurement of the QUEST program.**

The QUEST program is for Medicaid beneficiaries under the age of 65 without a disability. As of June 30, 2012, the QUEST program has approximately 239,000 beneficiaries. Through the demonstration evaluation period, the QUEST program had three health plans: AlohaCare, Hawaii Medical Services Association (HMSA), and Kaiser Permanente. In August 2011, the Med-QUEST Division (MQD) reprocured the QUEST program and added two additional health plans: ‘Ohana Health Plan and UnitedHealthcare Community Plan. The new QUEST procurement went into effect on July 1, 2012.

In the new procurement, MQD added or expanded on several new initiatives. These include:

- Value-based purchasing (e.g., patient centered medical homes and accountable care organizations);
- Financial incentives for improving quality to their members;

- Integration of medical and behavioral health services;
- Auto-assign algorithm based upon quality instead of cost; and
- Standardization of capitation payments amongst health plans.

MQD will report on the progress of these initiatives in the upcoming reports to CMS.

- **Implementation of the QUEST Adult Coverage Expansion (QUEST-ACE) program.**

In April 2007, the MQD implemented a new program called QUEST-ACE that provides medical assistance to a childless adult who is unable to enroll in the QUEST program due to the limitations of the statewide enrollment cap of QUEST as indicated in HAR §17-1727-26. The QUEST-ACE benefit package will encompass the same limited package of benefits currently provided under the QUEST-Net program. This program continues to reducing the number of uninsured and underinsured adults in our community.

- **Implementation of revised Quality Strategy.**

MQD implemented a new Quality Strategy in 2010 after receiving approval from CMS. As part of the implementation of the Quality Strategy, MQD has:

- Increased health plan monitoring;
- Standardized health plan reporting; and
- Implemented public reporting of health plan quality results.

- **Implementation of Pay for Performance through financial incentives in the QUEST program.**

MQD implemented a Pay for Performance program that provides financial incentives to QUEST health plans based upon improved quality results. Results of the implementation of this program during the demonstration year are provided below:

	AlohaCare	HMSA	Kaiser
Childhood Immunization (HEDIS 2010)	No	No	Yes
Chlamydia Screening (HEDIS 2010)	No	Yes	Yes
LDL Control- Comprehensive Diabetes Care (HEDIS 2010)	No	No	Yes
Getting Needed Care- Child CAHPS (CAHPS 2011)	No	No	No
Getting Needed Care- Adult CAHPS (CAHPS 2010)	Yes	No	No
ED Visits/1000 (HEDIS 2010)	Yes	Yes	Yes
Total PMPM	\$0.40	\$0.40	\$0.80

The implementation of these initiatives has occurred to decrease the uninsured population in Hawaii and improve the quality of services to Hawaii's Medicaid beneficiaries. Though results have not consistently met the benchmarks, MQD has identified several recommendations to improve future results. These recommendations include improved data gathering, collaborative partnership with health plans, and financial incentives to improve quality of services.

## **Information about the Demonstration**

### **Overview and Brief History of the Demonstration**

Hawaii's QUEST Expanded is a Med-QUEST Division (MQD) wide comprehensive section 1115 (a) demonstration that expands Medicaid coverage to children and adults. The demonstration creates a public purchasing pool that arranges for health care through capitated-managed care plans. The State of Hawaii implemented QUEST on August 1, 1994. The current extension period is from February 1, 2008 to June 30, 2013.

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 FPL. Low-income women and children and adults who had been covered by the two State-only programs were enrolled into fully capitated managed care plans throughout the State. 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. In order to be eligible for QUEST-Net, individuals must first have been enrolled in QUEST or Medicaid fee-for-service and may enroll in QUEST-Net when their income or assets rise above the QUEST or Medicaid fee-for-service eligibility limits. QUEST eligibles who are self-employed were previously assessed a premium. These individuals were allowed to opt for QUEST-Net as a source of insurance coverage.

In February 2007, the State requested to renew the QUEST demonstration, and the State reaffirmed its 2005 request to CMS to amend the Demonstration to advance the State's goals to develop a managed care delivery system for the Aged, Blind, and Disabled (ABD) population.

As a condition of the 2007 renewal the State was required to achieve compliance with the August 17, 2007, CMS State Health Official (SHO) letter that mandated by August 16, 2008, the State must meet the specific crowd-out prevention strategies for new title XXI eligibles above 250 percent of the Federal poverty level (FPL) for which the State seeks Federal Financial Participation (FFP). On March 30, 2009 the State requested that this provision be removed from the STCs. The State's request was a result of Public Law 111-3 The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), and the issuance of a Presidential memorandum to the Secretary of Health and Human services to withdraw the August 17, 2007 SHO letter. On February 6, 2009 the letter was withdrawn through SHO #09-001.

On February 18, 2010 the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment. The proposed amendment would provide a 12 month subsidy to eligible employers for approximately half of the employer's share for eligible employees newly hired between May 1, 2010 and April 30, 2011.

On July 28, 2010, the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment to eliminate the unemployment insurance eligibility requirement for the Hawaii Premium Plus (HPP) program. The HPP program was recently created to encourage employment growth and employer sponsored health insurance coverage in the State.

On August 11, 2010, Hawaii submitted an amendment proposal to add the pneumonia vaccine as a covered immunization. In addition to the July 28 and August 11, 2010 proposed amendments, several technical corrections were made regarding expenditure reporting for both Title XIX and XXI Demonstration populations.

On July 7, 2011, Hawaii submitted an amendment proposal to reduce QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL, including the elimination of the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. On July 8, 2011, Hawaii filed a coordinating budget deficit certification, in accordance with CMS' February 25, 2011, State Medicaid Director's Letter. This certification was approved by CMS on September 22, 2011. This certification grants the State a time-limited non-application of the maintenance of effort provisions in section 1902(gg) of the Act and provides the foundation for CMS to approve the State's amendment to reduce eligibility for non-pregnant, non-disabled adults with income above 133 percent of the FPL in both QUEST-Net and QUEST-ACE. On April 5, 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.

In the July 7, 2011 amendment, 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; provide QUEST Expanded Access (QExA) individuals with expanded primary and acute care benefits; remove the Hawaii Premium Plus program, a premium assistance program, due to a lack of Legislative appropriation to continue the program, and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

## **Population Groups Impacted**

Based on the goals and objectives of this demonstration, the targeted populations groups to be impacted are the most vulnerable and needy who do not have access to any other form of healthcare coverage. Individuals and family members who are sixty-five years old or older, or are blind, or are disabled are generally disqualified from the eligible groups. The scope of the population groups impacted by the demonstration has consistently and regularly been expanding from its initial focus. In its current form, the following populations are expected to benefit from this demonstration:

- Pregnant women in families whose income is up to 185 percent of the FPL.
- Infants and children in families whose income is up to 300 percent of the FPL.
- Adults and families with dependent children whose income is up to 100 percent of the FPL.
- Childless adults whose income is up to 100 percent of the FPL.
- Uninsured individuals in general.

## **Summary of the requirements for the evaluation in the special terms and conditions**

The State must provide an update on evaluation status monthly to the Centers for Medicare & Medicaid Services (CMS) during State/CMS calls.

The State must submit a draft evaluation design at the start of the waiver. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period when submitting a request for Demonstration extension. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

## **Purpose, aims, objectives, and goals of the demonstration**

### ***Goals and Objectives of the Demonstration***

The goals and objectives of the demonstration include:

- Developing a managed care delivery system for the Aged, Blind, and Disabled (ABD) population that would assure access to high quality, cost-effective care.
- Coordinating care for the ABD population across the care continuum (from primary care through long-term care).
- Increasing access to a health care benefit for low-income children.
- Developing a program design that is fiscally sustainable over time.
- Developing a program that places emphasis on the efficacy of services and performance.

### ***Hypotheses on the Outcomes of the Demonstration***

The state's hypotheses about the outcomes of the demonstration are based on State Quality Improvement Strategy targets. The following outcomes are expected in this demonstration:

- 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 (<130/80) to meet/exceed the 2010 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 75<sup>th</sup> 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): Improve performance on the state aggregate HEDIS 2010 Emergency Department Visits/1000 rate to meet/fall below the HEDIS 10th 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) clients: Increase by 5% the proportion of clients receiving HCBS instead of institutional-based long-term care services over the next year.

### ***Key Interventions Planned***

The key interventions planned in for the evaluation of the demonstration include:

- Monitoring of annual Healthcare Effectiveness Data and Information Set (HEDIS) measures gathered from health plans from both the QUEST and QExA programs
- Monitoring of utilization of home and community based services in the long term supports and services population
- Monitoring of enrollment numbers monthly
- Conducting CAHPS surveys annually
- Conducting provider surveys biennially

## Evaluation Design

### Management and Coordination of Evaluation

#### *Organization Conducting the Evaluation*

The evaluation will be conducted internally within Med-QUEST Division (MQD), primarily by the Health Care Services Branch (HCSB). The MQD works in concert with its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), on collection of information from the health plans. This includes validation of several HEDIS measures, performing annual CAHPS survey and biennial provider surveys.

The HCSB receives the raw data from HSAG and analyzes it against demonstration goals. The MQD team that conducts the evaluation includes:

- Jon Fujii, Research Officer- primary lead
- Lily Ota, RN, Nurse Consultant
- Dr. Curtis Toma, MQD Medical Director
- Madi Silverman, Home & Family Access Program Manager
- Christian Butt, Contract and Compliance Section Administrator
- Patricia M. Bazin, Health Care Services Branch Administrator
- Brian Pang, Finance Officer

#### *Timeline for Implementation of the Evaluation and for Deliverables*

##### Summary of Timeline for Annual Quality Activities

Time Frame	Activity
March	Mail CAHPS surveys to Medicaid beneficiaries
April/May	Health plan site visit by MQD and EQRO to gather HEDIS data from previous year
May	Close CAHPS surveys to Medicaid beneficiaries
June	Preliminary HEDIS results due to EQRO
July	Final HEDIS results released by EQRO to MQD
July	EQRO releases preliminary CAHPS star report to MQD
September	EQRO releases final CAHPS star report to MQD
October	Analysis of health plan HEDIS results to NCQA quality compass (i.e., compare to 75 <sup>th</sup> and 90 <sup>th</sup> results for Medicaid populations)
November	Develop consumer guides for QUEST and QExA health plans <small>Note: the consumer guide is a summary of several HEDIS measures and CAHPS survey results for health plans in both the QUEST and QExA programs that is provided to the public</small>
December	Release of the following items for public reporting: <ul style="list-style-type: none"><li>• EQRO annual report</li><li>• QUEST Consumer Guide</li><li>• QExA Consumer Guide</li></ul>

### Summary of Timeline for Biennial Quality Activities

Time Frame	Activity
April	Mail survey to Medicaid health plan providers
June	Close survey to Medicaid health plan providers
October	EQRO releases final provider survey results to MQD

### Summary of Timeline for Annual Deliverables

Time Frame	Activity
February	Submit quarterly report for September to December
March	Submit annual report for State Fiscal Year (July to June) of previous year
May	Submit quarterly report for January to March
August	Submit quarterly report for April to June
November	Submit quarterly report for July to August

### Summary of Timeline for Compilation of Demonstration Evaluation Report

July	Analyze data from previous demonstration years
August	Compile information into report
September	Submit report

## Performance Metrics

### Summary of Performance Metrics

When observing the various measures below, and unless stated otherwise, remember that a higher numeric score is considered positive and a lower numeric score is considered negative.

Measures	Reported Years	Latest Score	Target Score
<b>HEDIS Measures:</b>			
Use of Appropriate Medications for People With Asthma, Total (ASM)	HEDIS 2008-2012	75.6%	90.5%
Eye Exam (CDC)	HEDIS 2008-2012	59.4%	63.7%
HbA1c Testing (CDC)	HEDIS 2008-2012	81.2%	87.1%
HbA1c Control <7.0% (CDC)	HEDIS 2008-2012	24.2%	41.3%
Poor HbA1c Control >9% (CDC) #	HEDIS 2008-2012	52.8%	34.9%
LDL-C Screening (CDC)	HEDIS 2008-2012	77.2%	80.3%
LDL-C Level <100 mg/dL (CDC)	HEDIS 2008-2012	34.0%	41.4%
Medical Attention for Nephropathy (CDC)	HEDIS 2008-2012	79.0%	82.5%
Blood Pressure Controlled <140/80 mm Hg (CDC) *	HEDIS 2008-2012	36.2%	44.2%
LDL-C Screening (CMC)	HEDIS 2008-2012	81.0%	85.9%
LDL-C level <100 mg/dL (CMC)	HEDIS 2008-2012	41.7%	50.0%
Controlling High Blood Pressure (CBP)	HEDIS 2008-2012	47.1%	63.7%
Child Immunizations Status, Combination 2 (CIS)	HEDIS 2008-2012	61.9%	80.7%
Breast Cancer Screening (BCS)	HEDIS 2008-2012	49.7%	57.4%
Cervical Cancer Testing (CCS)	HEDIS 2008-2012	63.7%	74.2%
Chlamydia Screening (CHL)	HEDIS 2008-2012	58.2%	63.4%
Emergency Department Visits, per 1,000 member months, Total (AMB) @	HEDIS 2008-2012	43.0	44.4
<b>EPSDT Measures:</b>			
Screening Ratio	FFYE 2007-2011	0.98	0.82
Participant Ratio	FFYE 2007-2011	0.78	0.64
<b>CAHPS Measures:</b>			
Rating of Health Plan	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.51 QExA: 2.25	2.61
Rating of Personal Doctor	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.53 QExA: 2.54	2.65
Rating of Specialist Seen Most Often	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.48 QExA: 2.43	2.60
How Well Doctors Communicate	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.65 QExA: 2.57	2.70
Getting Needed Care	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.26 QExA: 2.23	2.43
Getting Care Quickly	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.29 QExA: 2.30	2.65
<b>Physicians' Assessment Measures</b>			
Attitude toward Hawaii Med-QUEST	2009, 2011	34.7%	N/A
Satisfaction with reimbursement from the Med-QUEST health plan	2009, 2011	26.4%	N/A
Does the health plan personnel have the necessary professional knowledge	2009, 2011	24.8%	N/A
Impact of the health plan's UM (prior authorizations) on quality care	2009, 2011	19.1%	N/A
<b>Med-QUEST Internal Measures</b>			
HCBS % of Nursing Home Population	2008 - 2012	68.5%	N/A
Cumulative Savings from Increase in HCBS Population	2008 - 2012	\$80,123,000	N/A
Medicaid Enrollment	2008 - 2012	287,902	N/A
Budget Neutrality Savings	DY 18	\$1,833,414,530	> 0

(#) Unlike the other measures, for this measure higher numeric scores are considered negative and lower numeric scores are considered positive. Accordingly, the targets for the HEDIS measures represent the score for the national Medicaid 25<sup>th</sup> %ile, NOT the score for the 75<sup>th</sup> %ile.

(@) Unlike the other measures, for this measure higher numeric scores are considered negative and lower numeric scores are considered positive. Accordingly, the targets for the HEDIS measures represent the score for the national Medicaid 10<sup>th</sup> %ile, NOT the score for the 75<sup>th</sup> %ile.

(\*) This numerator changed from BP <130/80 to BP < 140/80 in HEDIS 2011.

### ***Population Groups of Enrollees for which Data will be Analyzed***

- Individuals with a diagnosis of Asthma.
- Individuals with a diagnosis of Diabetes Mellitus.
- Individuals with a diagnosis of Cardiovascular disease.
- Children up to 21 years old.
- Women ages 21 years and older.

### ***Methods by which the data collected will be analyzed, including the statistical methodologies to be used***

The results of the data collection and calculation 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' Hawaii statewide QUEST 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 calculated values. These factors could be internal to DHS, specific to a plan's operations, or external at a state or national level. Either way, there will be a discussion on how we believe these factors are exerting influence on the values.

Initiatives related to each measure will be discussed. These may be conducted by the health plan or by the MQD, and in each case was implemented to improve the quality of care or collection of data related to the measure calculation.

### **Integration of the State Quality Improvement Strategy**

The MQD started working with CMS, with Gary Jackson as the contact, in January 2010 on the revision of the Quality Strategy. MQD followed the CMS toolkit and checklist for State Quality Strategies as well as the Delaware Quality Strategy as a template. In May 2010, MQD submitted the revised Quality Strategy to CMS. The public comment period ended on September 9, 2010 and MQD received approval of its Quality Strategy. A copy of the Quality Strategy is posted at the MQD website ([www.med-quest.us](http://www.med-quest.us)).

MQD's continuing goal is to ensure that our clients receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. MQD 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. HEDIS measures that the health plans report

to us are reviewed and updated each year. As MQD evaluates the demonstration, the Quality Strategy is used as the framework for the evaluation.

The Health Services Advisory Group (HSAG) is the MQD's External Quality Review Organization (EQRO). Many of the MQD's quality activities are completed in partnership with HSAG. HSAG compiles and validates both QUEST and QExA HEDIS measures annually. In addition, HSAG administers both the CAHPS and provider surveys for MQD.

HSAG provides this data to us in the timeframe established in the *Timeline for Implementation of the Evaluation and for Deliverables* section. MQD analyzes this data as part of the annual parts of the evaluation of the demonstration.

Finally, HSAG submits an annual report to MQD in November of each year. MQD posts this report on our website ([www. med-quest.us](http://www.med-quest.us)) under the Managed Care/Consumer Guides section for public awareness.

Steps were taken to ensure that measures in the State Quality Improvement Strategy were reported here. These measures included comparisons to the targets from the State Quality Improvement Strategy. There are also measures that are not a part of the State Quality Improvement Strategy in this report.

## Measures

The graphs used to illustrate the various measures are, unless otherwise noted, scaled from 0% to 100%. This was done to facilitate comparisons between graphs and to present a consistent scale of measurement.

Initiatives related to these measures are reported separately in a subsequent section of this report.

### HEDIS Measures

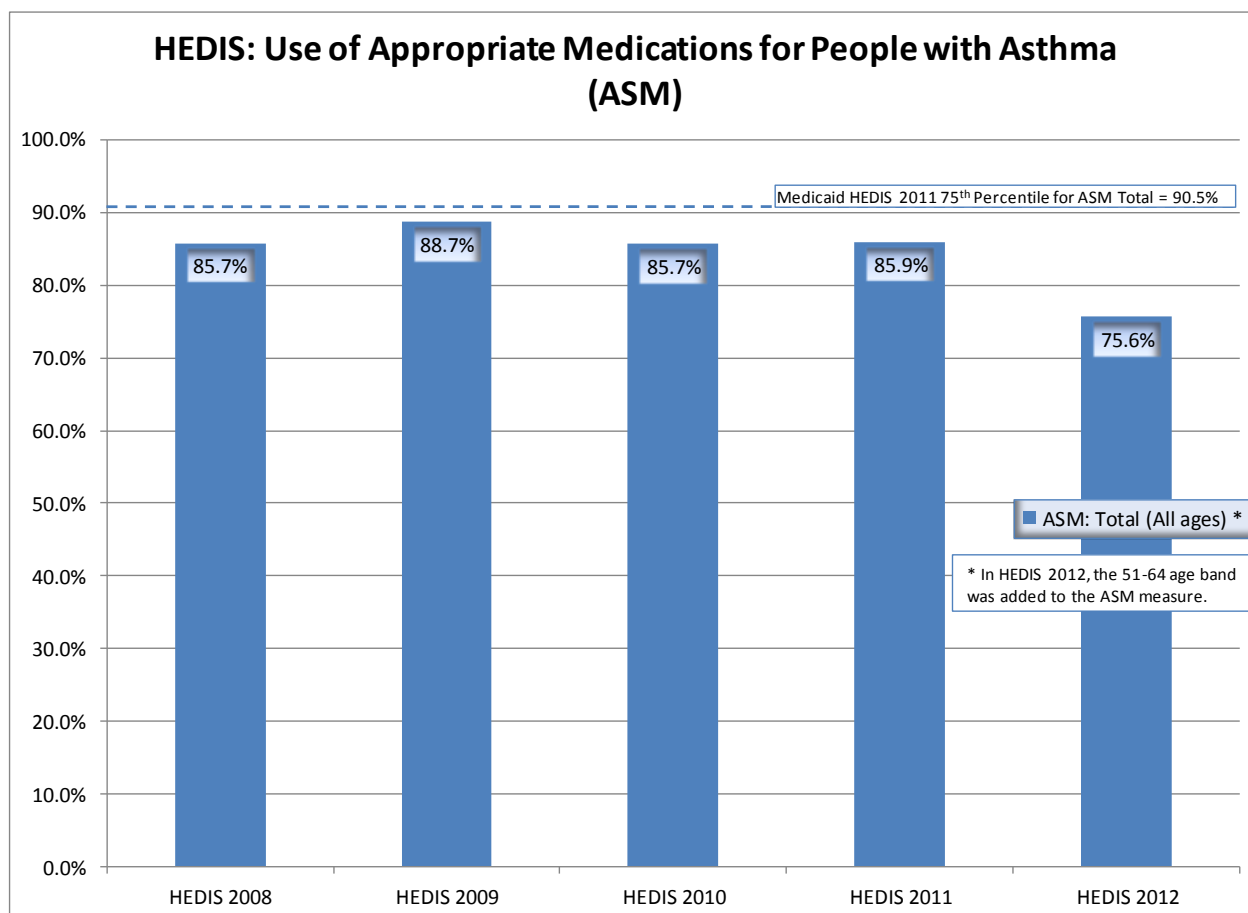
The Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure both the quality of healthcare delivered to, as well as the overall healthcare utilization levels of, the Hawaii QUEST and QExA recipients.

The HEDIS measures mostly involve ratios of a target behavior over the entire population that is eligible for that behavior. Occasionally ratios are reported on a sample of the population instead of the entire population, but on these occasions there are intensive internal claim audits applied to a sample of the claims. The HEDIS measures are based on self-reported HEDIS reports received from the five individual QUEST and QExA plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan, and UnitedHealth Community Plan. It should be noted that prior to HEDIS 2011, only the QUEST recipients are reflected in the HEDIS scores. HEDIS reports from the plans are based on a calendar year period, a twelve-month period beginning in January 1 and ending on December 31 of the report year, and are due to Med-QUEST on approximately June 30 of the following year. These are sent via standard NCQA electronic file (IDSS) to Med-QUEST, and are then weight-averaged to create composite HEDIS measures for the entire Med-QUEST population for a single year. The plans are required to report on most of the HEDIS measures in each year. The definitions of the various HEDIS measures reported by the plans are no different from the national standard HEDIS definitions – we do not have any HEDIS-like measures. All five plans are concurrently audited by our External Quality Review Organization (EQRO).

Annual audits on how the plans calculate and report their HEDIS scores are conducted by the HEDIS-certified External Quality Review Organization (EQRO) entity under contract with, and under the direction of, Med-QUEST. Typically, these audits involve a sample of three to six HEDIS measures. The measures presented below are a small sample of the complete set of HEDIS measures that are reported each year,

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. For most measures scores are reported for each year from 2008 to 2012. A comparison is made to the 2011 National Medicaid Median 75<sup>th</sup> Percentile score to bring perspective to where we score on a national level. Our Quality Strategy sets the National Medicaid 75<sup>th</sup> Percentile score as the target score for most of the HEDIS measures.

For all of the HEDIS measures except for the CDC: Poor HbA1c Control >9% and AMB: Emergency Department Visits, higher numeric scores are considered positive and lower numeric scores are considered negative; for these measures lower numeric scores are considered positive and higher numeric scores are considered negative.



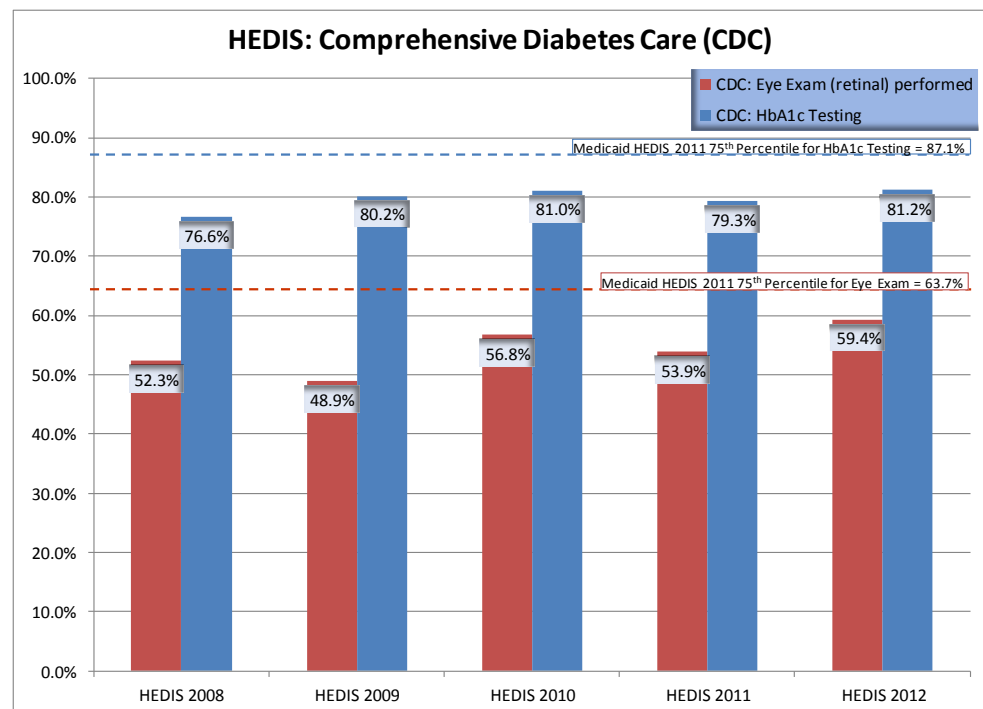
#### ASM:

- The statewide Medicaid percentage of members 5-64 years of age identified as having persistent asthma and who appropriately prescribed medication has varied between 75% and 89% from 2008 to 2012, with the highest rate of 88.7% occurring in 2009 and the lowest rate of 75.6% occurring in 2012. Note that although the 51-64 year of age group was added in 2012, removing this age group would not have increased the 2012 score past 76.0%.
- The 2012 year's score fell significantly from the previous four-year range between 85% and 88%, clearly falling out of the historical trend for this measure on the negative side.
- The HI Quality Strategy target percentage for the ASM measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 90.5%, which was better than all of the years reported.



## CDC – Eye Exam:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had a retinal eye exam performed varied between 48% and 60% from 2008 to 2012, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.



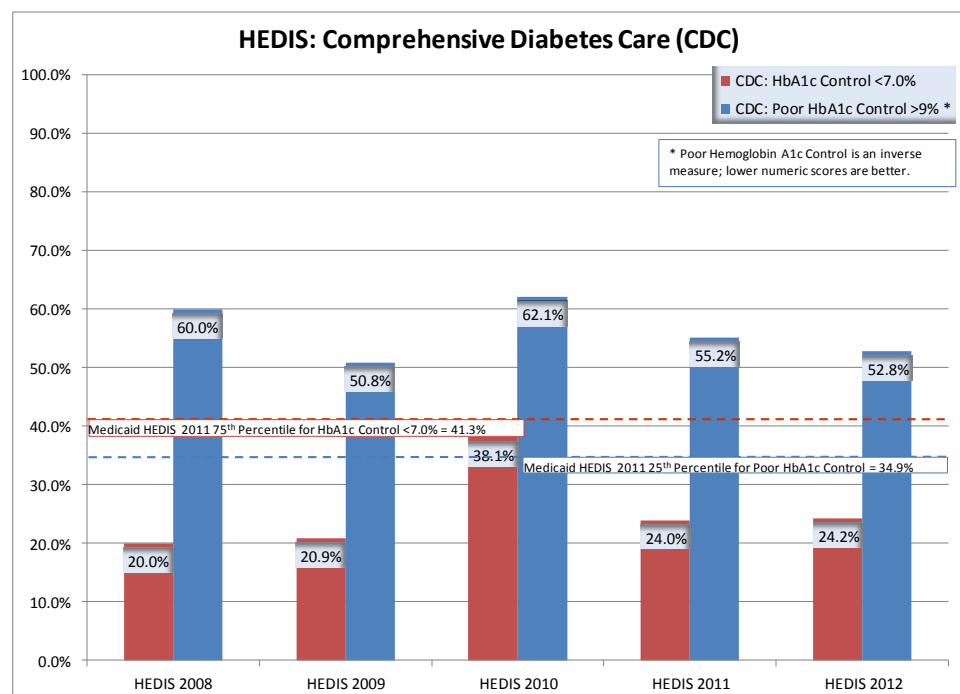
- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.
- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 63.7%, which was better than all of the years reported.

## CDC – HbA1c Testing:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an HbA1c test performed varied between 76% and 82% from 2008 to 2012, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.
- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.
- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 87.1%, which is above all of the years reported.

## CDC – HbA1c Control <7.0%:

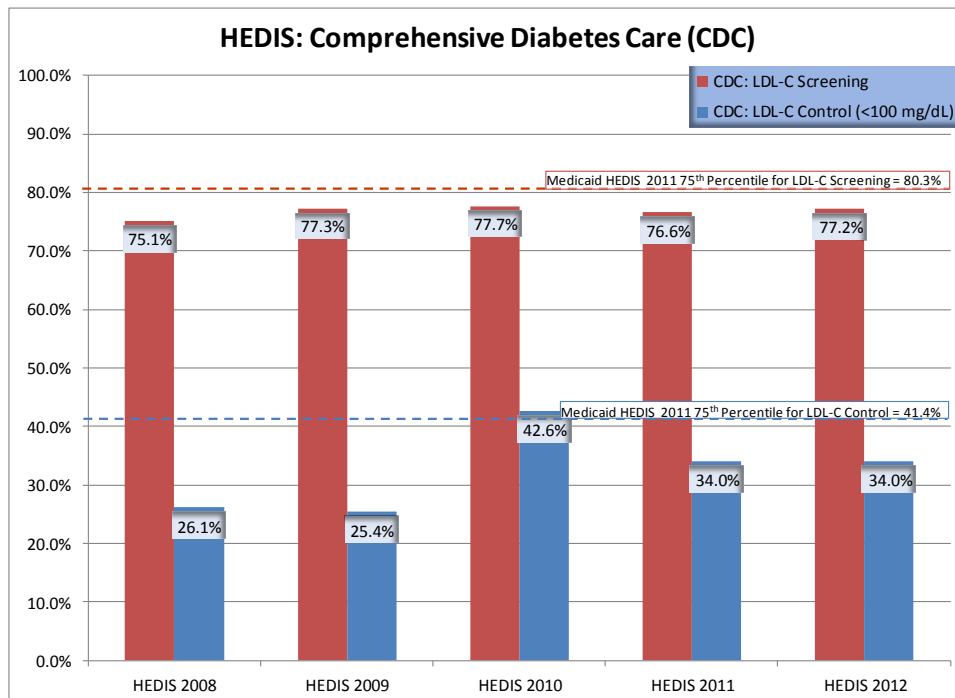
- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under good control varied between 20% and 39% from 2008 to 2012, with the highest rate of 38.1% occurring in 2010 and the lowest rate of 20.0% occurring in 2008.



- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the earliest year (2008) reported the lowest rate. There is what seems like an outlier score in 2010 of 38.1%, especially when considering the four other years' scores were bunched between 20.0% and 24.2%
- The HI Quality Strategy target percentage for the CDC – HbA1c Control <7.0% measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 41.3%, which is above all of the years reported.

## CDC – HbA1c Poor Control >9.0%:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control varied between 63% and 50% from 2008 to 2012, with the highest rate of 62.1% occurring in 2010 and the lowest rate of 50.8% occurring in 2009. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.
- There is a slight downtrend (good) to flat trend in the rates of the five years reported. The last three years' score went from 62.1% to 55.2% to 52.8%, yet the lowest score occurred in 2009 (50.8%).
- The HI Quality Strategy target percentage for the CDC – HbA1c Poor Control >9.0% measure is the 25<sup>th</sup> percentile of the national Medicaid population. For the 2011 this target was 34.9%, which is below (not good) all of the years reported.



#### CDC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an LDL-C screening performed varied between 75% and 78% from 2008 to 2012, with the highest rate of 77.7% occurring in 2010 and the lowest rate of 75.1%

occurring in 2008.

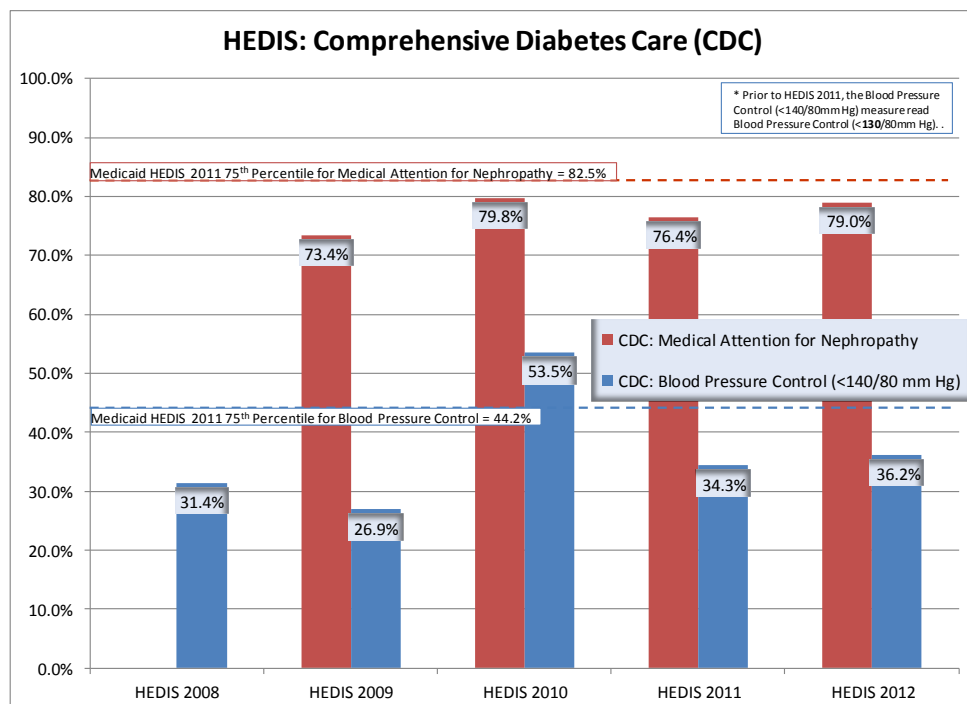
- There is a flat trend (no trend) in the rates of the five years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 80.3%, which is higher than all of the years reported.

#### CDC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had LDL-C under control varied between 25% and 43% from 2008 to 2012, with the highest rate of 42.6% occurring in 2010 and the lowest rate of 25.4% occurring in 2009.
- There is a flat trend (no trend) in the rates of the five years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 80.3%, which is higher than all of the years reported.

## CDC – Medical Attention for Nephropathy:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had medical attention for nephropathy varied between 73% and 80% from 2009 to 2012, with the

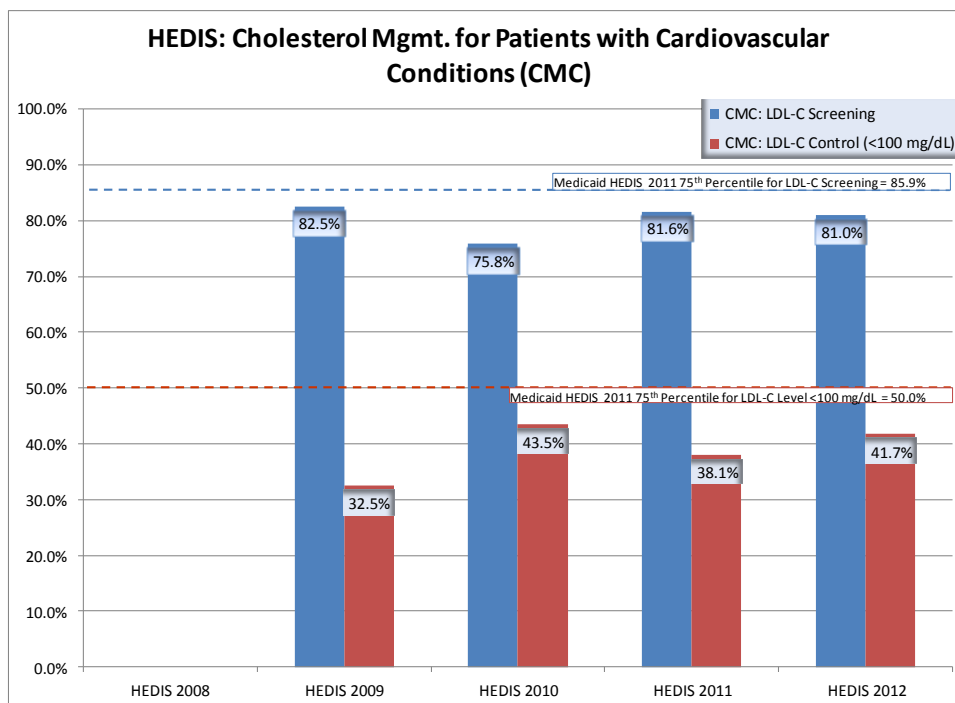


highest rate of 79.8% occurring in 2010 and the lowest rate of 73.4% occurring in 2009. Note that this was a new measure in 2009.

- There is a slight up trend in the rates of the four years reported. The lowest rate was reported in the first year (2009), and the latest year reported (2012) had a rate (79.0%) not much lower than the 79.8% in 2010.
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 this target was 82.5%, which is higher than all of the years reported.

## CDC – Blood Pressure Control (<140/80 mm Hg):

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had blood pressure under control below <140/80 mm Hg varied between 26% and 54% from 2008 to 2012, with the highest rate of 53.5% occurring in 2010 and the lowest rate of 26.9% occurring in 2009.
- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010 (which looks like an outlier), the highest two scores were in 2011 (34.3%) and 2012 (36.2%).
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 44.2%, which is higher than all of the years reported except for in 2010.



#### CMC – LDL-C Screening:

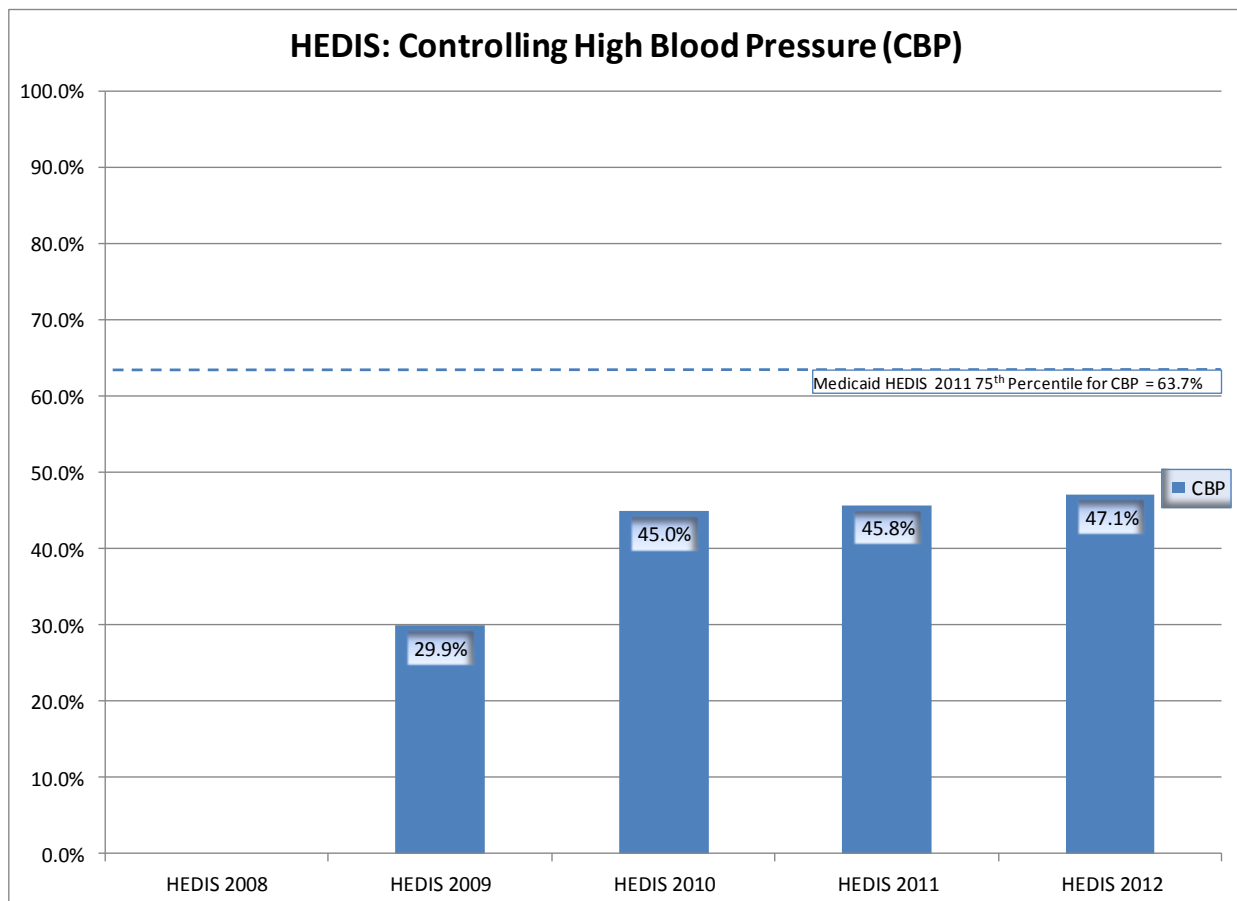
- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had an LDL-C screening performed varied between 75% and 82% from 2009 to 2012, with the highest rate of 82.5% occurring in 2009 and the lowest

rate of 75.8% occurring in 2010. Note that the first year for this measure is 2009.

- There is a flat trend (no trend) in the rates of the four years reported. The highest rate was reported in the first year (2009), the lowest rate occurred in the second year (2010), and the remaining two years' scores fell between these.
- The HI Quality Strategy target percentage for the CMC – LDL-C Screening measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 85.9%, which is higher than all of the years reported.

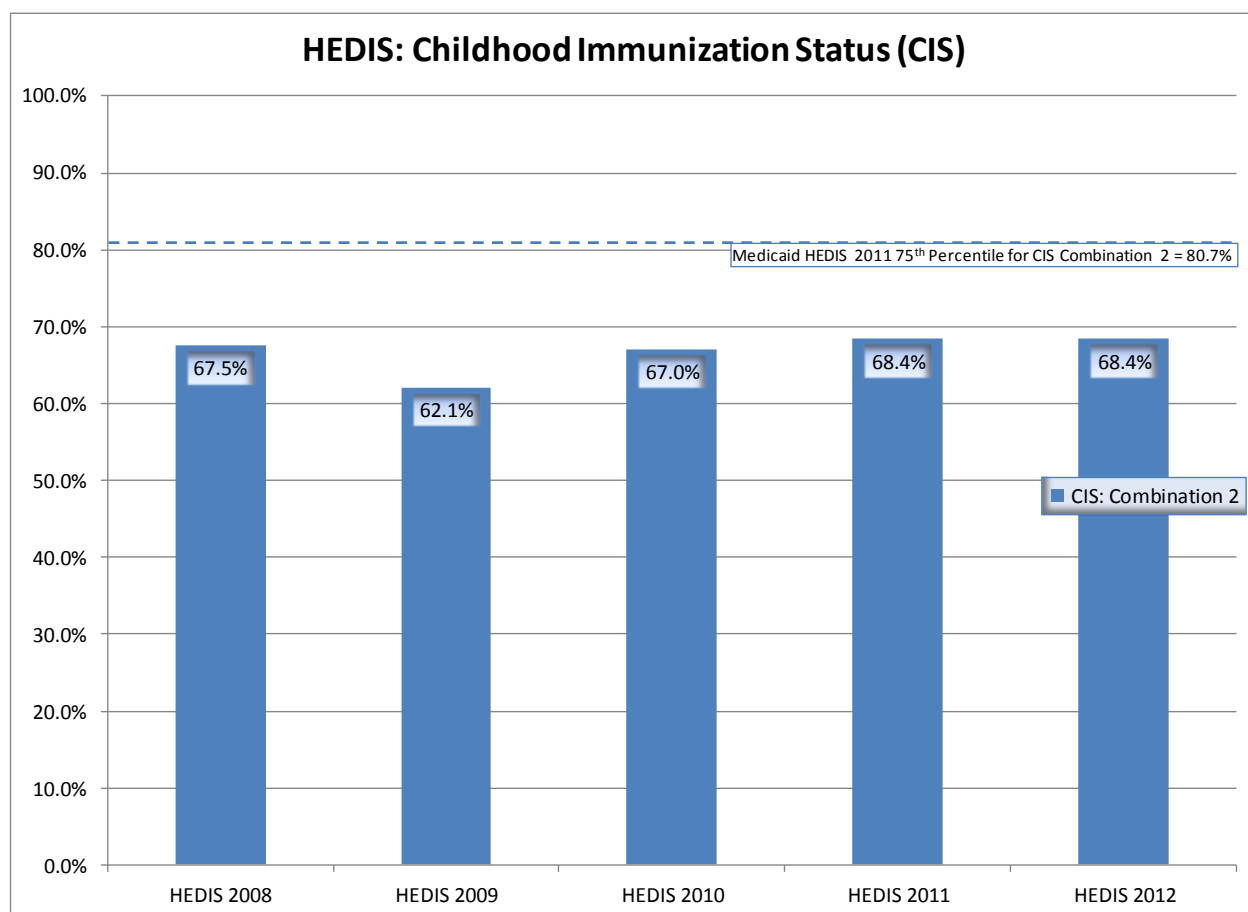
#### CMC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had LDL-C under control varied between 32% and 43% from 2009 to 2012, with the highest rate of 43.5% occurring in 2010 and the lowest rate of 32.5% occurring in 2009. Note that the first year for this measure is 2009.
- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010, the highest two scores were in 2011 (38.1%) and 2012 (41.7%).
- The HI Quality Strategy target percentage for the CMC – LDL-C Control measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 50.0%, which is higher than all of the years reported.



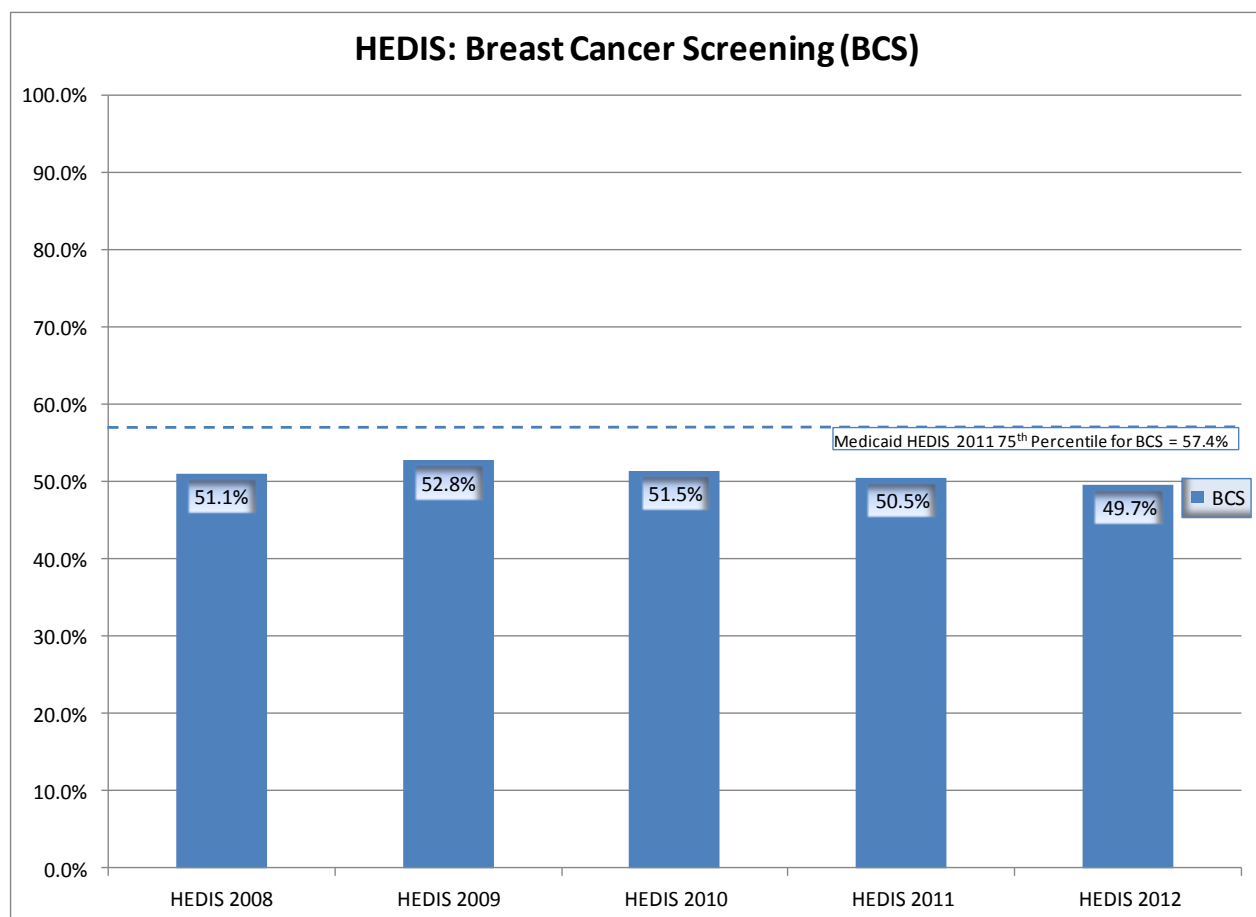
#### CBP:

- The statewide Medicaid percentage of members 18-85 years of age who had a diagnoses of hypertension and whose blood pressure was under control varied between 29% and 48% from 2009 to 2012, with the highest rate of 47.1% occurring in 2012 and the lowest rate of 29.9% occurring in 2009. Note that the first year for this measure is 2009.
- There is a clear up trend in the rates of the five years reported. From 2009 thru 2012, each subsequent year's score is higher than the last.
- The HI Quality Strategy target percentage for the CBP Control measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 63.7%, which is higher than all of the years reported.



#### CIS:

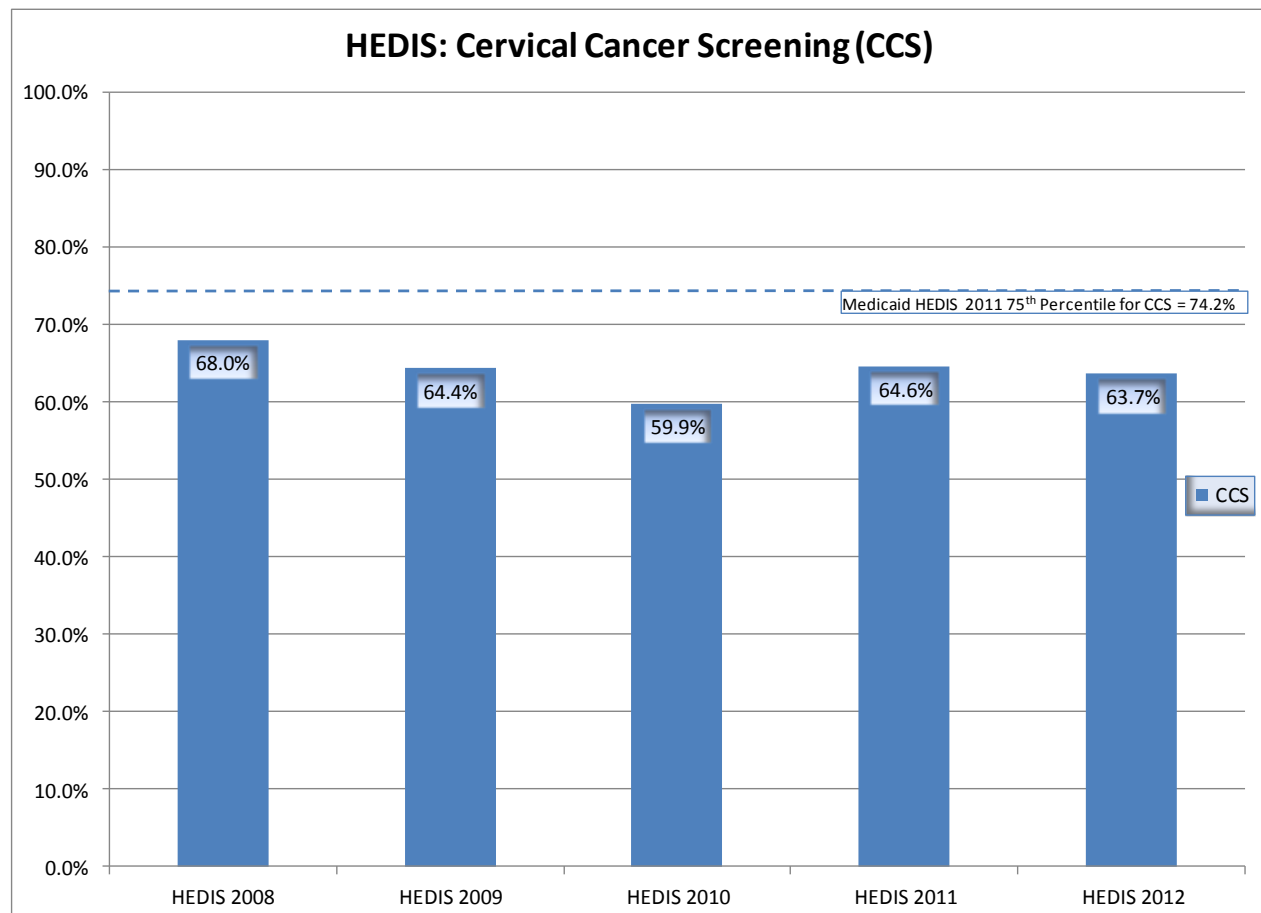
- The statewide Medicaid percentage of children 2 years of age who, by their second birthday, had received the entire suite of Combination 2 vaccines (4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB & 1 VZV) varied between 62% and 69% from 2008 to 2012, with the highest rate of 68.4% occurring in 2011 & 2012 and the lowest rate of 62.1% occurring in 2009.
- There is a slight up trend in the rates of the five years reported. Excluding the 2008 rate, the rates increased from 2009 to 2012 by 4.1 percentage points with not yearly decreases.
- The HI Quality Strategy target percentage for the CIS measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 80.7%, which is higher than all of the years reported.



#### BCS:

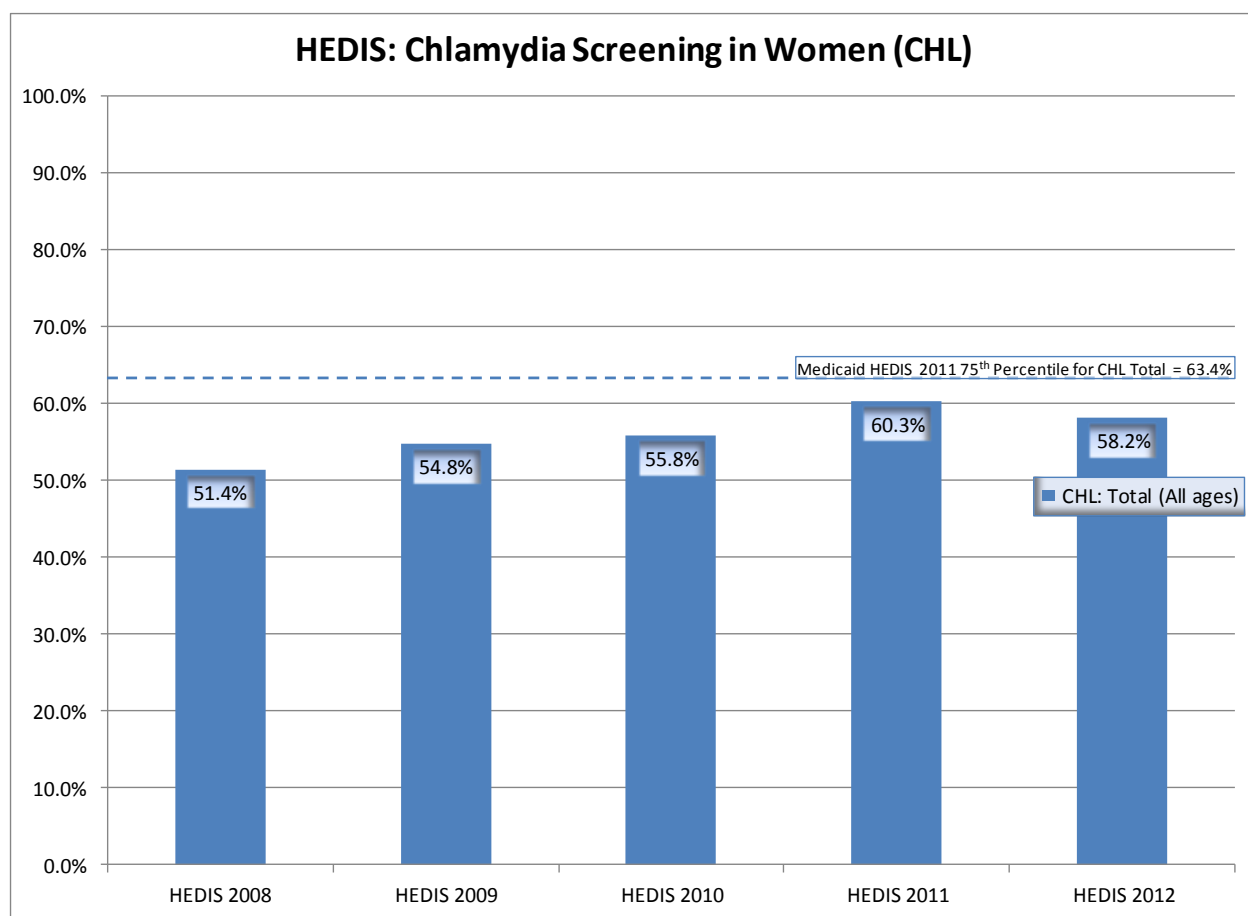
- The statewide Medicaid percentage of women 40 - 69 years of age who had a mammogram to screen for breast cancer varied between 49% and 53% from 2008 to 2012, with the highest rate of 52.8% occurring in 2009 and the lowest rate of 49.7% occurring in 2012.
- There is a clear down trend in the rates of the five years reported. Removing the 2008 score, the rates go consistently down approximately 1% per year from 52.8% (2009) to 49.7% (2012).
- The HI Quality Strategy target percentage for the BCS measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 57.4%, which is higher than all of the years reported.





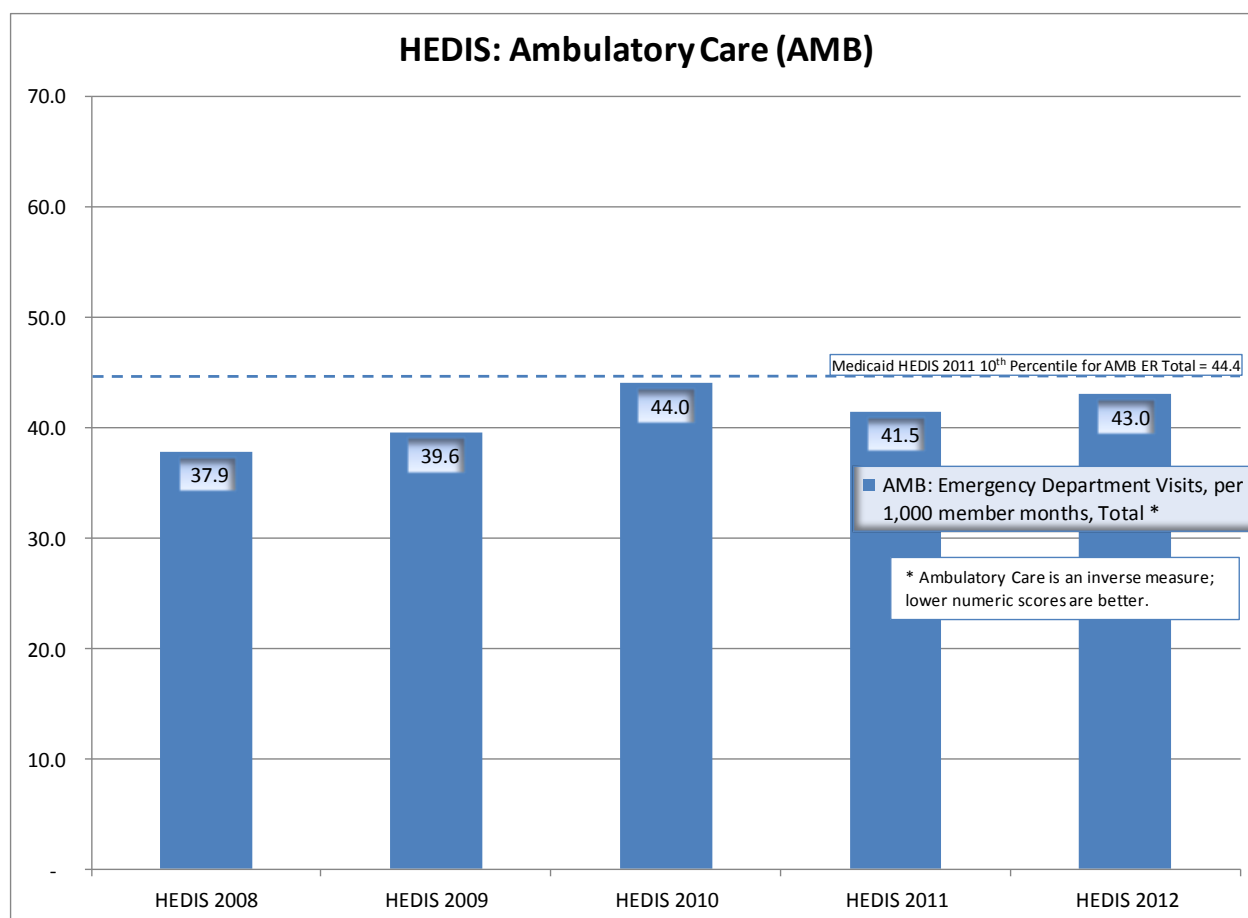
#### CCS:

- The statewide Medicaid percentage of women 21 - 64 years of age who received one or more Pap tests to screen for cervical cancer varied between 59% and 68% from 2008 to 2012, with the highest rate of 68.0% occurring in 2008 and the lowest rate of 59.9% occurring in 2010.
- There is a slight down trend in the rates of the five years reported. Removing the middle 2010 score, the highest rate (68.0%) is in 2008 and the lowest rate (63.7%) is in 2012.
- The HI Quality Strategy target percentage for the CCS measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 74.2%, which is higher than all of the years reported.



#### CHL:

- The statewide Medicaid percentage of women 16 - 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year varied between 51% and 61% from 2008 to 2012, with the highest rate of 60.3% occurring in 2011 and the lowest rate of 51.4% occurring in 2008.
- There is a clear up trend in the rates of the five years reported. Removing the most recent score, the lowest rate (51.4%) is in 2008 and the highest rate (60.3%) is in 2011.
- The HI Quality Strategy target percentage for the CCS measure is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 63.4%, which is higher than all of the years reported.



#### AMB:

- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 37.0 and 44.0 from 2008 to 2012, with the highest rate of 44.0 occurring in 2010 and the lowest rate of 37.9 occurring in 2008. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.
- There is a clear up trend (bad) in the rates of the five years reported. Putting aside the high rate in 2010, the lowest rate (37.9) occurred in 2008, and the highest rate (43.0) occurred in 2012.
- The HI Quality Strategy target percentage for the CCS measure is the 10<sup>th</sup> percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 44.4, which is higher (good) than all of the years reported.

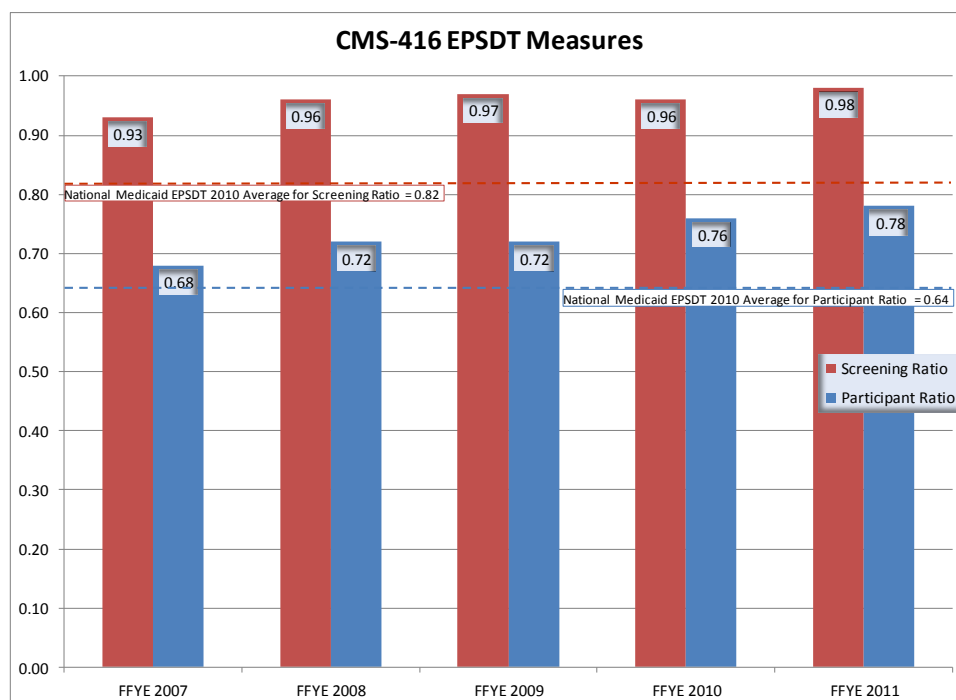
## EPSDT Measures

The EPSDT measures are included in this report to measure the degree of comprehensive and preventive child healthcare for individuals under the age of 21.

The EPSDT measures are based on self-reported EPSDT reports received from the five individual plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan and UnitedHealth Community Plan. The scores from these individual plan reports are then weight-averaged to calculate Hawaii composite scores. All five plans create custom queries to calculate their scores, and all of the EPSDT measures are reported in each year. The format and method of calculation for the various EPSDT measures reported by the plans is no different from the national standard CMS-416 EPSDT format, aside from small differences in the periodicity of visits by state. **Audits on how the plans calculate and report their EPSDT scores are not currently conducted;** future health plan audits on the EPSDT calculation and reporting are being considered. EPSDT reports from the plans are based on the federal fiscal year, a twelve month period beginning in October 1 and ending on September 30 of the report year, and are due to Med-QUEST on the last day of February in the year following the report year. The measures presented below are a small sample of the complete set of EPSDT measures that are reported each year.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Scores are reported for each year from 2007 to 2011. A comparison is made to the National Medicaid EPSDT Average score – the 50<sup>th</sup> percentile – to bring perspective to where we stand on a national level.

For all of the EPSDT measures, higher numeric scores are considered positive and lower numeric scores are considered negative.



#### EPSDT – Screening Ratio:

- The statewide Medicaid screening ratio from the EPSDT report varied between 0.93 and 0.98 from 2007 to 2011, with the highest rate of 0.98 occurring in 2011 and the lowest rate of 0.93 occurring in 2007.

- There is a clear up trend in the rates of the five

years reported. The lowest rate of 0.93 was reported in the first year (2007), and the highest rate of 0.98 was reported in the last year (2011), with a mostly steady uptrend in between.

- The MQD quality strategy has no benchmark for the EPSDT Screening Ratio. For comparison purposes in 2010 – the latest reported year – then national average is 0.82, which is lower than all of the years reported.

#### EPSDT – Participant Ratio:

- The statewide Medicaid participant ratio from the EPSDT report varied between a high of 0.78 occurring in 2011 and the lowest rate of 0.68 occurring in 2007.
- There is a clear up trend in the rates of the five years reported. Each year's score was at least equal to, and more often greater than, the previous year's score, ending in a high of 0.78 in 2011.
- The MQD quality strategy has no benchmark for the EPSDT Participant Ratio. For comparison purposes in 2010 – the latest reported year – then national average is 0.64, which is lower than all of the years reported.

## CAHPS Measures

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are included in this report to measure the degree of recipient satisfaction with Hawaii Med-QUEST.

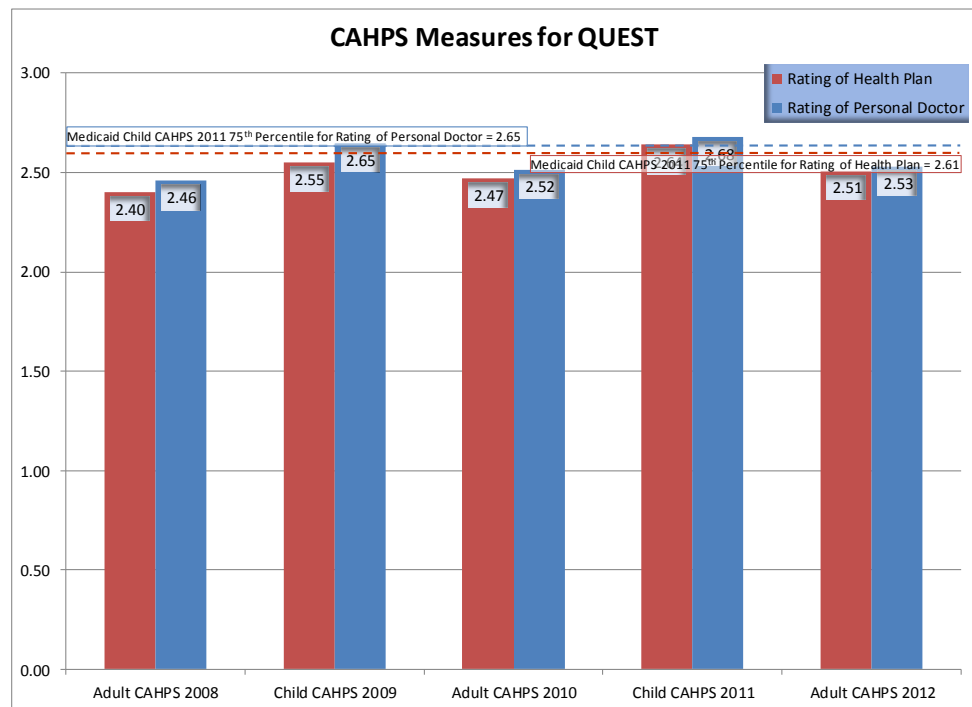
Med-QUEST is required by the State of Hawaii to conduct an annual HEDIS CAPHS member survey. The CAHPS measures are based on annual surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The method of these surveys and the definitions of the various CAHPS measures strictly adhere to required national standard CAHPS specifications. The surveys were sent to a random sample of recipients. The overall survey response rate was 45% in 2011 and 38% in 2012. The “question summary rates” are reported for the different measures used in this report. The Adult Medicaid surveys were done in 2008, 2010 & 2012, and the Child Medicaid survey was done in 2009 & 2011. All five years results are reported here. The survey asks which health plan the respondent is currently enrolled in, which enables the scores to be summarized by plan as well as program (QUEST vs. QExA). Since the QExA program was begun in February 2009, there are a limited number of years of CAHPS data for QExA. This report presents the rates of the QUEST population and the QExA population in separate charts. Going forward and as required by the State of Hawaii, these surveys will continue to be done annually, with the Child and Adult surveys being done in alternating years. The measures presented below are but a small sample of the entire slate of questions that were presented on the survey.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Because the populations surveyed are different between the Adult and Child surveys, these surveys are analyzed separately as the data allows. A comparison is made to the National Medicaid Child CAHPS 2011 75<sup>th</sup> percentile score to bring perspective to where we score on a national level; at the time of this report the National Medicaid Child CAHPS 2012 percentile scores were not available. The National Medicaid 75<sup>th</sup> percentile score will be the target score for all of the CAHPS measures, as is specified in our Quality Strategy.

For the CAHPS measures, higher numeric scores are considered positive and lower numeric scores are considered negative.

## CAHPS for QUEST – Rating of Health Plan:

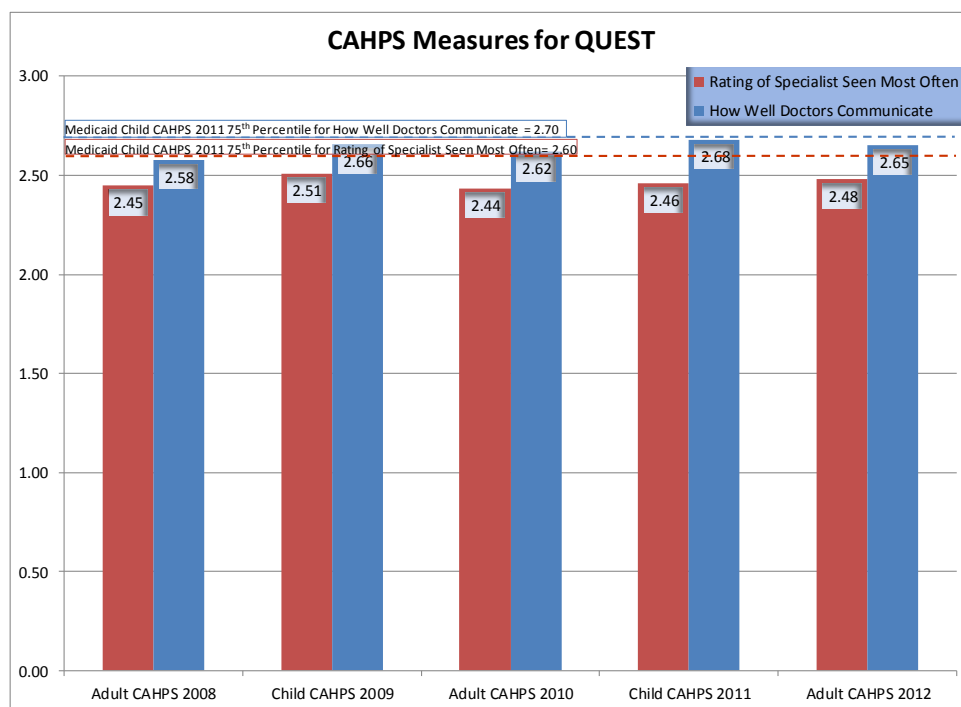
- The statewide CAHPS – Rating of Health Plan for the QUEST population varied between a high rate of 2.64 occurring in 2011 and the lowest rate of 2.40 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.



- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.40 to 2.47 to 2.51. The Child years show a similar pattern, moving from 2.55 to 2.64.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.61, which was exceeded by the 2.64 rate reported in 2011.

## CAHPS for QUEST – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.46 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.
- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.46 to 2.52 to 2.53. The Child years show a similar pattern, moving from 2.65 to 2.68.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was exceeded by the 2.68 rate reported in 2011.



### CAHPS for QUEST – Rating of Specialist Seen Most Often:

- The statewide CAHPS – Rating of Specialist Seen Most Often for the QUEST population varied between a high rate of 2.51 occurring in 2009 and the lowest rate of 2.44 occurring in 2010. Note that alternating years have alternating survey populations,

either Adult or Child.

- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move slightly up from 2.45 to 2.44 to 2.48. The Child years show a down pattern, moving from 2.51 to 2.46.
- The HI Quality Strategy target percentage for the CAHPS Rating of Specialist Seen Most Often is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.60, which was higher than all of the reported year.
- Improving the QUEST scores for CAHPS – Rating of Specialist Seen Most Often have involved: 1) Emphasizing telemedicine as an option for neighbor island clients seeking specialist services, 2) Increasing the frequency of specialists visits to neighbor islands, and 3) Implementing communication programs for physicians focused on skill building in the area of dealing with challenging situations.

### CAHPS for QUEST – How Well Doctors Communicate:

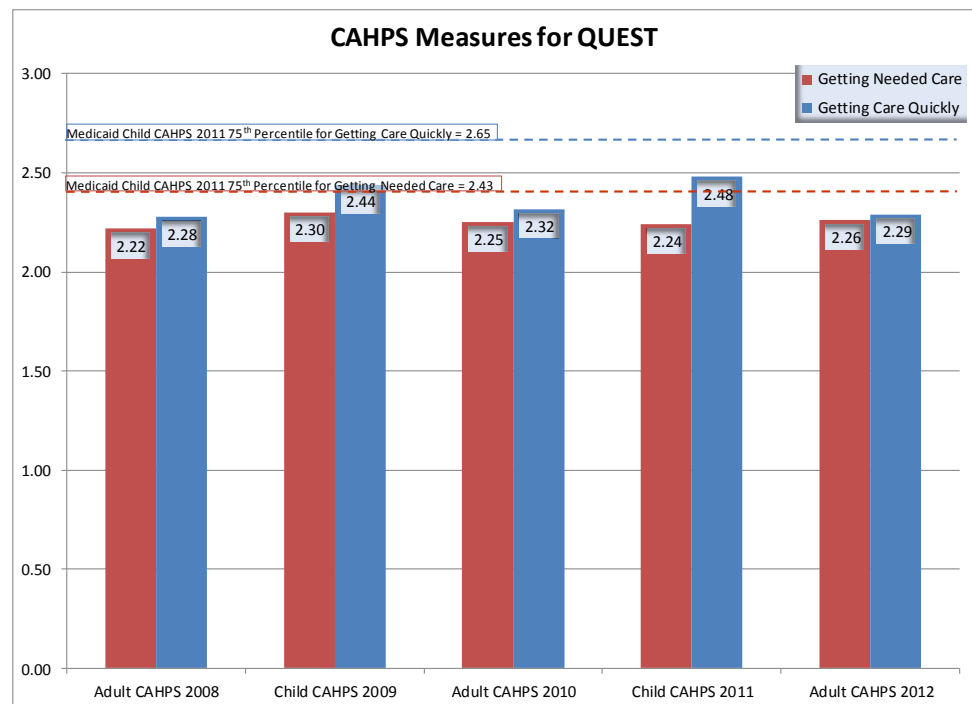
- The statewide CAHPS – How Well Doctors Communicate for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.58 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.
- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.58 to 2.62 to 2.65. The Child years show a similar pattern, moving from 2.66 to 2.68.



- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.70, which was higher than all of the reported year.
- The QUEST plans have taken the following step to improve the CAHPS – How Well Doctors Communicate rates: 1) Improving the care coordination and communication between member and the primary care team.

#### CAHPS for QUEST – Getting Needed Care:

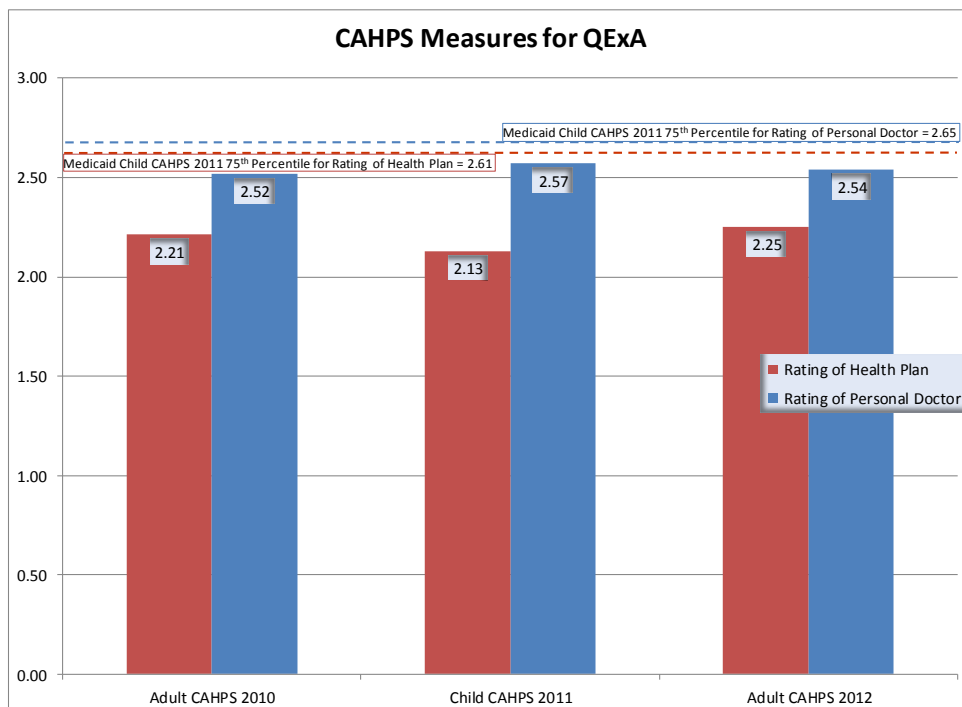
- The statewide CAHPS – Getting Needed Care for the QUEST population varied between a high rate of 2.30 occurring in 2009 and the lowest rate of 2.22 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.



- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move slightly up from 2.22 to 2.25 to 2.26. The Child years show a down pattern, moving from 2.30 to 2.24.
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.43, which was higher than all of the reported year.

### CAHPS for QUEST – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QUEST population varied between a high rate of 2.48 occurring in 2011 and the lowest rate of 2.28 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move sideways from 2.28 to 2.32 to 2.29. The Child years show an up trend, moving from 2.44 to 2.48.
- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported year



#### CAHPS for QExA – Rating of Health Plan:

- The statewide CAHPS – Rating of Health Plan for the QExA population varied between a high rate of 2.25 occurring in 2012 and the lowest rate of 2.13 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child. Also note

that the QExA program began in February 2009, which limits the number of data points.

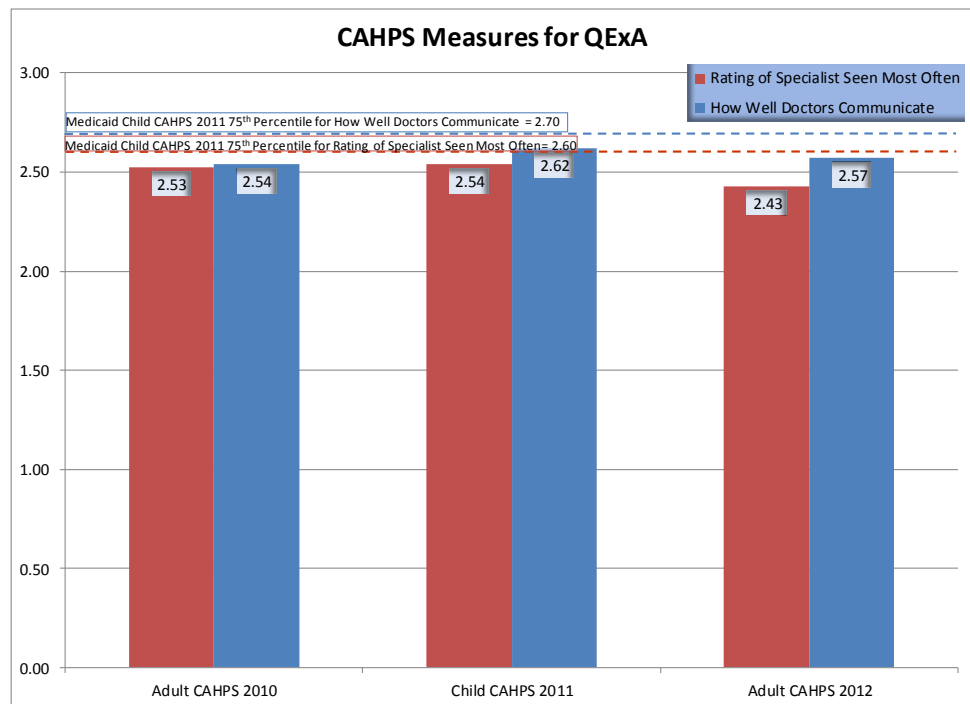
- There is a flat trend in the rates of the three years reported. The low point in 2011 was the only data point for the Child population.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year this target was 2.61, which was better than all reported rates.

#### CAHPS for QExA – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QExA population varied between a high rate of 2.57 occurring in 2011 and a low rate of 2.52 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the three years reported. All years lie within a 0.05 point window.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported years' rates.

CAHPS for QExA  
– Rating of  
Specialist Seen  
Most Often:

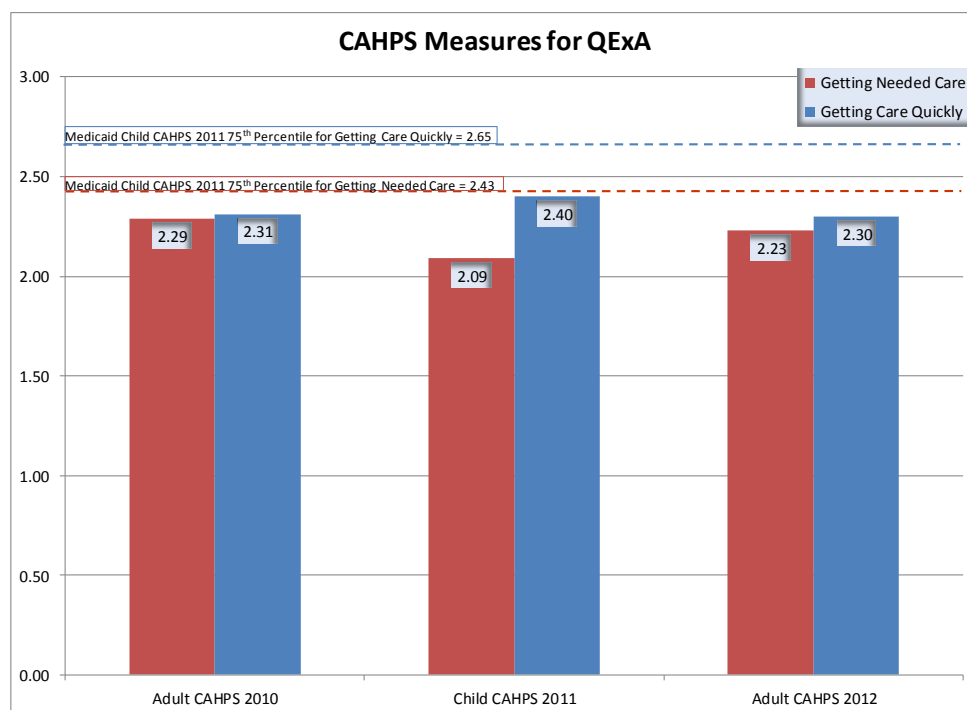
- The statewide CAHPS – Rating of Specialist Seen Most Often for the QExA population varied between a high rate of 2.54 occurring in 2011 and a low rate of 2.43 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.



- There is no clear trend in the rates of the three years reported.
- The HI Quality Strategy target percentage for the CAHPS – Rating of Specialist Seen Most Often is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.60, which was higher than all of the reported year.

CAHPS for QExA – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QExA population varied between a high rate of 2.62 occurring in 2011 and the lowest rate of 2.54 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no trend in the rates of the three years reported. Removing the Child year in 2011, the Adult score moves from 2.54 to 2.57 from 2010 to 2012.
- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.70, which was higher than all of the reported year.



#### CAHPS for QExA – Getting Needed Care:

- The statewide CAHPS – Getting Needed Care for the QExA population varied between a high rate of 2.29 occurring in 2010 and the lowest rate of 2.09 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the three years reported.
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.43, which was above each of the reported years.

#### CAHPS for QExA – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QExA population varied between a high rate of 2.40 occurring in 2011 and the lowest rate of 2.30 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.
- There is no clear trend in the rates of the three years reported.
- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75<sup>th</sup> percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported year.

## Physicians' Assessment Measures

The Physician Assessment measures are included in this report to measure the degree of provider satisfaction with the Hawaii Med-QUEST program as well as the individual plans that contract with Med-QUEST to provide services to the QUEST recipients. The survey includes ONLY physicians and related professionals.

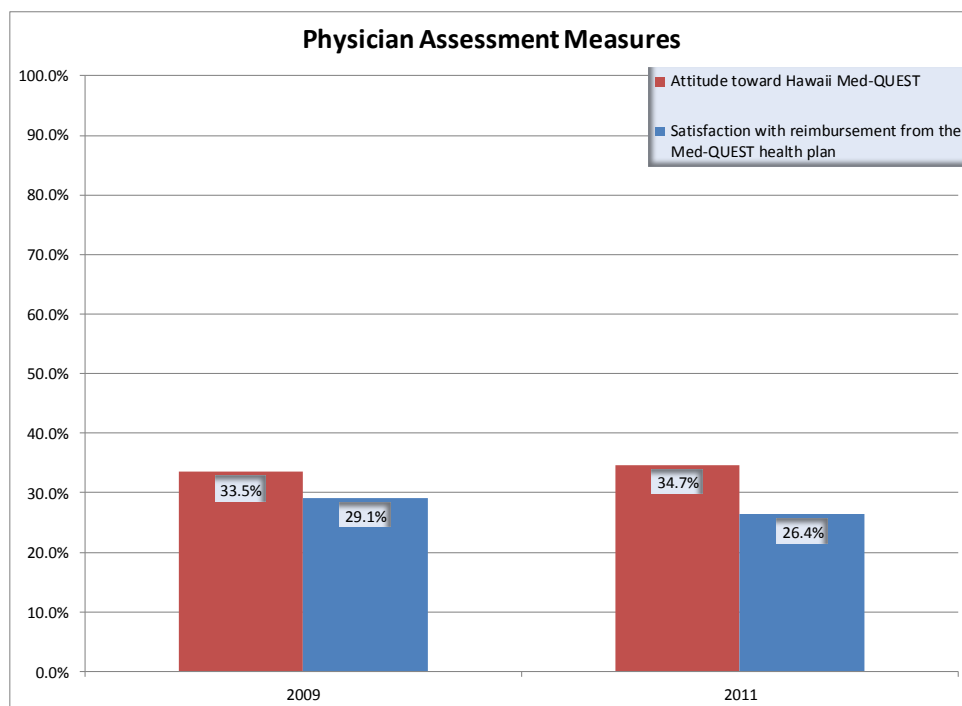
The Physician Assessment measures are based on surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The scores are based on clean responses from a survey of randomly selected PCPs and high-volume specialties, and are expressed as percentage scores. The overall survey response rate was 30% in 2009 and 26% in 2011. Going forward, these surveys will not be done every year. The measures presented below are but a small sample of the entire slate of questions that were presented on the survey.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of years. Scores are reported for 2009 and 2011. Unfortunately, there are no national standards that can bring perspective to where we score on a national level.

For the Physician Assessment measures, higher numeric scores are considered positive and lower numeric scores are considered negative.

### Physician Assessment – Attitude Toward Hawaii Med-QUEST:

- The statewide Physician Assessment –Attitude Toward Hawaii Med-QUEST went from 33.5% in 2009 to 34.7% in 2011.



- With only two data points, a clear trend in the rates cannot be established.

- There are no National average percentages available for the Physician Assessment Measures.

#### Physician Assessment – Satisfaction with reimbursement from the Med-QUEST health plan:

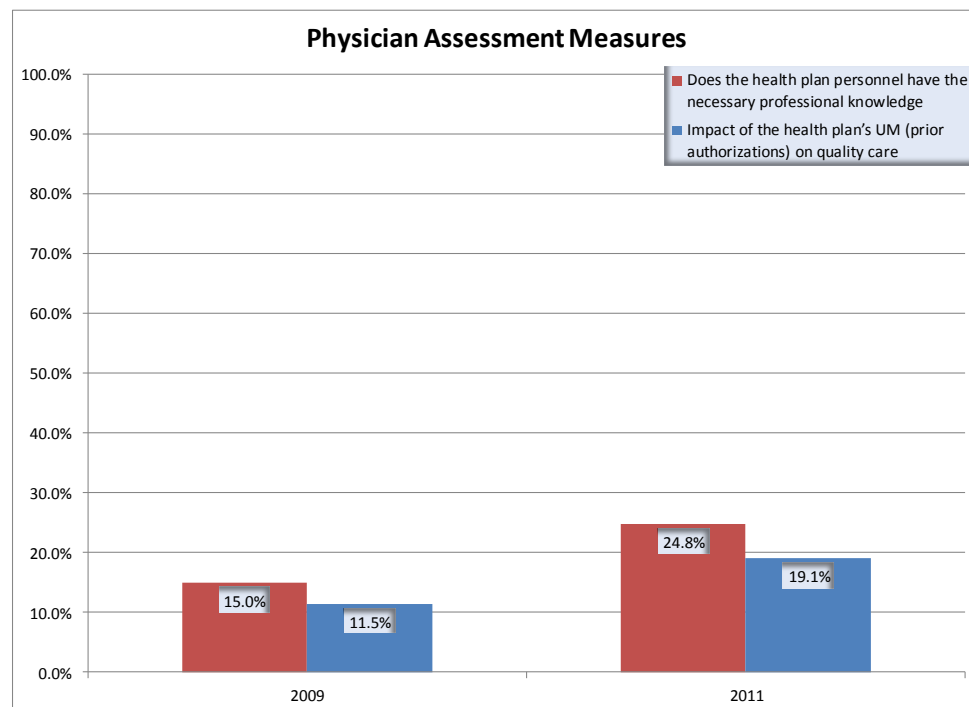
- The statewide Physician Assessment – Satisfaction with reimbursement from the Med-QUEST health plan went from 29.1% in 2009 down to 26.4% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

#### Physician Assessment – Necessary Professional Knowledge:

- The statewide Physician Assessment – Necessary Professional Knowledge went from 15.0% in 2009 to 24.8% in 2011.

- With only two data points, a clear trend in the rates cannot be established.

- There are no National average percentages available for the Physician Assessment Measures.



#### Physician Assessment – Impact of the health plan's UM:

- The statewide Physician Assessment – Impact of the health plan's UM went from 11.5% in 2009 down to 19.1% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

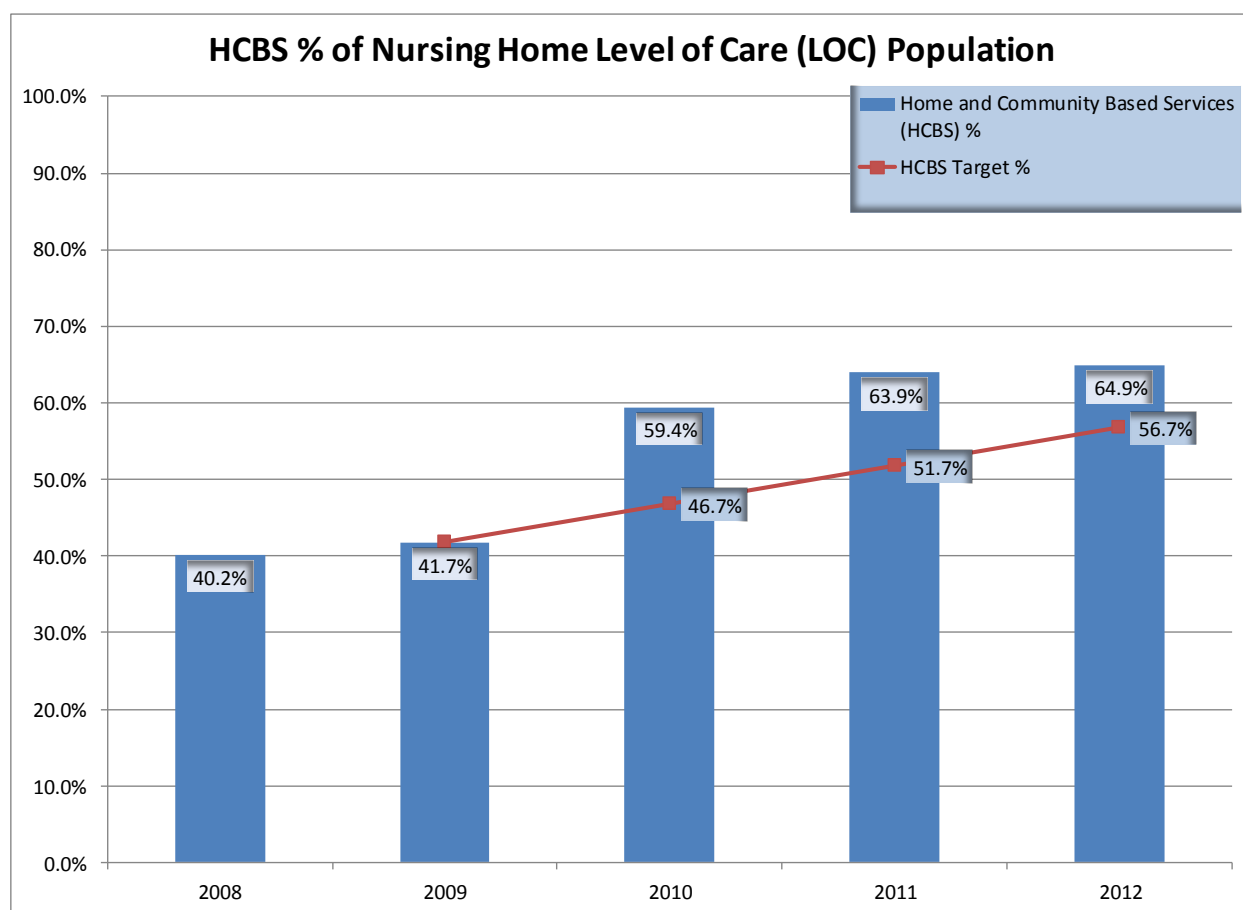
## **Med-QUEST Internal Measures**

The Med-QUEST internal measures are included in this report to measure the financial aspects of the Hawaii Med-QUEST program. How is money being spent, and on how many and what type of recipients, is the focus of these measures.

The QUEST Expanded Access (QExA) program began February 1, 2009 and moved aged, blind, and disabled. One of the goals of QExA was to increase the percentage of nursing home level of care (LOC) clients in Home and Community Based Services (HCBS) provided to nursing home level of care (LOC) clients is an alternate service delivery model to traditional nursing home institutions. Instead of nursing home clients staying in an institution, they are out in the community and interacting. HCBS facilitate the continued social and mental stability of the client, as well as reduce the cost of serving this population. The average monthly \$ PMPM difference between a HCBS client and an institutional client was \$6,194.86 in calendar year 2011. We look at both the increase in HCBS % of the total nursing home LOC population as well as the MQD's cumulative annual dollars saving from this increase in HCBS %. The cumulative dollar savings is calculated by determining taking the difference between the current year's HCBS % and the 2009 HCBS%, multiplying it by the total nursing home LOC population to get a monthly savings figure, and then multiplying it by twelve to get an annual savings figure.

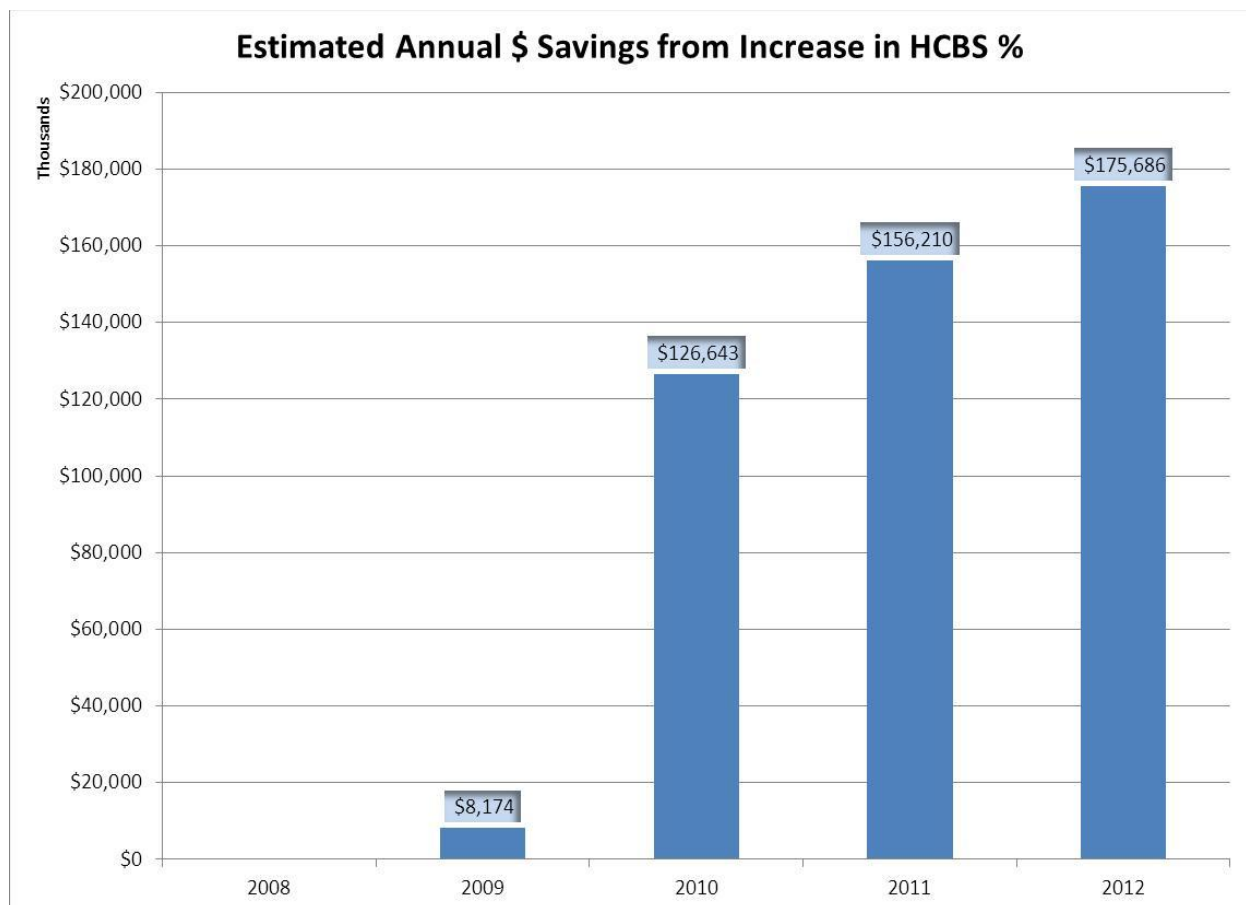
The member month measure used is a sum of member months, and will consist of entire populations based on reports run at the end of each month. The capitation payment file is a detail of all capitation payments made to each plan, and is the source of member month data. This file has enrollments for retro payments reflected in the month that payment was made. Initial months are paid pro-rated daily amounts based on the start date. Termination always occurs at the end of the month, except for retro termination for disability or death.





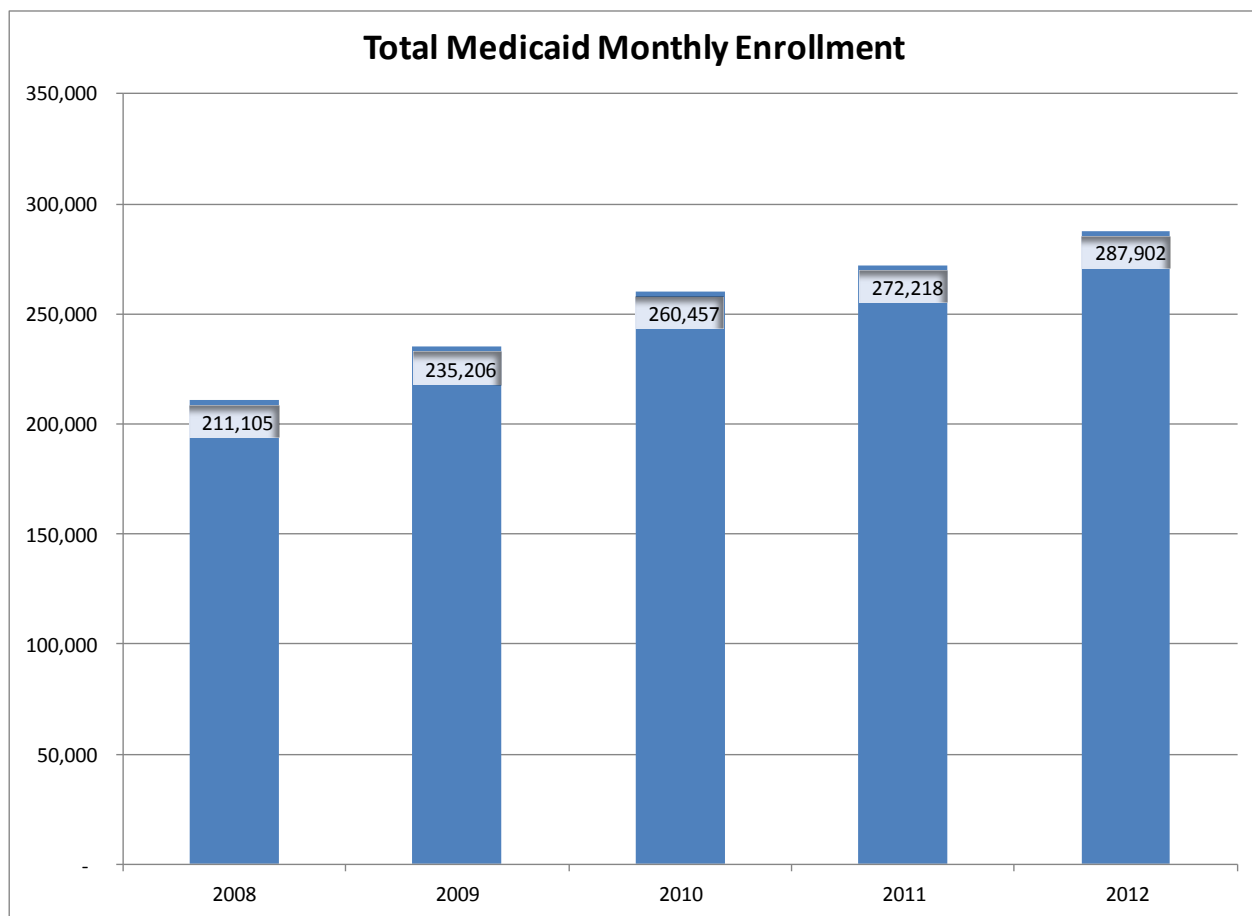
#### HCBS % of Nursing Home LOC Population:

- The statewide HCBS % of Nursing Home LOC Population went from 40.2% in 2008 to 64.9% in 2012.
- There is a clear upward trend in the rates. The QExA program began in February of 2009, and the largest percentage jump occurred between 2009 and 2010.
- Our Quality Strategy sets as a target a 5% per year increase in the HCBS % for our QExA program. Since beginning in February 2009 to the current year, this goal has been exceeded in each year.
- Prior to July 2010, the MQD had a fiscal incentive for the QExA health plans to move nursing home LOC clients from an institutional setting to a HCBS setting, which involved different capitation payments for HCBS vs. institutional settings. Beginning July 2010, the QExA health plans were paid a composite (average) capitation payment for all nursing home LOC clients, which changed the method of financial incentive in moving clients into an HCBS setting. This would explain the flattening off of the increases in percentage of clients that are in an HCBS setting.



**Estimated Annual \$ Savings from Increase in HCBS %:**

- The statewide Estimated Annual \$ Savings from Increase in HCBS % went from \$8,174,000 in 2009 to \$175,686,000 in 2012. The 2011 actual differential in \$ pmpm cost between institutional care and HCBS care is \$6,194.86, and this was used in the calculation of cost savings.
- Following the clear upward trend in the HCBS %, there is a corresponding cumulative increase in the dollars saved from this transition to HCBS.
- There is no National average available for dollars saved based on the move to HCBS.



**Total Medicaid Monthly Enrollment:**

- The statewide Total Medicaid Monthly Enrollment went from 211,105 in 2008 to 287,902 in 2012, which equates to an average annual increase of 5.8%.
- There is a clear upward trend in Medicaid enrollment, with each year logging consistent gains.
- There is no National average available for annual Medicaid enrollment increase.
- The Hawaii economy and unemployment rate continue to hover above 2008 pre-recession levels, causing the Hawaii Medicaid enrollment to continue to rise.
- With implementation of the Affordable Care Act (ACA), MQD does not expect a decrease of enrollment.

## Budget Neutrality Savings

Budget neutrality savings is a reflection of the fiscal performance of the waiver. Specifically, it compares the expenditures with the waiver in place – inclusive of all the demonstration group costs -- against the hypothetical expenditures if the waiver were not in place at all. If the “With Waiver” expenditures are less than the “Without Waiver” expenditures, then Budget Neutrality Savings will result. The following table details the budget neutrality calculation through Demonstration Year 18 (DY18) of the 1115 waiver. The overall total computable savings is \$1,833,414,530. An additional version of the Budget Neutrality information is found in Appendix A.

Hawaii 1115 QUEST Waiver TOTAL COMPUTABLE		12	13	14	15	16	17	18
		Std Renewal/Extension			Renewal			
WITHOUT WAIVER	FMAP	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081
	MEG Description and Comments	58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%
		58.81%	57.55%	56.50%	67.35%	54.24%	62.63%	50.48%
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	\$261.16	\$281.11	\$302.59	\$322.62	\$343.98	\$366.75	\$391.03
	TANF Adults	\$458.35	\$493.37	\$531.07	\$564.90	\$600.88	\$639.18	\$679.87
	Aged				\$1,204.63	\$1,281.84	\$1,364.01	\$1,451.44
	Blind/Disabled				\$1,489.42	\$1,597.11	\$1,712.58	\$1,836.40
Member Months								
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,978	422,741
	Aged				98,211	228,008	236,945	234,307
	Blind/Disabled				115,266	273,836	288,269	286,344
	Total Without Waiver Member Months	1,282,911	1,261,533	1,193,278	1,540,890	1,994,062	2,130,996	2,166,975
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	\$402,056,806	\$424,960,513	\$443,327,661	\$837,493,616	\$1,343,204,149	\$1,520,758,456	\$1,631,791,072
DSH		\$80,364,047	\$81,971,327	\$83,856,667	\$87,546,360	\$89,735,019	\$91,350,249	\$94,547,507
Total Ceiling		\$482,420,853	\$506,931,840	\$527,184,328	\$925,039,976	\$1,432,939,168	\$1,612,108,705	\$1,726,338,579
WITH WAIVER	1115	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902 R 2	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902 R 2X	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902R2	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	AFDC	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Aged w/Mcare	\$0	\$0	(\$295)	\$121,310,557	\$314,957,371	\$350,728,888	\$330,293,296
	Aged w/o Mcare	\$0	\$0	\$0	\$2,424,989	\$17,555,107	\$24,896,097	\$19,060,304
	B/D w/Mcare	\$0	\$0	(\$13,736)	\$31,795,707	\$74,850,400	\$81,249,425	\$77,690,468
	B/D w/o Mcare	\$0	\$0	(\$28,991)	\$81,514,842	\$211,801,011	\$248,768,345	\$251,740,251
	Breast Cervical Cancer Treatment (BOCT)	\$0	\$0	\$0	\$0	\$4,051	\$545,195	\$734,188
	CURRENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	CURRENT POP	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Current-Haw aii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Demo Elg Adults	\$127,983,510	\$129,458,220	\$154,645,707	\$177,396,443	\$201,629,508	\$238,017,265	\$245,339,887
	FosterCare(19-20)	\$0	\$0	\$91,499	\$83,366	\$94,158	\$137,233	\$77,745
	Haw aii Quest-1902(R)(2)	\$0	\$0	\$33,061	\$26,332	\$0	\$0	\$0
	HCCP	\$0	\$0	\$135,520	\$683,159	\$0	\$0	\$0
	HealthQuest-Current	(\$2,325,152)	\$0	\$0	\$0	\$0	\$0	\$0
	HealthQuest-Others	(\$621,643)	\$0	\$0	\$0	\$0	\$0	\$0
	Med Needy Adults	\$56,504	\$120,767	\$115,893	\$58,345	\$117,005	\$109,837	\$8,305
	Med Needy Children	\$0	\$0	\$0	\$7,715	\$3,960	\$0	\$0
	MFCP	\$0	\$0	\$122,839	\$581,513	\$0	\$0	\$0
	NH w/o W	\$0	\$0	\$5,100,418	\$16,199,737	\$0	\$0	\$0
	Opt St Pl Children	\$76,678	\$103,084	\$80,075	\$257,166	\$253,182	\$31	\$0
	Others	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Others-Haw aii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	OthersX	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	QUEST ACE	(\$2,751)	\$798,681	\$5,696,094	\$14,353,208	\$23,872,001	\$30,434,166	\$28,884,029
	RAACP	\$0	\$0	\$7,862,479	\$17,432,949	\$0	\$0	\$0
	St Pl Adults-Preg Immig/OOFAs	\$0	\$0	\$0	\$0	\$24,990	\$2,622,138	\$2,718,679
	State Plan Adults	\$111,983,043	\$118,021,622	\$109,034,691	\$128,225,127	\$132,187,409	\$123,786,545	\$118,966,463
	State Plan Children	\$181,803,156	\$179,673,972	\$155,394,295	\$168,854,083	\$203,903,281	\$214,486,295	\$199,141,564
	Supp. - Private	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Supp. - State Gov.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	UCC-Governmental	\$15,688,221	\$22,546,108	\$18,919,184	\$16,356,580	\$24,507,605	\$34,064,491	\$40,634,690
	UCC-Private	\$10,056,500	\$3,403,710	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000	\$0
		\$444,698,066	\$454,126,164	\$464,688,533	\$785,061,818	\$1,213,269,040	\$1,357,345,951	\$1,315,289,869
		-\$1,459,097	-\$1,189,919	-\$660,309	-\$4,962,002	-\$38,297,536	-\$43,476,661	-\$38,375,159
		\$443,238,969	\$452,936,245	\$464,028,224	\$780,099,816	\$1,174,971,504	\$1,313,869,290	\$1,276,914,710
		\$39,181,885	\$53,995,595	\$63,156,104	\$144,940,160	\$257,967,664	\$298,239,415	\$449,423,868
		\$565,691,724	\$619,687,319	\$682,843,423	\$827,783,582	\$1,085,751,247	\$1,383,990,662	\$1,833,414,530
		-\$334,903	-\$352,488	-\$217,644	-\$22,587	-\$15,945,497	-\$15,835,580	-\$10,164,390
		-\$323,973	-\$263,058	-\$239,466	-\$19,777	-\$6,517,946	-\$9,185,458	-\$9,300,862
		-\$347,005	-\$279,056	-\$147,219	-\$22,317	-\$9,503,023	-\$9,356,037	-\$9,335,080
		-\$453,216	-\$295,317	-\$55,980	-\$4,897,321	-\$6,331,070	-\$9,099,586	-\$9,574,826

## **QUEST Expanded Member Months**

The most basic measure of how many members you are impacting through your waiver program is member months. The capitation payment file, which is a detail of all capitation payments made to each plan, is used to calculate these figures. These amounts represents paid member month through June 30, 2012. A detailed copy of the member months may be found in Appendix B.

## **Expenditures for QUEST-ACE Program**

The QUEST Adult Coverage Expansion (QUEST-ACE) is program that provides medical assistance to a childless adult who is unable to enroll in the QUEST program due to the limitations of the statewide enrollment cap of QUEST as indicated in §17-1727-26. The enrollment cap for this program is currently set by CMS at 12,000. The QUEST-ACE benefit package encompasses the same limited package of benefits currently provided under the QUEST-Net program, which includes limited medical benefits. A childless adult under the QUEST-ACE program is defined as a person who is:

- Between nineteen years of age through age 64;
- Is not a child under age twenty-one who is in foster care placement or is covered by a subsidized adoption agreement; and
- Does not have a dependent child in the home.

QUEST-ACE started offering coverage for recipients on April 1, 2007. Financial expenditures for QUEST-ACE beneficiaries are approximately \$28 to \$30 million per year in demonstration years 17 and 18 respectively. More information on QUEST-ACE expenditures may be found in Budget Neutrality calculations in Appendix A.

## Recent Initiatives on Measures

The following section will discuss initiatives that the health plans have taken recently to improve the rates of the various measures discussed above.

### HEDIS Initiatives

#### *Use of Appropriate Medications for People with Asthma (ASM) Initiatives:*

- Implemented health education programs for asthma and physician/patient education on medication.
- Provided community education and outreach activities.
- In 2012, one plan implemented pay-for performance for HEDIS ASM (age5-20) and (age21-64) for child and adult primary care providers.

#### *Comprehensive Diabetes Care (CDC) Initiatives:*

- Is an MQD Quality Strategy measure.
- Improving the health of members with diabetes is a focus in MQD's Quality Strategy. CDC – LDL < 100 mg/dL is a QUEST pay for performance measure.
  - One health plan has allocated \$1.75 million each year for the past 3 years in a QI Incentive Program to provide support for provider-based quality improvement projects and to reward quality improvements. In 2012 this health plan implemented pay-for performance for the following HEDIS CDC measures: Eye exam, HbA1c control, and LDL-C control.
- Implemented health education programs for a variety of diabetes-related issues, including healthy eating and weight loss programs, monitoring of alcohol consumption, smoking cessation programs, and physician/patient education on medication. This includes both written and electronic health education materials.
  - In 2011, one health plan reported more members have participated in their Health Media: Care for Diabetes, which is an online program that is free to their members. The program is customized specifically by assessing a member's daily routine, general health and providing ways to manage their diabetes more effectively. The member receives follow-up emails to track their progress. After completing a questionnaire, the member receives an action plan and tools that are tailored to their preferences, and their willingness and ability to use them. The member can review their plan online, or print a copy to discuss with their physician at the next office visit.
- Implemented reminder systems to inform diabetics of needed preventive services and to contact non-compliant members using letters and/or calls. Several health plans also inform providers of members who were overdue for preventive visits and screenings.

- Provide outreach to diabetics by identifying new diabetic members in a new welcome call assessment. One health plan also sends a letter and diabetes member toolkit, called the “ABCs of Diabetes” to all members who were identified as diabetic. This toolkit included an educational brochure and diabetes checklist for members to use in managing their diabetes.
- Distributing periodic newsletters with diabetes articles and updates.

***Cholesterol Management for Patients with Cardiovascular Conditions (CMC) and Controlling High Blood Pressure (CBP) Initiatives:***

- Provided education to member and provider to increase awareness of cholesterol management and the importance of medication compliance.
- Implemented reminder systems for members who have had cardiovascular condition. These reminder systems may be in various forms, including postcards phone calls, or e-mails.
  - One health plan initiated process management improvements by identifying patients discharged for MI or CVA/TIA for referral for lipid management and partner with the cardiology department to help identify and refer CVD patients for HTN/lipid management.
  - One health plan implemented a “Hospital to Home” care management program for those high-risk members who have been hospitalized in which a service coordinator conducts an assessment within 3 days of hospital discharge on the member’s understanding of his/her disease and care management and the ability of the member to manage their care post-hospitalization. Interventions are applied as appropriate to the individual member’s case.

***Childhood Immunization Status (CIS) Initiatives:***

- Provided physicians with a list of patients who are due or past due for routine immunizations so the physician can follow up with the patient.
- Established patient reminder and recall systems that include: 1) Postcard reminders, and 2) Telephone to non-responders for missed appointments and/or immunizations.
  - One plan has a unique alert system for the customer service representatives. When a member calls customer service for assistance, upon completion of assisting the member with their request, the alert system informs the customer service representative of an outstanding care gaps (non-compliant HEDIS measures) in which the member is overdue. The customer service representative briefly explains the care gap and offers to assist the member in making an appointment with his or her provider.
- Conducted regular assessments of immunization rates.

- One plan reports on the trends and performance: clinic level via the Keiki Score Card-Provider specific Level via the How Are we Doing Reports and conducts systems and process improvement recommendations for underperforming clinics.
- Implemented provider incentives and/or a comparison of performance to a goal or standard.
  - Several plans meet with providers regularly to provide them with their HEDIS reports and discuss their progress.
- Implemented mechanisms to collect and report the data in a supplemental database so that immunizations that are provided without a claim being submitted to the plan can still be tracked and reported.

***Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), & Chlamydia Screening in Women (CHL) Initiatives:***

- Implemented reminder systems that inform patients of upcoming mammogram, cervical cancer screening appoints and eligible females who have not received a screening for Chlamydia in the recommended time frame.
- Reduced barriers that may be preventing the patient from receiving a mammogram.
  - One health plan reports success with their Mobile Health Vehicle and plans to expand this service in 2012 to include diagnostic breast imaging in addition to screening mammography
  - One health plan is trialing evening outreach for pap appointments and focusing pap clinics in areas with highest screening needs.
- Improved the capture of screenings for members who have been screened.
  - One plan executed contract amendments with the two main laboratories in Hawaii to assure lab results' supplemental data are obtained for those performance measures which require a result determination.
  - One plan receives supplemental data from an FQHC that does not submit claims to the health plan for Chlamydia screening. The health plan obtains a list of members who have received a screening as well as a sample of the Electronic Health Records for primary source verification, which is then reviewed by an auditor for compliance. This supplemental data had a positive impact on the 2011 HEDIS rate as there was an increase of 10% in the number of members receiving a Chlamydia test during the measurement year for the QUEST population.

***Ambulatory Care (AMB) Initiatives:***

- Implemented education of members on appropriate ER use.



- One health plan provided intervention for high utilizers with active case management by clinicians and case managers. Case managers assigned to these members directed them to appropriate care, ensuring that the patient has an assigned PCP, identified any barriers in care, reason for frequent visits to the ER and provided education on appropriate use of the ER.
- One health plan has Disease Management staff address care gaps during the assessment process and follow-up calls, in addition to supporting and reminding members of the importance of complying with disease management recommendations.

## **CMS-416 EPSDT Measures Initiatives**

In 2011 health plans began receiving aggregated reports based on Hawaii EPSDT forms that contained the following information: BMI metrics, immunizations, screenings, referrals, care coordination, and abnormal screenings. These reports will assist the health plans in determining gaps in EPSDT visits/screenings, and to follow-up with referrals and care coordination.

## **CAHPS (QUEST & QExA) Initiatives**

### ***Rating of Health Plan & Rating of Personal Doctor Initiatives:***

- Utilized online and technology assets to outreach to members.
  - One plan launched a new Health & Wellness section on its website, along with notifying member of this new section.
  - One plan updated their secure member portal, to add functionality to include ordering and printing ID cards, change PCPs, and update demographic information.
- Used face-to-face meetings to assess and evaluate the membership experience with the health plan.
  - One plan conducted member education sessions on various health topics as well as emphasizing the need to communicate with their doctors.
  - One plan conducted quarterly focus groups to gain a better understanding of the member needs, expectations and dissatisfactions.
- Utilized “hard copy” media to outreach to the member and increase member satisfaction with the health plans.
  - One plan sent out members-specific letters detailing preventive visits and screenings or tests that are coming due, as well as an explanation as to the necessity of these visits.

- One plan created and deployed a new set of documents for the Service Coordinators to share with the member that will improve their understanding of their benefits, and how the plan supports these benefits.
- Conducted an internal review of information flow to improve health plan responsiveness to member problems.
  - One plan recently improved its process to reimburse dual-eligible members for erroneously paid co-pays. Service coordinator and call center staff were re-trained to follow new protocols to speed the identification and reimbursement to the member. Provider education was provided on appropriate billing for dual-eligible members to prevent this from occurring in the first place.

***Rating of Specialist Seen Most Often & How Well Doctors Communicate Initiatives:***

- Utilized online and technology assets to outreach to provider to improve care delivery.
  - One plan made available members' HEDIS care gaps to providers via secure online content. Providers could then close these recommended care gaps with their members.
- Incentivized providers to improve care.
  - One plan offered \$100 per member incentives to providers to complete care gaps for dual eligible members.

***Getting Needed Care & Getting Care Quickly Initiatives:***

- Utilized online and technology assets to improve the ability of members to connect to providers.
  - One plan streamlined the provider search functionality on their website.
  - One plan increased the update frequency of the online provider directories to daily.
  - One plan improved the online provider directory by adding hospital privileges, and increasing the update frequency to monthly.
  - One plan added online 'enter' and 'view' functionality for prior authorizations, admissions and referrals
- Reached out to members to gauge provider access and care delivery.
  - One plan conducted telephonic member surveys on access to provider care, and relaying these findings to providers during regular, periodic training visits.
  - One plan conducted ongoing member surveys to further gauge timely access to care.

- Personally assisted members with obtaining needed provider appointments.
  - One plan coordinated the scheduling of appointments for “hard to find” specialists such as Neurosurgeons, Pulmonologists, Gastroenterologists, etc. when the member was having a difficult time doing this on their own.
  - One plan encouraged open access scheduling models at physician offices, where part of the physician’s schedule is left open for same-day patient access or urgent visit reservations.
  - One plan merged systems that track gaps in HEDIS-related care with customer service, so that during member calls the customer service rep can remind the member that they need to see a provider and even offer to set up an appointment.
  - One plan implemented a Complex Case Management program to assist members that have experienced a critical event or diagnoses that requires extensive use of resources. This program provides a comprehensive assessment of the member’s condition, development and implementation of a care plan, and monitoring and follow-up with the member’s PCP.
- Other miscellaneous improvements were made.
  - All of the QUEST plans simplified the drug prior authorization process by standardizing the form across all QUEST plans.
  - One plan made physician biography cards available at clinic locations to facilitate physician comparisons and selection.
  - One plan allocated \$300,000 over the past four years to support recruitment and retention of providers, particularly on the neighbor islands.
  - One plan implemented a 24-hour nurse triage call line equipped with specialty trained nurses and an audio health library.
  - One plan added the ability of QUEST members to email the plan’s QUEST department directly from the health plan website.
  - One plan began implementation of Patient-Centered Medical Homes in key FQHCs. A data analyst and care advocate works with the FQHC to provide data on care opportunities, and to assist with coordination of care related to these opportunities.

## **Physicians’ Assessment Initiatives**

### ***Attitude Toward Hawaii Med-QUEST & Satisfaction with Reimbursement from the Med-QUEST Health Plan Initiatives:***

- Utilized online and technology assets to improve the ability of members to connect to providers.

- One plan created a centralized email inbox to streamline provider inquiries to the health plan's provider relations department, including reimbursement and claim issues.
- Created internal advocacy for provider needs and interests.
  - One plan started a Provider Advisory Group within the Health Plan to take the provider's point of view, and to review new provider forms and programs.

***Does the Health Plan Personnel have the Necessary Professional Knowledge & Impact of the Health Plan's UM (prior authorizations) on Quality Care Initiatives:***

- Improved the knowledge base of their employees through various training modalities.
  - One plan implemented an on-line learning system containing all staff training material, and pre- and post-testing, made available to all front-line staff.
  - One plan added training on appeals and grievance, benefits, authorization and utilization management to basic New Employee Orientation agendas.
  - One plan increased staff coaching and mentoring activities.
  - One plan conducted monthly knowledge quizzes to gauge whether additional training is needed.
- Initiated improvements to the prior authorization process.
  - One plan reviewed notification and prior authorization (PA) requirements, and eliminated PA requirements for many behavioral health services and cardiology services.
  - One plan added an online PA application to streamline the PA process.
  - One plan increased provider training and education related to the online PA process.
  - One plan distributed handouts on the PA process during periodic provider relations visits.
  - One plan conducted statewide provider workshops to educate providers on referrals and pre-certifications, and had follow-up Q&A opportunities post-workshop as well as through evaluation forms.
  - One plan analyzed the rate of PA approvals by specialty category, and for those categories with high approval rates removed the PA requirement for those services.
  - One plan reviewed the compliance to the health plan's clinical review criteria for selected providers, and eliminated the PA requirement where compliance was consistent.

## **Home and Community Based Services (HCBS) Initiatives**

- Streamlined ability to receive HCBS instead of nursing facility placement since start of QExA
  - By moving HCBS from the 1915(c) waivers into an 1115 demonstration waiver in health plans, MQD was able to minimize the silos that existed previously to “get into a waiver.”
  - Health plan members are assessed for their choice of placement for long term supports and services (LTSS).
  - Choices offered include:
    - Their home with support provided by home care agencies or family members provided as a health plan paid consumer-directed personal assistant
    - Residential settings such as community care foster family homes or assisted living facilities
    - Institutional setting
  - Once member is assessed for needing long term supports and services, health plans are able to provide LTSS within approximately thirty (30) days.
  - DHS had a wait list of approximately 1,000 for all four 1915(c) waivers combined prior to QExA implementation
- Standardized assessment tools for HCBS
  - At the start of QExA, MQD and the health plans developed a standardized personal assistance and skilled nursing tool to assure consistency with health plan assessments for receipt of HCBS
  - The use of these assessment tools have helped to streamline receipt of services

## **Hawaii Medicaid Enrollment Initiatives**

- MQD is focused on assuring processing of applications for Medicaid within 45-days or else providing presumptive eligibility.
- MQD has enacted eligibility for beneficiaries five-days prior to submittal of application to assure that medical services received will be covered.
- MQD has amended its 1115 demonstration waiver to provide eligibility up to 133% of Federal Poverty Level to be prepared for implementation of ACA.

## Recommendations

Though the MQD has seen improvement in many of its performance measures over the past five years, we are not meeting the requirements that we have established in our Quality Strategy of at least 75<sup>th</sup> percentile of the national Medicaid population. MQD has the following recommendations for improving health plan performance:

### 1. Improve process for gathering information from providers

The majority of Medicaid providers in Hawaii are single providers (i.e., not part of a group practice and are not part of an Independent Physician Association (IPA)). In addition, up to this point, both the QUEST and QExA health plans provide information to Hawaii Medicaid providers retrospectively. It has been very difficult to make changes in HEDIS results for critical areas such as diabetes or cardiovascular disease when the penetration into the provider community is provider-by-provider.

Some recommendations for the future are:

- A. Encourage providers to move to electronic medical records and achieve meaningful use by implementing the Electronic Health Record (HRE) initiative that is part of the ACA.
- B. Offer reminders to providers in real-time for best practices (i.e., reminders for preventative screenings).

### 2. Explore mechanisms to improve health plans' supplemental data collection

Health plans have identified that immunizations and certain screenings like Chlamydia are often performed and paid for outside the health plan. Therefore, these services are not captured for coordination of care or for reporting in the health plan's HEDIS measures. MQD is committed to support and encourage collaborative endeavors by the health plans to work with FQHCs and other large providers to obtain data for services paid through federal grants for Medicaid members.

### 3. Increase the Pay for Performance withhold from health plans

MQD implemented a Pay for Performance (P4P) withhold from the QUEST program in 2010. In this program, MQD withholds \$1.00 PMPM for every capitation payment for each member that has been with them for the entire month. Annually, MQD will review the health plans' HEDIS and CAHPS results compared to 75<sup>th</sup> percentile of the national Medicaid population as well as look to see if they have improved their results by at least 50% over the past year. If a health plan has met one of the desired results, then they receive a payment of \$0.20 PMPM for each performance measure they have met.

The results of the first year of the program are listed below.

	<b>AlohaCare</b>	<b>HMSA</b>	<b>Kaiser</b>
Childhood Immunization (HEDIS 2010)	No	No	Yes
Chlamydia Screening (HEDIS 2010)	No	Yes	Yes
LDL Control- Comprehensive Diabetes Care (HEDIS 2010)	No	No	Yes
Getting Needed Care- Child CAHPS (CAHPS 2011)	No	No	No
Getting Needed Care- Adult CAHPS (CAHPS 2010)	Yes	No	No
ED Visits/1000 (HEDIS 2010)	Yes	Yes	Yes
Total PMPM	\$0.40	\$0.40	\$0.80

MQD has increased the P4P withhold to \$2.00 PMPM to encourage the health plans to strive for quality in the care they are providing to their members. In addition, payment of the P4P is based solely on meeting 75<sup>th</sup> percentile of the national Medicaid population.

#### 4. Implement auto-assignment percentages based upon results of HEDIS and CAHPS results

In the new QUEST contract that is effective July 1, 2012, MQD will revise the auto-assignment percentages based upon results of HEDIS and CAHPS results. These auto-assign percentages will be revised annually based upon previous year results. The first auto-assign percentages will be implemented on January 1, 2014.

#### 5. Implement Health Plan Collaborative with EQRO

Part of the Quality Strategy is to have two health plan collaboratives annually. In the health plan collaborative, MQD and its EQRO will meet with health plans to review performance measures over the past year. During these meetings, the health plans and MQD will strategize on techniques to improve the quality of services provided to Medicaid beneficiaries.

The collaborative consist of MQD staff, EQRO staff, health plan administrators, medical directors, and quality improvement staff. MQD will have its first health plan collaborative in the fall of 2012.

#### 6. Revise and update Quality Strategy

MQD will update its quality strategy to add its P4P initiatives. In addition, MQD will expand on the CAHPS requirements in its P4P. These changes will be made to its Quality Strategy by the end of the calendar year.

## Conclusion

MQD has seen some improvement in the results of the program over the past five years. However, additional changes are required to assure better preventative screening and disease treatment of our beneficiaries. Through implementation of the recommendations provided, MQD anticipates improved health plan performance and better quality of services to our beneficiaries.

## Appendix A



Hawaii 1115 QUEST Waiver								
TOTAL COMPUTABLE		12	13	14	15	16	17	18
		Std Renewal/Extension			Renewal			
WITHOUT WAIVER	FMAP	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081
		58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%
	MEG Description and Comments	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%
					67.35%		62.63%	
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	\$261.16	\$281.11	\$302.59	\$322.62	\$343.98	\$366.75	\$391.03
	Adults	\$458.35	\$493.37	\$531.07	\$564.90	\$600.88	\$639.18	\$679.87
	\$1,204.63	\$1,281.84	\$1,364.01	\$1,451.44				
	Blind/Disabled				\$1,489.42	\$1,597.11	\$1,712.58	\$1,836.40
Member Months								
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,978	422,741
	Aged				98,211	228,008	236,945	234,307
	Blind/Disabled				115,266	273,836	288,269	286,344
	Total Without Waiver Member Months	1,282,911	1,261,533	1,193,278	1,540,890	1,994,062	2,130,996	2,166,975
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	\$402,056,806	\$424,960,513	\$443,327,661	\$837,493,616	\$1,343,204,149	\$1,520,758,456	\$1,631,791,072
DSH		\$80,364,047	\$81,971,327	\$83,856,667	\$87,546,360	\$89,735,019	\$91,350,249	\$94,547,507
Total Ceiling		\$482,420,853	\$506,931,840	\$527,184,328	\$925,039,976	\$1,432,939,168	\$1,612,108,705	\$1,726,338,579
WITH WAIVER	1115	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902 R 2	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902 R 2X	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	1902R2	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	AFDC	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Aged w /Mcare	\$0	\$0	(\$295)	\$121,310,557	\$314,957,371	\$350,728,888	\$330,293,296
	Aged w/o Mcare	\$0	\$0	\$0	\$2,424,989	\$17,555,107	\$24,896,097	\$19,060,304
	B/D w /Mcare	\$0	\$0	(\$13,736)	\$31,795,707	\$74,850,400	\$81,249,425	\$77,690,468
	B/D w/o Mcare	\$0	\$0	(\$28,991)	\$81,514,842	\$211,801,011	\$248,768,345	\$251,740,251
	Breast Cervical Cancer Treatment (BCCT)	\$0	\$0	\$0	\$0	\$4,051	\$545,195	\$734,188
	CURRENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	CURRENT POP	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Current-Hawaii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Demo Elig Adults	\$127,983,510	\$129,458,220	\$154,645,707	\$177,396,443	\$201,629,508	\$238,017,265	\$245,339,887
	FosterCare(19-20)	\$0	\$0	\$91,499	\$83,366	\$94,158	\$137,233	\$77,745
	Haw aiiQuest-1902(R)(2)	\$0	\$0	\$33,061	\$26,332	\$8,001	\$0	\$0
	HCCP	\$0	\$0	\$135,520	\$683,159	\$0	\$0	\$0
	HealthQuest-Current	(\$2,325,152)	\$0	\$0	\$0	\$0	\$0	\$0
	HealthQuest-Others	(\$621,643)	\$0	\$0	\$0	\$0	\$0	\$0
	Med Needy Adults	\$56,504	\$120,767	\$115,693	\$58,345	\$117,005	\$109,837	\$8,305
	Med Needy Children	\$0	\$0	\$0	\$7,715	\$3,960	\$0	\$0
	MFCP	\$0	\$0	\$122,839	\$581,513	\$0	\$0	\$0
	NH w/o W	\$0	\$0	\$5,100,418	\$16,199,737	\$0	\$0	\$0
	Opt St Pl Children	\$76,678	\$103,084	\$80,075	\$257,166	\$253,182	\$31	\$0
	Others	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Others-Haw aii Quest	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	OthersX	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	QUEST ACE	(\$2,751)	\$798,681	\$5,696,094	\$14,353,208	\$23,872,001	\$30,434,166	\$28,884,029
	RAACP	\$0	\$0	\$7,862,479	\$17,432,949	\$0	\$0	\$0
	St Pl Adults-Preg Immig/COFAs	\$0	\$0	\$0	\$0	\$24,990	\$2,622,138	\$2,718,679
	State Plan Adults	\$111,983,043	\$118,021,622	\$109,034,691	\$128,225,127	\$132,187,409	\$123,786,545	\$118,966,463
	State Plan Children	\$181,803,156	\$179,673,972	\$155,394,295	\$168,854,083	\$203,903,281	\$214,486,295	\$199,141,564
	Supp. - Private	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	Supp. - State Gov.	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	UCC-Governmental	\$15,688,221	\$22,546,108	\$18,919,184	\$16,356,580	\$24,507,605	\$34,064,491	\$40,634,690
	UCC-Private	\$10,056,500	\$3,403,710	\$7,500,000	\$7,500,000	\$7,500,000	\$7,500,000	\$0
		\$444,698,066	\$454,126,164	\$464,688,533	\$785,061,818	\$1,213,269,040	\$1,357,345,951	\$1,315,289,869
		-\$1,459,097	-\$1,189,919	-\$660,309	-\$4,962,002	-\$38,297,536	-\$43,476,661	-\$38,375,159
		\$443,238,969	\$452,936,245	\$464,028,224	\$780,099,816	\$1,174,971,504	\$1,313,869,290	\$1,276,914,710
		\$39,181,885	\$53,995,595	\$63,156,104	\$144,940,160	\$257,967,664	\$298,239,415	\$449,423,868
		\$565,691,724	\$619,687,319	\$682,843,423	\$827,783,582	\$1,085,751,247	\$1,383,990,662	\$1,833,414,530
		-\$334,903	-\$352,488	-\$217,644	-\$22,587	-\$15,945,497	-\$15,835,580	-\$10,164,390
		-\$323,973	-\$263,058	-\$239,466	-\$19,777	-\$6,517,946	-\$9,185,458	-\$9,300,862
		-\$347,005	-\$279,056	-\$147,219	-\$22,317	-\$9,503,023	-\$9,356,037	-\$9,335,080
		-\$453,216	-\$295,317	-\$55,980	-\$4,897,321	-\$6,331,070	-\$9,099,586	-\$9,574,826

## **Appendix B**

	Section 1931. In the second six month period, family income may not exceed 185% FPL	18,055	17,604	7,165	16,619	
<b>Optional State Plan Groups</b>						
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	Up to 100% FPL	456	442	594	496	
Children through the S-CHIP Medicaid expansion	101 - 200% FPL and for whom the State is claiming Title XXI funding	187,674	195,679	201,322	215,957	2
Medically Needy Adults and Children	Up to 300% FPL, if individuals otherwise eligible under State Plan groups described above spend down to Medicaid income limits. (Benefits are FFS)					
CHIPRA						2
Children who are not eligible for SCHIP	201- 300% FPL - who could be eligible through 1902 (r) (2) and for whom the State is claiming Title XIX funding. Eligibility criteria requiring prior enrollment in QUEST or Medicaid fee for service is eliminated in QUEST Expanded.	1	603	1,051	2,100	
<b>Demonstration Eligible Groups</b>						
Adult AFDC related family members who are TANF cash recipients who are otherwise ineligible for Medicaid.	Up to 100% FPL (using TANF methodology)	1,913	1,541	1,814	613	
Childless adults who are General Assistance (GA) cash recipients but are otherwise ineligible for Medicaid.	Up to 100% FPL (using GA methodology)	38,252	39,232	41,860	48,602	
Childless adults who meet Medicaid asset limits.	Up to 100% FPL (subject to an enrollment cap presently set at 125,000)	270,673	256,759	268,786	296,483	3
Quest Net Adults	Up to 100% FPL Eligible to enroll in QUEST but elected QUEST-Net	4,711	4,383	4,433	3,115	
Quest Net Adults	Up to 300% FPL but exceed QUEST asset or income	10,377	10,071	9,997	9,790	
QUEST ACE		1,132	22,587	70,038	115,481	1
<b>QUEST-Net-Children</b>						
<b>Demonstration Eligible Groups</b>						
<b>FPL Level and/or other qualifying Criteria</b>						
Children who could be eligible for SCHIP	201-300% FPL for whom the State is claiming Title XXI funding. Eligibility criteria requiring prior enrollment in QUEST or Medicaid fee for service is eliminated in QUEST Expanded.	8,943	10,129	20,253	29,714	
<b>Total</b>						
		1,806,586	1,801,914	1,811,781	2,047,170	2

## **Attachment C**

# **HAWAII MED-QUEST QUALITY STRATEGY 2010**

## **I. QUALITY STRATEGY INTRODUCTION AND OVERVIEW**

- Mission
- Guiding Principles
- History of Managed Care
- Quality Strategy Development
- Quality Strategy Implementation
- Goals and Objectives

## **II. ASSESSMENT**

- Quality and appropriateness of care
  - Race, ethnicity and primary language
  - External Quality Review (EQR) activities and technical report
  - Clinical standards and guidelines
  - Performance measures
- State Standards and Contract Compliance
  - Access to Care
  - Structure and Operations
  - Quality Measurement and Improvement
- Monitoring and Evaluation
  - Monitoring and Quality Improvement Flow Process
  - Sources for Monitoring and Quality Improvement  
MCO monitoring reports, EQRO technical report, Compliance audit report, CAHPS survey results/report, Provider survey results/report, HEDIS results, PIP reports, MCO consumer guide/'report card', Encounter data, Enrollment/Disenrollment data
  - Non-duplication Strategy
  - HCBS Monitoring and Quality Improvement
- Health Information Technology

## **III. IMPROVEMENT AND INTERVENTIONS**

- Interventions
  - State Agency Collaboration
  - MCO Collaboration
  - Performance Measures Validation
  - Performance Improvement Projects
  - Public Reporting
  - Financial Incentives and Disincentives
  - MCO Sanctions
  - HCBS Quality Improvement Interventions
  - EPSDT Transformation Grant and MCO collaboration
- Progress towards objectives

#### **IV. QUALITY STRATEGY REVIEW AND EFFECTIVENESS**

- Process and Timeline for Review and Updates
- Reporting Requirements

#### **V. ACHIEVEMENTS AND OPPORTUNITIES**

- Achievements
- Challenges and Future Plans

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2. QUEST MCO Baseline for Goal 1 Objectives
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1. Summary of Quality Strategy Oversight
2. MQD Quality Flow Process Calendar of Events
3. Race and Code Categories
4. Primary Language Codes
5. Selected HEDIS Performance Measures for 2009
6. Monitoring Mechanisms and Frequency
7. QUEST MCO 2008 Baseline Measurement for Goal 3 Satisfaction Measures
8. QExA MCO Baseline Data for Nursing Facilities and HCBS Clients

**List of Attachments:**

1. State Standards and Contract Compliance
2. QUEST Contract/RFP
3. QExA Contract/RFP
4. QUEST MCO Reporting Calendar
5. QExA MCO Reporting Calendar
6. HCBS Quality Monitoring Grid (including DDMR and QExA HCBS Monitoring)
7. Deeming Strategy and Crosswalk

## I. QUALITY STRATEGY INTRODUCTION AND OVERVIEW

The State of Hawaii Department of Human Services Med-QUEST Division (MQD) is required to develop and maintain a Medicaid Quality Strategy, with requirements specified by the Code of Federal Regulations (CFR) 438.202. The MQD takes this opportunity to assess past and current quality efforts and build a cohesive quality strategy encompassing the division's goals, objectives, interventions, and ongoing evaluation.

The Quality Strategy is comprehensive, systematic, and continuous. It will be amended as necessary to support the continuous quality improvement process, to reflect changes from legislated state, federal or other regulatory authority, and to respond to any significant changes in membership or provider demographic. The purposes of the strategy include:

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

### MISSION

The Quality Strategy supports the Mission of the MQD, which is:

*To be a leader for improving the health status of Hawaii residents and to ensure that those eligible for Med-QUEST programs have access to and receive coordinated and comprehensive high quality care.*

The MQD will ensure that its clients receive high quality care by providing effective oversight of managed care organizations (MCOs) and other contracted entities to promote accountability and transparency for improving health outcomes. MQD has adapted the Institute of Medicine's (IOM) framework of quality and strive for our clients to receive care that is:

- *Safe* - prevents medical errors and minimizes risk of patient harm
- *Effective* – evidence-based services consistently delivered to the population known to benefit from them
- *Efficient* - cost-effective utilization that avoids waste, including waste of equipment, supplies, ideas, and energy



- *Patient-centered* - respectful of and responsive to individual patient preferences, needs, and values
- *Timely* - medically appropriate access to care and healthcare decisions with minimal delay
- *Equitable* - without disparities based on gender, race, ethnicity, geography, and socioeconomic status.

## **GUIDING PRINCIPLES**

The MQD's quality approach aspires to the following:

### **Collaborative Partnerships**

To a large extent in Hawaii, the same providers deliver healthcare to patients who have public or private health insurance. Improving the quality of healthcare for Medicaid clients means improving the care for all Hawaii residents and requires collaboration among State Departments, MCOs, and private sector stakeholders. Quality measure alignment among Medicaid programs and private health plans would promote evidence based care, simplify reporting and measurement for providers, and allow easier and more transparent comparison for consumers. Measures will be evidence-based, and as much as possible, validated and endorsed by the National Quality Forum (NQF). The MQD, MCOs, and partner agencies will work together on common issues, such as obesity, tobacco abuse, and early screening and intervention.

### **Patient-Centered Medical Home**

The MQD seeks to advance the patient-centered medical home. In a medical home, the patient's personal physician and his or her team take responsibility for managing, coordinating, and integrating preventive, acute, chronic, long term, and end of life care, across all elements and continuum of a complex health care system. Care is facilitated by information technology, health information exchange, and other means to assure that patients get necessary care in a manner that is effective, safe, prompt, and culturally/linguistically appropriate.

### **Transparency**

The MQD is committed to making information readily available to the public. Information about MCO performance on measures, reflecting satisfaction, access, chronic disease care, immunizations, cancer screening, behavioral health, etc., will be available through public reporting to promote informed choice in MCO enrollments. This information will also be communicated to the MCOs to include comparisons to benchmarks and encourage quality improvement. Information about MCO coverage of important benefits (e.g. smoking cessation programs, disease management programs), where they vary, will also be available. In addition, we plan to develop a quality section on our website.

### **Data Driven**

A newly developed Data Warehouse will allow the MQD to have better access to encounter/claims data potentially linked with eligibility and enrollment data. This information will allow more rigorous measurement and analysis. The challenge with the variety of data sources is to put together a coherent quality picture that can be easily collected, validated, trended, and fed back to MCOs, clients, and stakeholders. The Data Warehouse is expected to integrate a variety of information that will facilitate analysis and monitoring.

### **Quality Based Purchasing**

The MQD wants to incentivize the provision of care that improves health outcomes and disincentivize care that does not. Potential non-financial incentives include provider and MCO report cards and public reporting. Potential financial incentives include increased payment to providers and MCOs for high quality care, and disincentives include not paying for avoidable medical errors or low quality care. Incentives may also be used to encourage client healthy behaviors and adherence to recommended care. MQD is beginning to implement a public reporting and an incentive program for a subset of MCOs.

## **HISTORY OF MANAGED CARE**

Hawaii's statewide comprehensive 1115(a) demonstration waiver began on August 1, 1994 with the QUEST program, which converted medical assistance coverage to people younger than 65 and not blind and/or disabled from fee-for-service to managed care. Beginning February 1, 2009, medical assistance coverage for the population age 65 or older and disabled of all ages has likewise been converted from fee-for-service (FFS) to managed care through the QUEST Expanded Access (QExA) program. Adults and children eligible for Medicaid receive their healthcare through QUEST and QExA. Children and pregnant women eligible for the State Children's Health Insurance Program (SCHIP) are also enrolled in the QUEST program and receive the same benefits as QUEST members. QUEST-ACE offers a limited benefits package through the QUEST MCOs to adults without dependant children below certain income and asset thresholds but not eligible for admission into the QUEST program due to the enrollment capitation of 125,000. Currently, there are three QUEST and two QExA MCOs.

Clients from the 'Medically Fragile', 'Residential Alternative Community Care', 'Nursing Home without Walls', and 'HIV Community Care' waiver programs were likewise transitioned from the FFS program into the QExA MCOs in February 1, 2009. Only the Developmentally Disabled/Mentally Retarded (DD/MR) 1915(c) waiver remains as a waiver program, providing services jointly with the QExA MCOs.

The **rationale for the implementation of a managed care** is improved access, quality, and cost-efficiency. Using managed care systems improves the care delivered to Medicaid clients by improving coordination of care, consistent application of

managed care principles, strong quality assurance programs, partnership with providers, emphasis on the medical home, and achieving cost-effective service delivery.

With nearly all of the State's Medicaid clients receiving their healthcare through MCOs, the MQD advances its reformation from a passive payer to an active purchaser. In this role, the MQD has primarily an oversight role and utilizes the MCO infrastructures to emphasize prevention, chronic disease management, and home and community based services. The MQD continually strives to improve the health status of its program clients by promoting MCO population-based care, provider quality of care, and patient healthy behaviors and self-management.

## **QUALITY STRATEGY DEVELOPMENT**

The Quality Strategy Leadership Team (QSLT) within the MQD initiates the development of the Quality Strategy, reviews its effectiveness, and revises it accordingly. This team is a multidisciplinary group with representation from MQD branches and offices. Input is also incorporated from the External Quality Review Organization (EQRO), partner government agencies (e.g. Department of Health), providers, clients, and advocates, all providing information useful in identifying metrics and quality activities important to the Medicaid population. Also informing the Quality Strategy are assessments of the previous year's quality plan, the EQR technical report, and results from MCO reports.

### **EQRO Input**

The annual technical report provides detailed information about MCO performance with respect to quality, access, and timeliness of care and services, which guides our Quality Strategy. Specifically, we receive information on regulatory compliance, a set of validated Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and performance improvement projects (PIPs). The EQRO also administers and reports on provider satisfaction surveys as well as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of client satisfaction, both of which inform the quality strategy. Furthermore, the EQRO assists MQD in the compiling of an MCO comparison guide of various performance measures. Importantly, the EQRO reviews and provides input on the Quality Strategy. The EQRO will also be consulted at various times during the implementation of the Quality Strategy.

### **Client and Provider Input**

Client and provider input most directly occur through the results of client and provider surveys that are administered and reported by the EQRO. In addition, information from Member Grievance and Appeals Reports as well as Provider Complaints Reports is submitted by the MCOs and guides our Quality Strategy.

### **Partner Government Agency and Stakeholder Input**

Reports from and regular meetings with partner agencies and stakeholders give input on statewide priorities and progress that also inform our strategy.

### **Public Input**

Public input will be obtained by submitting the Quality Strategy for public comment initially, every 5 years, or when significant changes are made to the strategy. A public notice will be posted in major newspapers, informing the public of their access to the quality strategy document and allowing for a 30-day period for public input.

## **QUALITY STRATEGY IMPLEMENTATION**

The MQD QSLT has the overall responsibility for the quality oversight process that governs all Medicaid programs, including the MCOs, the DD/MR waiver, and other contracts. The Leadership Team serves as the unifying point for various Quality Strategy Committees (QSCs), which track/trend report information from MCOs and other programs and provide recommendations for improvement and corrective action. Quality Collaboratives between MQD and the MCOs/programs close the loop in ensuring that remediation and systems changes are implemented.

### **Quality Flow Process**

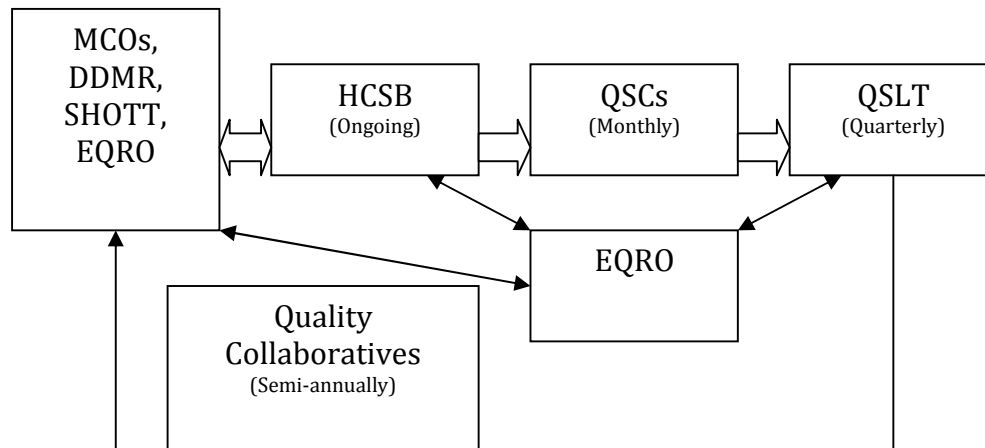
The Health Care Services Branch (HCSB) at MQD receives and reviews all monitoring and quality reports from the MCOs, the DD/MR waiver, the State of Hawaii Organ and Tissue Transplant (SHOTT) program, and the EQRO. Standardized reporting and review tools are being developed for all MCOs and programs to allow for improved oversight, plan-to-plan comparisons, and trending over time.

Findings from the reports will be presented to various QSCs on a monthly rotation. The Committees are composed of representation from the QSLT, technical experts from the program(s) being reviewed, as well as the HCSB reviewer(s). The Committee meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The Committees will recommend feedback to the MCOs and programs, and corrective action will be requested if needed. Findings and recommendations will be properly documented.

The QSLT will meet quarterly to review the findings and recommendations from the various QSCs, focusing on critical and high impact issues requiring systems change that relate to meeting established goals and objectives. Semi-annually, the Leadership Team will meet collaboratively with the MCOs and programs. These Quality Collaboratives will allow opportunity for dialogue, feedback, follow-up of corrective actions and performance improvement projects (PIPs), exchange of information, and identification of best practices.

See Figure 1 for a diagram of the quality flow process described above. Table 1 gives a summary of the membership and responsibilities of the QSLT, QSCs, and quality collaboratives. Table 2 shows the quality flow process through a calendar of events.

**Figure 1: Quality Flow Process Diagram:**



**Table 1: Summary of the Quality Strategy Oversight:**

Entities	Membership	Responsibilities
Quality Strategy Leadership Team (QSLT)	<ul style="list-style-type: none"> <li>MQD leadership from several MQD branches and offices</li> <li>MQD Medical Director</li> <li>EQRO consultant as needed</li> </ul>	<ul style="list-style-type: none"> <li>Lead the development, review, and revision of Quality Strategy.</li> <li>Oversight for review of quality data and monitoring reports</li> <li>Oversight for quality improvement recommendations and implementation of these recommendations by MCOs and programs.</li> <li>Meets quarterly and more often as needed.</li> <li>Meets semi-annually in Collaboratives with MCOs and programs.</li> </ul>
Quality Strategy Committees (QSC)	<ul style="list-style-type: none"> <li>QSLT representative</li> <li>MQD technical expert(s)</li> <li>MQD HCBS reviewer(s)</li> </ul>	<ul style="list-style-type: none"> <li>Committees may include: QUEST/QExA compliance, QUEST/QExA ambulatory care quality, HCBS, Long-term Care, Inpatient Care, Mental Health</li> <li>Review of quality data and monitoring reports from MCOs, programs, and EQRO.</li> <li>Recommendations for corrective actions, quality improvement, and system changes.</li> <li>Follow-up of corrective actions and quality improvement recommendations.</li> <li>Meets in a monthly rotation.</li> </ul>
Quality Collaboratives	<ul style="list-style-type: none"> <li>QSLT representative(s)</li> <li>MQD technical expert(s)</li> <li>MCO or program representative(s)</li> <li>EQRO consultant</li> </ul>	<ul style="list-style-type: none"> <li>Serves as forum between MQD and MCOs/programs for dialogue, feedback, follow-up of corrective action, PIPs, best practices.</li> </ul>

**Table 2: MQD Quality Flow Process Calendar of Events**

<b>July</b>	<b>August</b>	<b>September</b>	<b>October</b>	<b>November</b>	<b>December</b>
QSC review (analysis of reports received in June)  Quality Collaborative	QSC review (analysis of reports received in July)	QSC review (analysis of reports received in August)  QLST meeting (review information from 2 <sup>nd</sup> quarter of year)	QSC review (analysis of reports received in September)	QSC review (analysis of reports received in October)	QSC review (analysis of reports received in November)  QLST meeting (review information from 3 <sup>rd</sup> quarter of year)
<b>January</b>	<b>February</b>	<b>March</b>	<b>April</b>	<b>May</b>	<b>June</b>
QSC review (analysis of reports received in December)  Quality Collaborative	QSC review (analysis of reports received in January)	QSC review (analysis of reports received in February)  QLST meeting (review information from 4 <sup>th</sup> quarter of year)	QSC review (analysis of reports received in March)	QSC review (analysis of reports received in April)	QSC review (analysis of reports received in May)  QLST meeting (review information from 1 <sup>st</sup> quarter of year)

Legend:

QSC	Quality Strategy Committee	QLST	Quality Strategy Leadership Team
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## GOALS AND OBJECTIVES

The MQD is focused on ensuring that its clients receive high quality care that is safe, effective, efficient, patient-centered, timely, and equitable, by providing effective oversight of health plans and other contracted entities to promote accountability and transparency for improving health outcomes.

### Goal 1: Improve preventive care for women and children

Objectives:

- **Childhood Immunizations:** For calendar year HEDIS 2010 data, increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the 2010 Medicaid 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
- **Chlamydia Screening:** For calendar year 2010, increase performance on the state aggregate HEDIS Chlamydia Screening measure to meet/exceed the 2010 Medicaid 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of

50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.

- Breast Cancer Screening: For calendar year 2010, increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the 2010 Medicaid 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
- Establish baselines for the above measures for the QExA MCOs using HEDIS 2010 data.

## **Goal 2: Improve care for chronic illness**

### **Objectives:**

- Comprehensive Diabetes Care Measures:
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (>9) to meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<7) to meet/exceed below the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL screening to meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL control (<100) to meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
  - For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<130/80) to

meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.

- For calendar year 2010, increase performance on the state aggregate HEDIS Diabetes Care Measure for eye exams to meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in the calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
- Establish baselines for nephropathy measure for both QUEST and QExA MCOs.
- Cholesterol Screening and Control in Patients with Cardiovascular Conditions:
  - For calendar year 2010, increase performance on the state aggregate HEDIS Cholesterol Screening measure to meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
  - Establish baselines for LDL control (<100) in patients with cardiovascular conditions for QUEST and QExA health plans.
- Blood Pressure Control in the General Population: For calendar year 2010, increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 25% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
- Appropriate Medications in Asthma: For calendar year 2010, increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the 2010 HEDIS 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in calendar year 2009.
- Establish a baseline of the above measures for QExA MCOs using HEDIS 2009 data.

### **Goal 3: Improve client satisfaction with health plan services**

#### **Objectives:**

- For calendar year 2010, increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS 2010 Adult Medicaid 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2008 and the CAHPS 2010 Adult Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in 2008.
- For calendar year 2010, increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS 2010 Adult Medicaid 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of



50% of the difference between the rate in calendar year 2008 and the CAHPS 2010 Adult Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in 2008.

- For calendar year 2010, increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS 2010 Adult Medicaid 75<sup>th</sup> percentile OR to meet/exceed the rate that is an improvement of 50% of the difference between the rate in calendar year 2008 and the CAHPS 2010 Adult Medicaid 75<sup>th</sup> percentile, above the state aggregate rate in 2008.
- Establish a baseline of the above measure for QExA MCOs using the 2010 Adult CAHPS survey results.

#### **Goal 4: Improve cost-efficiency of health plan services**

Objectives:

- Over the next 2 years, develop the use of Episode Treatment Groups (ETGs) to compare health plans for a variety of chronic conditions.
- Over the next 2 years, establish baseline data for hospital readmission rate in line with specifications set by the Medicaid Medical Directors Learning Network, in order to allow comparison to other states and begin quality improvement process with MCOs.
- Over the next year, explore and establish baselines for ED data from the data warehouse encounter data, to include all ED visits leading to inpatient hospitalizations.
- Improve performance on the state aggregate HEDIS 2010 Emergency Department Visits/1000 rate to meet/fall below the HEDIS 2010 10<sup>th</sup> percentile OR to meet/fall below the rate that is an improvement of 50% of the difference between the rate in calendar year 2009 and the HEDIS 2010 Medicaid 10<sup>th</sup> percentile.
- Establish baseline of the above measure for the QExA MCOs using HEDIS 2009 data.

**Goal 5:** Monitor Home and Community Based Service (HCBS) clients who have transitioned from waiver programs into QExA health plans

Objectives:

- Increase by 5% the proportion of clients receiving HCBS instead of institutional-based long-term care services over the next year.
- Establish baseline for ED visits in HCBS clients.
- Establish baseline for hospital admissions in HCBS clients.

## **II. ASSESSMENT**

This section addresses a) Quality and Appropriateness of Care, b) State Standards and Contract Compliance, c) Monitoring and Evaluation, and d) Health Information Technology.

## QUALITY AND APPROPRIATENESS OF CARE

### **Race, Ethnicity, and Primary Language**

Consistent with Federal Regulations, the procedure for MQD obtaining data and communicating data to MCOs include the following: The eligibility workers at MQD, while processing the application and determining eligibility, obtain information about the client's race, ethnicity, and primary language. This information is entered into the Department of Human Services Hawaii Automated Welfare Information (HAWI) eligibility system and transferred monthly to the MCOs through the health plan enrollment file (834 file). Any changes are updated and transferred to the MCOs daily via the 834 file format as well. The procedure is the same for clients receiving Supplemental Security Income. Eligibility workers at the Benefit Employment and Support Services Division (BESSD) obtain this information while processing the application and the information is transferred to the MCOs monthly and changes updated daily.

The ethnic categories in Hawaii include Hispanic (HI) and non-Hispanic (NH). Race categories include the following in the table below.

**Table 3: Race Codes and Categories**

RACE CODE	DATE FROM	DATE TO	DESCRIPTION	FED GROUP
AI	010187	999999	AMERICAN INDIAN/ALASKAN NATIVE	AI
BL	010187	999999	BLACK	BL
CH	010187	999999	CHINESE	AN
FI	010187	999999	FILIPINO	AN
HA	010187	999999	HAWAIIAN	NH
JA	010187	999999	JAPANESE	AN
KO	010187	999999	KOREAN	AN
OA	010187	999999	OTHER ASIANS	AN
OP	010187	999999	OTHER PACIFIC ISLANDERS	NH
SA	010187	999999	SAMOAN	NH
WH	010187	999999	WHITE	WH

Primary language categories are in the process of being updated in the HAWI system. The table below shows the current primary language codes as well as the new codes that will be added to the system.

**Table 4: Primary Language Codes**

<b><i>Current Codes/Languages</i></b>		<b><i>New Codes/Languages to be added</i></b>			
CA	Cambodian	AR	Arabic	MA	Malay
CC	Cantonese	AM	Aramaic	ML	Maltese
CM	Mandarin	BE	Bengali	MO	Maori
EN	English	BI	Bisayan	MR	Marquesan
FI	Ilocano	BU	Bulgarian	MS	Marshallese

FO	Filipino Other	CE	Cebuano	MK	Mon-Khmer
FT	Tagalog	CH	Chamorro	NA	Navaho
HA	Hawaiian	CU	Chuukese	NO	Norwegian
JA	Japanese	CZ	Czech	OA	Other Asian
KO	Korean	DA	Danish	OI	Other Indo-European
KS	Kosraean	DU	Dutch	ON	Other North American Indian
LA	Laotian	ES	Estonian	PW	Paiwan
OT	Other	FJ	Fijian	PP	Papuan
PA	Palauan	FN	Finnish	PE	Persian
SA	Samoan	FM	Formosan	PO	Pohnpeian
SI	Sign Language	FR	French	PL	Polish
SO	Other So. Pacific	FC	French Creole	PR	Portuguese
SP	Spanish	GE	German	RA	Rapanui
TO	Tongan	GR	Greek	RO	Romanian
UN	Unknown	GU	Gujarathi	RU	Russian
VI	Vietnamese	HE	Hebrew	SE	Serbian
YA	Yapese	HI	Hindi	SN	Sinhalese
		HM	Hmong	SL	Slovak
		HU	Hungarian	SV	Slovenian
		IB	Ibo	SW	Swedish
		IN	Indonesian	TA	Tahitian
		IR	Irish	TH	Thai
		IT	Italian	TU	Turkish
		KR	Kru	VS	Visayan
		KU	Kurdish	YI	Yiddish
		LT	Latvian	YO	Yoruba
		LI	Lithuanian		

### **External Quality Review (EQR) Activities and Report**

MQD contracts with an EQRO to perform, on an annual basis, an external, independent review of quality outcomes of, timeliness of, and access to, the services provided to Medicaid clients by MCOs, as outlined in 42 CFR 438, Subpart E. MQD currently contracts with Health Services Advisory Group (HSAG) for EQR activities. HSAG has been the EQRO for the State of Hawaii since 2001.

The EQRO and each of its subcontractors must meet the competency and independence requirements detailed in 42 CFR 438.354. Competency of its staff is demonstrated by experience and knowledge of: a) the Medicaid program; b) managed care delivery systems; c) quality assessment and improvement methods; and d) research design and methodology, including statistical analysis. The EQRO must have sufficient resources and possess other clinical and nonclinical skills to perform EQR

activities and to oversee the work of any subcontractors. To maintain its independence, the EQRO must be governed by a board whose members are not government employees; and must not: a) review an MCO if the EQRO or the MCO exerts control over the other as evidenced by stock ownership, stock options, voting trusts, common management, and contractual relationships; b) furnish health care services to Medicaid recipients; c) perform Medicaid managed care program operations related to the oversight of the quality of the MCO on the State's behalf, except for the activities specified in 42CFR 438.358; or d) have a financial relationship with the MCO that it will review.

The EQRO is responsible to perform mandatory and optional activities as described in 42 CFR 438.358. Mandatory activities for each MCO include: a) validation of performance improvement projects; b) validation of performance measures reported as required by the State of Hawaii; and c) 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. Optional activities as required by the State of Hawaii have included: a) administration of the CAHPS Consumer Survey; b) administration of a provider satisfaction survey; c) encounter data validation; and c) provision of technical assistance to the MCOs to assist in conducting activities related to the EQR activities.

For the EQR activities conducted, the EQRO will submit an annual detailed technical report that describes data aggregation and analysis, and the conclusions that were drawn as to the quality, timeliness, and access to the care furnished by each MCO. The report will also include: a) an assessment of each MCO's strengths and opportunities for improvement; b) recommendations for improving quality of health care; c) comparative information about the MCOs; and d) an evaluation of how effectively the MCOs addressed the improvement recommendations made by the EQRO the prior year.

The EQR results and technical reports will be reviewed by the appropriate Quality Strategy Committee (QSC) and the Quality Strategy Leadership Team (QSLT). The QSC will analyze the information and make recommendations for corrective actions, quality improvement and system changes to the MCOs and will monitor MCO compliance to corrective actions. The QSLT will provide oversight of implementation of quality recommendations and will review and revise the Quality Strategy accordingly.

### **Clinical Standards and Guidelines**

The MQD uses clinical guidelines to guide its policy development. Guidelines are adapted or adopted from national professional organizations, such as the United States Preventive Services Task Force (USPSTF) for screening recommendations, the Centers for Disease Control/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.

At the same time, MQD requires contracted MCOs to adopt practice guidelines consistent with 42 CFR 438.6(h) and 422.208, which are relevant to MCO membership, 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. MQD requires the MCOs to develop at least three clinical guidelines for medical conditions and at least 2 for behavioral health conditions. These may include asthma, diabetes, high risk pregnancy, depression, and attention deficit hyperactivity disorder, among others.

MCO compliance with Federal Regulations with regards to clinical guidelines is reviewed by the EQRO at least every 3 years.

### **Performance Measures**

Since CMS, in consultation with the States, has not mandated specific performance measures and topics for performance improvement projects (PIPs), the MQD has identified a set of performance measures and PIP topics that address a range of priority issues for Medicaid clients. The measures have been identified through a process of analysis and trending of data within the Medicaid population, from MCO reports, and from the EQR technical report. Client and provider input, through results of client and provider surveys as well as member grievance and provider complaint reports, also guides the selection of performance measures. Reports from regular meetings with partner agencies and stakeholders also inform the selection of performance measures. Performance measures are updated each year.

**Table 5: Selected HEDIS Performance Measures for 2009**

HEDIS 2009						
I	Effectiveness of Care	Note	QUEST	QExA		Rate %tile
	Childhood Immunization Status		X	X	Combination #2	67.55% 25-50
	Lead Screening in Children		X	X		59.51% N/A
	Breast Cancer Screening		X	X		51.15% 25-50
	Cervical Cancer Screening		X	X		68.05% 50-75
	Colorectal Cancer Screening	added 2009	X	X		
	Chlamydia Screening in Women		X	X	Overall Rate	51.44% 50-75
	Appropriate Treatment for children with Upper Respiratory Infection	added 2009	X	X		
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	added 2009	X	X		
	Use of Appropriate Medications for People with Asthma		X	X	Combined Rate	85.74% 25-50
	Cholesterol Management for Patients with Cardiovascular Conditions	added 2009	X	X		
	Controlling High Blood Pressure	added 2009	X	X		
	Persistence of B Blocker Treatment after a Heart Attack	added 2009	X	X		
	Comprehensive Diabetes Care					
	Hemoglobin A1c (HbA1c) Tested		X	X		76.63% 25-50
	HbA1c Poor Control (>9%)		X	X		59.95% 25-50
	HbA1c Good Control (<7%)		X	X		19.99% N/A
	Eye Exam (Retinal) Performed		X	X		52.32% 50-75
	LDL-C Screening Performed		X	X		75.11% 10-25
	LDL-C Screening Level < 100 mg/dL		X	X		26.15% 10-25
	Systolic and Diastolic BP Levels < 130 / 80		X	X		31.38% N/A
	Antidepressant Medication Management		X	X	Optimal Practitioner Contacts for Medication	34.14% 90-100
	Follow-Up of Care for Children Prescribed ADHD Medication	added 2009	X	X		
	Follow-Up After Hospitalization for Mental Illness		X	X	7 days	32.60% 25-50
	Annual Monitoring for Patients on Persistent Medications	added 2009	X	X		
	Medication Reconciliation Post-Discharge	added 2009	X	X		
	Use of High-Risk Medications in the Elderly	added 2009	X	X		
	Osteoporosis Testing in Older Women	added 2009	X	X		
	Flu Shots for Older Adults	added 2009	X	X		
	Medical Assistance With Smoking Cessation	added 2009	X	X		
	Pneumonia Vaccination Status for Older Adults	added 2009	X	X		
II	Access/Availability of Care					
	Adults' Access to Preventive/Ambulatory Health Services			X	20-44 years	76.41% 25-50
	Prenatal and Postpartum Care		X		Prenatal	55.98% 0-10
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		X	X	Initiation of AOD Dependence Treatment	48.96% 75-90
III	Use of Services					
	Well-Child Visits in the First 15 Months of Life		X	X	Children who received six or more visits	51.85% 50-75
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life		X	X		60.87% 25-50
	Inpatient Utilization -- General Hospital/Acute Care		X	X	Total Days/1,000 Member Months (MM)	21.12 10-25
	Ambulatory Care		X	X	Total Outpatient Visits/1,000 MM	188.53 0-10
	Mental Health Utilization -- Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Services		X	X	Any Mental Health Services, Total %	8.57% 50-75
IV	Cost of Care					
	Relative Resource Use for People with Diabetes		X	X		N/A
	Relative Resource Use for People with Asthma		X	X		N/A
V	Health Plan Descriptive Information					
	Member Months of Enrollment by Age and Sex		X	X		N/A

## STATE STANDARDS AND CONTRACT COMPLIANCE

All standards for access to care, structure and operations, and quality measurement and improvement, listed in the table below are incorporated in the MCO contracts/requests for proposal (RFPs) and in accordance with Federal Regulations. The language in the MCO contracts for each standard is in alignment with the regulations, and in some cases, more stringent than the regulations. See **Attachment 1** for a detailed crosswalk. The QUEST and QExA contracts are also included as **Attachments 2 and 3** for detailed documentation of contract language. Monitoring for each of these standards is achieved by a variety of methods, including required

reporting and EQRO compliance reviews. This monitoring is more fully detailed in the next section.

## **MONITORING AND EVALUATION**

### **Monitoring and Quality Flow Process**

Staff of the MQD HCBS branch reviews monitoring and quality reports from the MCOs and programs. During regularly scheduled meetings, the QSCs review and analyze the data received, root causes, barriers, and improvement interventions. Feedback is provided to the MCOs and programs, and corrective action is requested if needed. The Committees also review and suggest changes to the reporting templates and monitoring mechanisms as needed. The QSLT in regular meetings review the findings and recommendations from the various QSCs and focus on critical issues requiring systems changes. The Leadership Team regularly meets in collaboratives with the MCOs and programs to provide opportunity for dialogue, feedback, follow-up of corrective actions and PIPs, exchange of information, and identification of best practices. This flow process is fully detailed under the Quality Strategy Implementation Section.

### **Sources for Monitoring and Quality Improvement**

**MCO Monitoring Reports:** These are contractual reporting required from MCOs. MQD is standardizing report templates as well as review tools for each required report. These include reports on Provider Network and Credentialing, Authorization Denials, Member Grievances, Provider Complaints, Timely Access, Availability of Services, Claims Payment, Call Center, Case Management, among others. See ***Attachment 4 and 5*** for the most recent QUEST and QExA MCO Reporting Calendars. Reporting calendars are updated annually. The DD/MR program also has required reporting. Please refer to ***Attachment 6*** for reporting details.

**EQRO Technical Report:** Each year, the EQRO technical report compiles and analyzes results from mandatory and optional activities performed that year to monitor the MCOs. These include compliance reviews of standards on access, structure and operations, and quality measurement and improvement; validation of PIPs; validation of performance measures; and consumer satisfaction surveys. It may also include provider satisfaction surveys and encounter data validation if performed. The report includes recommendations for MCO quality improvement, comparative information about the MCOs, and an evaluation of how effectively the MCOs addressed improvement recommendations from the EQRO in the prior year.

**Compliance Audit Report:** This is the full report submitted by the EQRO summarizing the findings for each MCO on compliance reviews of standards on access, structure and operations, and quality measurement and improvement. It contains the analysis of findings as well as recommendations for corrective action if needed.

**CAHPS Survey Report:** The EQRO administers and analyzes the CAHPS survey for the MCOs, alternating each year between children and adults. The report summarizes the findings for each MCO on performance on the CAHPS surveys. It contains the analysis of findings as well as recommendations for improvement.

**Provider Survey Report:** The EQRO administers and analyzes a Provider Survey for providers of the MCOs every other year. The report summarizes the findings for each MCO on performance on the provider surveys. It contains the analysis of findings as well as recommendations for improvement.

**HEDIS Results:** The MQD requests HEDIS data from the MCOs annually. These are tracked and trended. They are used for comparisons among MCOs, discussed collaboratively among MCOs to promote sharing of best practices, and may serve as a basis for public reporting and financial incentive programs. Approximately six of these HEDIS measures are validated by the EQRO annually and included in the EQRO Technical Report.

**Performance Improvement Project Reports:** The EQRO validates two PIPS per MCO each year. The report summarizes the findings for each MCO on the validated PIPs. It contains the analysis of findings as well as recommendations for improvement. Technical assistance is provided to the MCOs for PIPs based on the report recommendations.

**MCO Consumer Guide / Report Card:** Based on CAHPS and HEDIS measures, the MQD (with assistance from the EQRO) recently compiled a report card comparing the performance of the QUEST MCOs on selected measures. This guide was distributed to the MCOs to promote transparency and sharing of best practices. The guide will continue to be generated on a regular basis and expanded to QExA MCOs. It will also be posted on the MQD website and eventually distributed to clients during open enrollment, to partner state agencies, and to stakeholders.

**Encounter Data:** All MCOs submit encounter data to MQD. These are stored in the claims system as well as the data warehouse. These encounter data will be used to generate information to monitor measures on a variety of clinical performance measures, services, and access. In the past, encounter data validation was performed by the EQRO on QUEST MCOs. As the data warehouse becomes more used, validation of the encounter data that feeds the data warehouse will be an important optional EQRO activity to perform.

The grid below summarizes monitoring for the required standards.

**Table 6: Monitoring Mechanisms and Frequency**



Monitoring Mechanism	MCO and program Reports	EQRO Technical Report	Compliance Audit Report	CAHPS Survey Results	Provider Survey Results	HEDIS Validation /Reporting	Validation of PIPs	MCO Report Card	Encounter Data
Frequency	Various Timeframes	Annual	At least once in 3 years	Annual	Every other year	Annual	Annual and Ongoing	Ongoing	Ongoing
<b>Access to Care Standards</b>									
Availability of Services	X	X	X	X					X
Delivery of Network Adequacy	X	X	X	X	X				
Timely Access to Care	X	X	X	X			X	X	
Cultural Considerations	X	X	X	X					
Primary Care and Coordination / Continuity of Services	X	X	X	X	X				
Special Health Care Needs	X	X	X	X		X			
Coverage and Authorization of Services	X	X	X	X	X				
Emergency and Post Stabilization Services		X	X						
<b>Structure and Operational Standards</b>									
Provider Selection and Credentialing	X	X	X		X				
Confidentiality		X	X	X					
Enrollment and Disenrollment		X	X						
Grievance Systems	X	X	X						
Sub-contractual Relationships and Delegation		X	X						
<b>Quality Measurement and Performance Improvement Standards</b>									
Practice Guidelines		X	X			X			
Quality Assessment and Performance Improvement Program		X	X						
Health Information Systems		X	X						X
Performance Improvement Projects		X				X	X		
Performance Measurement		X				X	X	X	X

### **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 42 CFR 438.204(g). The standards that may be considered for this deemed compliance as referenced in 438.204(g) 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 PIPs and calculating performance measures) are an option for deeming only for plans that serve only dual eligible clients and therefore does not apply to our contracted MCOs.

Hawaii Revised Statute 432E-11 requires that managed care plans doing business in Hawaii become accredited by a national accrediting organization. Currently, the QUEST MCOs are accredited by either National Committee for Quality Assurance

(NCQA) or URAC. The QExA MCOs have not been operating in Hawaii for sufficient time to seek accreditation but plan to be accredited by either NCQA or URAC as well no later than January 1, 2012.

Although MQD has not fully implemented the non-duplication strategy, it has begun work on establishing guidelines and processes, with guidance and assistance from the EQRO, by which the non-duplication strategy may be implemented. The proposed process includes:

- MQD identifies deemable standards and with assistance from the EQRO, verifies the crosswalks to ensure that all federal, state, and contractual requirements pertaining to the deemable standards are met.
- The MCO must have achieved full compliance on deemable standards through a prior State EQRO review.
- The MCO must be fully accredited by a CMS approved organization.
- The MCO must be reviewed by the CMS approved accrediting organization and achieve full compliance with the deemable standards.
- The MCO must provide the accreditation review results to MQD.
- The MQD will in turn provide the review results to the EQRO.
- The EQRO uses the results in the State's annual EQR report.

The EQRO will not duplicate the review of specified deemable standards if all the criteria above are met. However, if there are certain federal, state, or contractual requirements that do not match the accreditation standards, the EQRO will perform a limited review of those requirements in addition to reviewing the accrediting organization's review results for the specified standards.

The first two standards being considered include 'Credentialing' and 'Clinical Practice Guidelines', with additional standards to be considered in the future. See **Attachment 7** for further details on EQRO recommendations regarding the non-duplication strategy and crosswalks for the two standards being considered.

### **Home and Community Based Services (HCBS) Monitoring and Quality Improvement**

Since February 2009, when the aged, blind, and disabled clients were transitioned from the FFS program into the QExA MCOs, the clients from the 'Medically Fragile', 'Residential Alternative Community Care', 'Nursing Home without Walls', and 'HIV Community Care' waiver programs were likewise transitioned. Only the DD/MR waiver remains as a waiver program, providing services jointly with the QExA MCOs. With these transitions, MQD is committed to monitoring the provision and quality of HCBS services, both in the QExA MCOs as well as the DD/MR waiver. The attached grid, **Attachment 6** details a quality monitoring program with performance measures that span the six assurances and sub-assurances to include Level of Care, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability.

## **HEALTH INFORMATION TECHNOLOGY**

In accordance with 42 CFR 438.42, each MCO will maintain a health information system that collects, analyzes, integrates, and reports data. The system will provide information in areas including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The data must be collected on enrollee and provider characteristics, and on services furnished to enrollees through an encounter data system.

MQD expects that the MCOs submit encounter data at least once per month and install the MQD-approved software to allow for secure transfer of the data. The submissions must meet specified criteria for timeliness, accuracy and completeness.

- **Timeliness** – Eighty percent (80%) of the encounter data shall be received by MQD no more than one-hundred twenty (120) days from the date that services were rendered and ninety-nine percent (99%) within (15) months from the date of services.
- **Accuracy and Completeness** – The data and information provided to MQD shall be accurate and complete. Encounter data will be certified and represent services provided to QUEST and QExA enrollees only and be complete with no material omissions.

MQD will impose financial penalties or sanctions on the MCO for inaccurate, incomplete and late submissions of required data, information and reports.

As specified in CFR 438.204(f), the Hawaii Prepaid Medical Management Information System (HPMMIS) supports MQD's administration of the QUEST and QExA programs and provides for the following: a) enrollment processing; b) encounter record processing; c) claims processing; d) premium collection; e) per capita payments; and f) related tracking and reporting.

Information from HPMMIS is utilized to produce reports, which identify and aid in the investigation of provider abuse or misuse. The recent development of a Data Warehouse will enhance MQD's efforts in this area. The Data Warehouse will also enhance efforts in quality improvement as it will enable MQD to monitor HEDIS-like quality and utilization measures for specific populations (HCBS clients, DD/MR recipients, elderly clients, among others) outside of MCO annual HEDIS reporting. Through the Data Warehouse, the MQD can also monitor utilization and cost-efficiency through the tracking of Episode Treatment Groups.

In Hawaii, the use of health information technology has expanded to include an online EPSDT form, which provides a database of previous vaccines, screenings, and referrals, and will provide prompts and alerts for services that are due. This pilot

project also encompasses the collection of all EPSDT data, whether submitted electronically or through a paper form, into the online database and allows MQD to track and trend clinical information associated with EPSDT exams. Connectivity between provider electronic health systems and the EPSDT database to facilitate submission of EPSDT data is actively being explored. Connectivity among the State's Vaccine for Children's program, the Immunization Registry, and the EPSDT database is also being pursued. This connectivity will prevent the duplication of providers entering immunization information into the EPSDT online system as well as the Immunization Registry and/or Vaccines for Children database.

Although in its infancy, the proposed development and implementation of a statewide health information exchange network will give health care professionals quick access to all available records and has the potential to improve health care quality by preventing medical errors, increasing the efficiency of care, reducing unnecessary health care costs, decreasing paperwork and expanding access to affordable care. MQD is vital part of these discussions.

### **III. IMPROVEMENT AND INTERVENTIONS**

Interventions for improvement of quality activities are varied and based on the review and analyses of results from each monitoring activity. As results from assessment activities are produced, it is likely that MQD will be able to further and more clearly define interventions for quality improvement as well as progress towards objectives.

#### **INTERVENTIONS**

##### **State Agency Collaboration**

MQD is in regular communication with the Department of Health's (DOH's) branches. These include the various Chronic Disease Prevention and Control Branches for Asthma, Diabetes, and Tobacco, the Maternal and Child Health Programs, the Mental Health Divisions, and the Developmental Disabilities Division, among others. The MCO performance on measures related to chronic diseases, maternal and child health, mental health, or the DD/MR waiver may trigger discussion with DOH to collaborate on assisting the MCOs in improving their performance. DOH branches also benefit from these collaborations since their grant requirements often include education of providers and patients that can be facilitated by the MCOs. The MQD, MCOs, and DOH branches often work together on common issues, such as obesity, tobacco abuse, and early screening and intervention.

##### **MCO Collaboration**

The collaborative relationship between MQD and the MCOs has been important in fostering improvement interventions. Monthly meetings occur with MQD and the QUEST MCOs as well as with MQD and the QExA MCOs. There are also regular medical director meetings that bring together the MQD medical director with the medical directors of the QUEST and QExA MCOs. Sharing of common problems, monitoring activities, and performance measures occur in these meetings, and these collaborations result in the sharing of best practices. In addition, MQD will be instituting Quality Collaboratives, bringing together the QLST and the MCOs, allowing opportunity for dialogue, feedback, follow-up of corrective actions and PIPs, exchange of information, and identification of best practices.

### **Performance Measure Validation**

Performance measures are tracked and trended. The information is used to focus future quality activities and direct interventions for existing quality activities. MCOs performing poorly in certain performance measures are expected to conduct root cause analyses and causal barrier analyses to identify appropriate interventions. Technical assistance is provided to the MCOs to assist in these processes. The EQRO, in the review of performance measures, offers recommendations for improvement to the MCOs and follows-up to make sure that these recommendations are implemented.

Six HEDIS performance measures per MCO are validated during the EQR process, with corrective action required for lack of improvement. In active development is the use of a 'report card' to allow performance on selected measures to be transparent. An Incentive/Disincentive Program has also been established to incentivize/disincentivize the MCOs performance, initially for QUEST MCOs, and later expanding to the QExA MCOs. A dollar amount is withheld from MCO capitation payments and returned when performance measure goals are met.

During review and discussion of performance measures at the QSCs and QSLT meetings, opportunities are sought to implement cross- organizational and inter-agency interventions.

### **Performance Improvement Projects**

A PIP is intended to improve the care, services, or member outcomes in a focus area of study. MQD selects certain PIP topics to be collaboratively performed by the MCOs, and the MCOs also select topics individually that address specific areas of concern. The MQD/HCSB works with the EQRO and the MCO to guide the selection of the PIPs. The current mandatory PIP topics for the QUEST MCOs are focused on Childhood Obesity and Access to Care. A third PIP related to a HEDIS clinical performance measure is chosen by the QUEST MCOs. For the QExA MCOs, the mandatory PIP is focused on HEDIS clinical performance measure. The QExA MCO selects a second clinical or non-clinical PIP.

The general expectations for PIPs include:

Year 1: PIP development process, appropriate study topic, clearly defined study question and indicators, correctly identified study population, baseline results, valid

sampling methods, accurate and complete data collection, analyses identify interventions for the re-measurement year;  
Year 2: Interventions implemented and results reported;  
Year 3: Re-measurement and ongoing improvement with adjustment in interventions as appropriate;  
Year 4: Re-measurement demonstrating ongoing improvement or sustainability of results; and future years to be determined based on results, sustainability, and member needs.

The EQRO will validate two PIPs per MCO each year. Results are expected to demonstrate progress toward achievement of the identified goal. For areas of noncompliance, technical assistance will be provided if needed, and corrective action plans can be required and monitored.

During review and discussion of PIPs at the QSCs and QSLT meetings, opportunities are sought to implement cross-organizational and inter-agency interventions.

### **Public Reporting**

The MQD is actively implementing a public reporting mechanism, which includes a variety of performance measures, displayed by MCO, in a simple and understandable 'report card' or 'consumer guide'. This guide allows a comparison of the MCOs across a variety of measures and can be distributed to clients, providers, and stakeholders. The guide has been developed for QUEST MCOs and will be expanded to QExA MCOs as they become more established. Implementation will include the creation of a consistent process to distribute these public reports.

### **Financial Incentives and Disincentives**

A financial incentive/disincentive program has been developed for QUEST MCOs and will be expanded to include QExA MCOs as they become more established. The incentives involve a variety of HEDIS and CAHPS performance measures. A dollar amount is withheld from the MCO capitation payments and returned as the performance measure goals are met.

### **MCO Sanctions**

Sanctions may be imposed on MCOs upon failure to meet reporting requirements. When corrective action is required, sanctions may also be imposed when timelines and activities for the correction action are not met. Sanctions are written into the MCO contracts and are used when other interventions have failed.

### **HCBS Quality Improvement Interventions**

Refer to ***Attachment 6*** for more details. The grid details a quality monitoring program with performance measures and interventions that span the six assurances and sub-assurances to include Level of Care, Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability.

### **EPSDT transformation grant and MCO collaboration**

The EPSDT transformation grant is a pilot project that includes the development and implementation of an online EPSDT system that allows providers to submit EPSDT data electronically. The system provides a database of previous vaccines, screenings, and referrals, and will provide prompts and alerts for services that are due. EPSDT data whether submitted electronically or through a paper form, is captured into this database and allows MQD and the MCOs to track and trend clinical information associated with EPSDT exams, and will allow the MCOs to target education to providers and members based on the information.

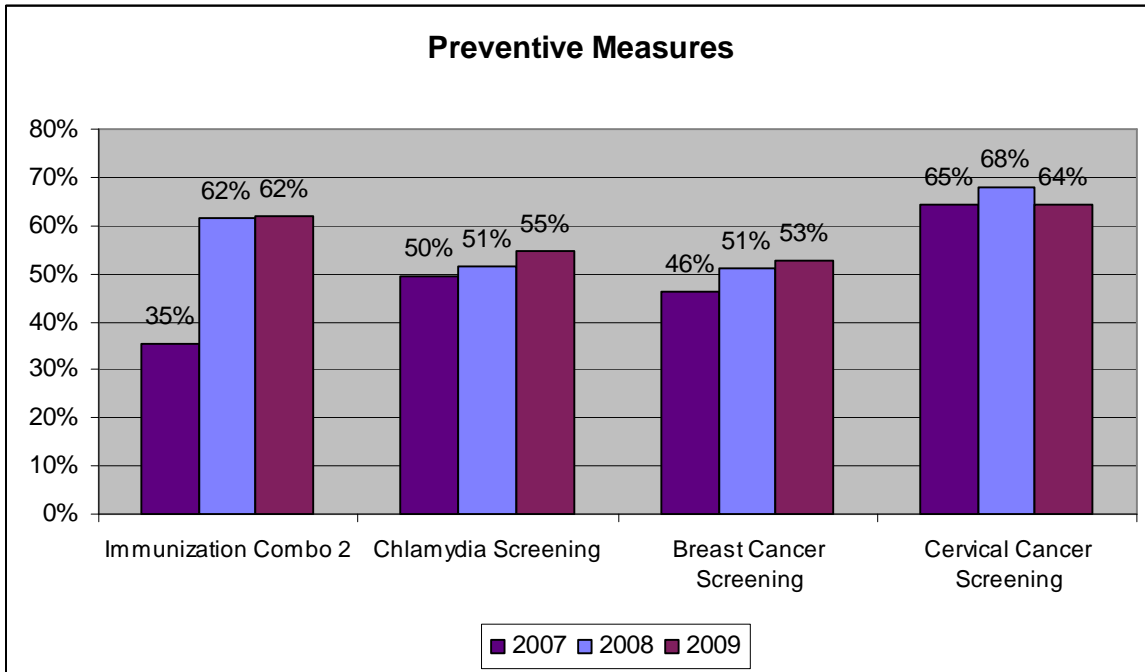
## **PROGRESS TOWARDS OBJECTIVES**

Efforts are ongoing to promote transparency and sharing of best practices among the QUEST MCO administrators and clinical leadership. Active EQRO and MQD technical assistance are given to promote quality improvement processes related to these measures. Increasing collaboration has been established with DOH Chronic Disease Branches, and there are renewed efforts by DOH to work with MCOs directly. Recently for the first time, public reporting and financial incentives/disincentives are being implemented for QUEST MCOs, and it is expected that future results for these measures will improve. The new QExA MCOs will be undergoing measurement for the first time and establishing baselines.

### **Goal 1: Improve preventive care for women and children**

For the measures under Goal 1, there is baseline data for the QUEST MCOs who have been submitting HEDIS data to MQD. The figure below shows data from the last three years. The large increase for the Immunization measure was the increased efforts in data collection using the hybrid methodology with data collected from chart reviews as well as administrative data. Both Chlamydia Screening and Breast Cancer Screening have had small increases over the years that MQD would like to sustain. There have been recent interventions with the QUEST MCOs, including the move to public reporting (all three measures) as well as financial incentives/disincentives (Immunization and Chlamydia measures), which should support further improvements. The QExA MCOs are establishing baselines this year.

**Figure 2: QUEST MCO Baseline for Goal 1 Objectives**

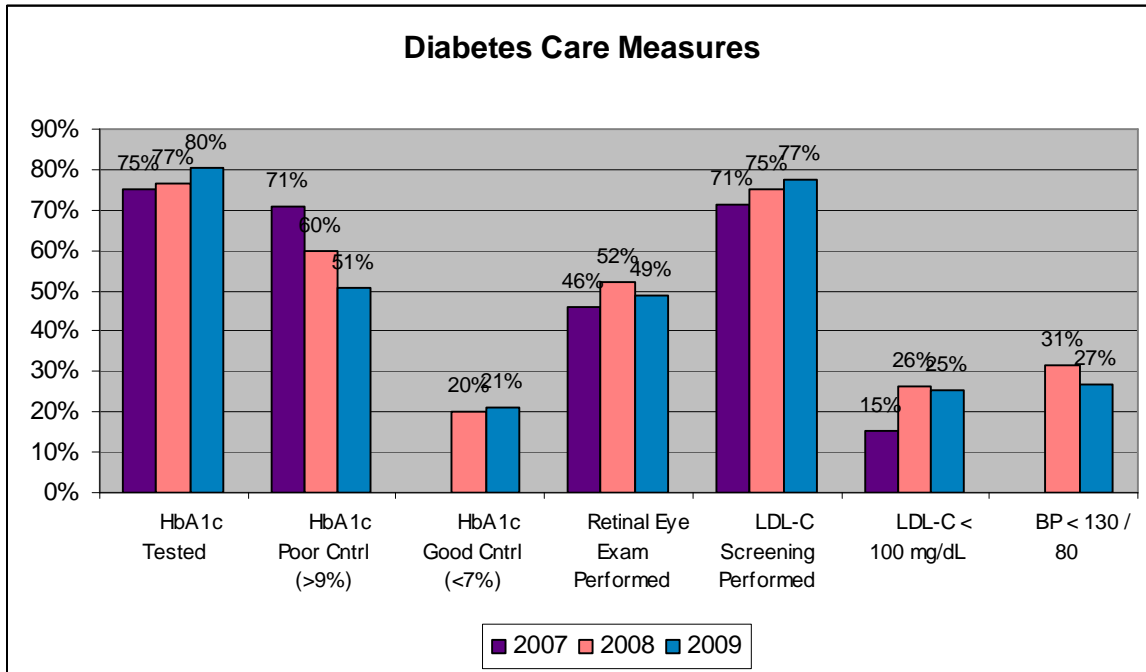


### **Goal 2: Improve care for chronic illness**

For the measures under Goal 2, the most robust baseline data is for the Diabetes Care Measures for the QUEST MCOs who have been submitting HEDIS data to MQD. Figure 3 below shows data from the last three years. There are multiple areas for improvement, including HbA1c, LDL, and blood pressure control in diabetes patients. The LDL control in diabetes patients is included in the new financial incentive/disincentive program for the QUEST MCOs this year. All of the diabetes care measures are included in recently developed QUEST MCO consumer guide/report card.

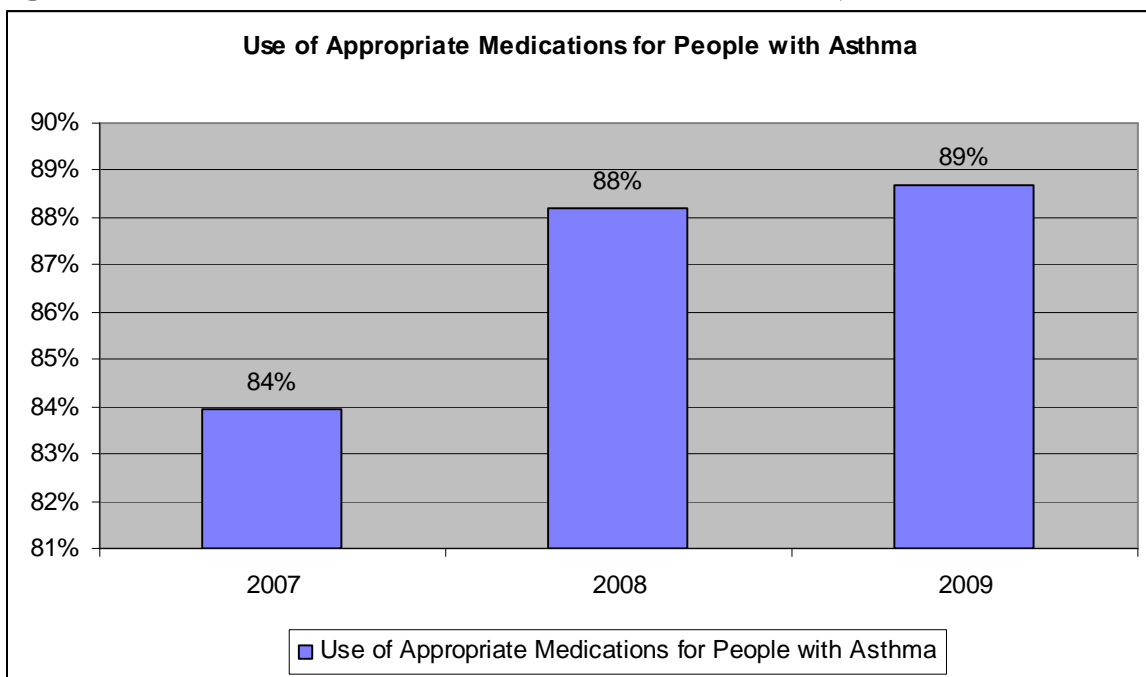
**Figure 3: QUEST MCO Baseline for Goal 2 Diabetes Care Objectives**





The asthma measure also has baselines for QUEST MCOs (See Figure 4). This measure is also included in the newly developed QUEST MCO consumer guide/report card.

**Figure 4: QUEST MCO Baseline for Goal 2 Asthma Care Objectives**



The measures for cholesterol screening and control in patients with Cardiovascular Conditions as well as Blood Pressure Control in the general populations are new

measures with limited baselines only from the QUEST MCOs in 2009. In 2009, the QUEST MCO aggregate for Cholesterol Screening in cardiovascular patients was 83% and for Blood Pressure Control in the general population was 30%. There is no baseline for LDL cholesterol control in cardiovascular patients, and QUEST MCOs are establishing this baseline this year.

The QExA MCOs are establishing baselines for all these measures this year.

**Goal 3: Improve client satisfaction with health plan services**

The measures for client satisfaction come from the CAHPS survey, administered for adults and children in alternate years. The measure in the adult CAHPS for 'Getting Needed Care' is included in the new QUEST MCO financial incentive/disincentive program. These satisfaction measures are also included in the recently developed consumer guide/report card. The QUEST MCO aggregate 2008 baseline rates for the selected Adult CAHPS measures are shown in Table 7 below. The QExA MCOs are establishing baselines for these measures.

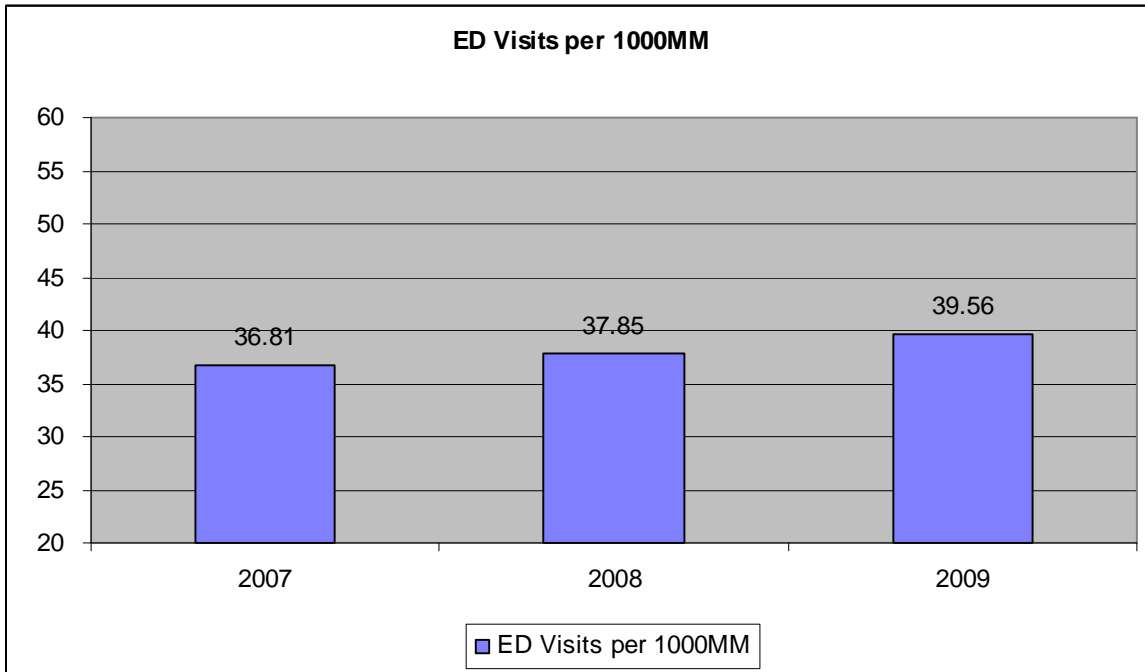
**Table 7: QUEST MCO 2008 Baseline for Goal 3 Satisfaction Measures**

Getting Needed Care	2.218	25 <sup>th</sup> -49 <sup>th</sup> CAHPS Adult 2008 Medicaid Percentile
Rating of Health Plan	2.404	50 <sup>th</sup> -74 <sup>th</sup> CAHPS Adult 2008 Medicaid Percentile
How Well Doctors Communicate	2.578	50 <sup>th</sup> -74 <sup>th</sup> CAHPS Adult 2008 Medicaid Percentile

**Goal 4: Improve cost-efficiency of health plan services**

The use of ETGs is in the beginning stages of development and no baselines are available. Examining readmissions is also in the beginning stages of development and no baselines are yet available. Below in Figure 5 are the baselines for ED utilization measures from HEDIS for the QUEST MCOs. MQD is currently exploring ED visits from encounter data, including ED visits resulting in inpatient hospitalizations, and will be establishing baselines and goals based on these baselines. The QExA MCOs are establishing baselines for ED measures.

**Figure 5: QUEST MCO Baseline for Goal 4 ED HEDIS Measure**



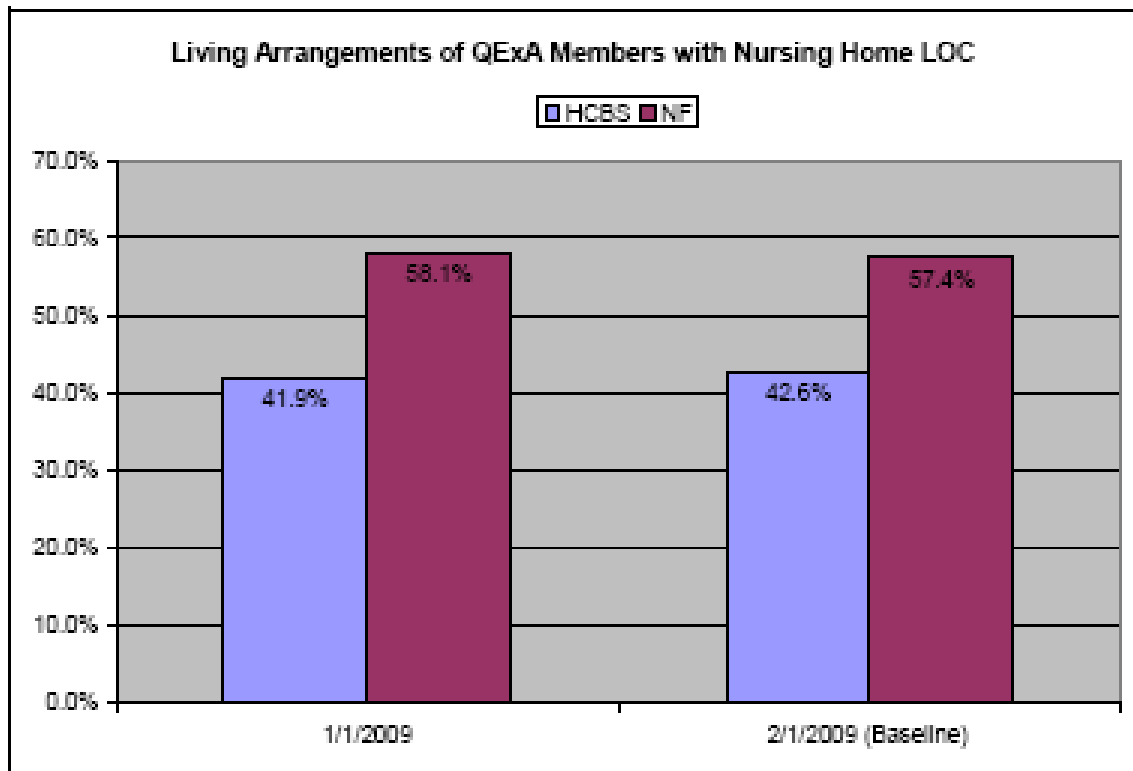
**Goal 5: Monitor HCBS clients who have transitioned from waiver programs into QExA health plans.**

These set of objectives pertain to the QExA MCOs. Below are the data (Table 8 and Figure 6) that shows the baseline and first year data for clients receiving long-term care services in both HCBS and institutional settings. Examining ED visits and hospital admissions in HCBS clients are new measures, and baselines are still being established.

**Table 8: QExA MCO Baseline on Nursing Facility and HCBS Clients**

Living Arrangement	(1/1/09)	
	Number of clients	% of clients
Home or Community Based Services (HCBS)	2,065	41.9%
Nursing Facilities (NF)	2,862	58.1%
Total	4,954	100.0%
	Baseline (2/1/09)	
	Number of clients	% of clients
Home or Community Based Services (HCBS)	2,110	42.6%
Nursing Facilities (NF)	2,840	57.4%
Total	4,954	100.0%

**Figure 6: QExA MCO Baseline on Nursing Facility and HCBS Clients**



## IV. QUALITY STRATEGY REVIEW AND EFFECTIVENESS

### PROCESS AND TIMELINE OF QUALITY STRATEGY REVIEW

The Quality Strategy will be reviewed at least annually by the QSLT and revised based on analyses results. However, the QSCs may suggest changes to the QSLT throughout the year that will be reviewed to identify whether a suggested change necessitates a review and revision of the quality strategy sooner than the appointed time. At each review and revision of the strategy, the QSLT will determine whether the changes made to the Quality Strategy are significant enough to require additional stakeholder input and a public comment period. Significant changes are changes that significantly impact quality activities and/or threaten the potential effectiveness of the Quality Strategy. At least once every 5 years, unless significant changes dictate a sooner timeframe, a 30-day public comment period will be made available.

In subsequent years, a yearly Work Plan will be written to supplement the Quality Strategy during the annual review and revision process. The development of the Work Plan begins with an assessment of accomplishments and challenges from the previous year's Work Plan, the EQR technical report, and summary reports/input

from the QSCs. The Work Plan development also incorporates input from other sources such as MCOs, clients, providers, partner government agencies, and stakeholders. The Work Plan will clearly document the effectiveness of the Quality Strategy by summarizing successes and challenges as well as interim performance results for each strategy objective. The Work Plan also outlines areas of focus for quality activities, such as quality improvement measures, improvement projects, and performance indicators.

## **REPORTING REQUIREMENTS**

The MCOs are held to a strict reporting calendar. Reports can be required monthly, quarterly, bi-annually, or annually, based on the type of report. See ***Attachments 4 and 5*** for further details. The analyses of these reports, as outlined in previous sections of this strategy, are an important basis of the yearly Quality Strategy revision and/or Work Plan development.

The revised Quality Strategy and the supplemental Work Plan will be shared with CMS annually. In addition, already established quarterly reports to CMS are headed by the MQD/HCSB staff and include updates on quality initiatives as well as Quality Strategy implementation and changes. The quarterly report also gives information on quantifiable achievements, data analyses, variation from expected results, barriers, interventions, best practices, and systems changes.

## **V. ACHIEVEMENTS AND OPPORTUNITIES**

### **ACHIEVEMENTS**

Drafting the Quality Strategy has allowed MQD to think strategically about the flow of quality data and the management of intervention activities. This is the first time that MQD has a cohesive Quality Strategy that can guide monitoring and intervention activities for all MCOs and programs. The plan to use QSCs to regularly guide reviewers and recommend corrective action/follow-up as well as the QSLT as a central team to which all quality activities are funneled will be an important step to ensuring the implementation of quality activities.

MQD continues to promote and support ongoing efforts of transparency and sharing among MCOs. There has also been significant improvement in the collaboration between MQD and the MCOs as well as between MQD and other programs (specifically the DD/MR waiver) on quality activities. The plan to institute formal Quality Collaboratives on a regular basis will strengthen these collaborations and assure a forum for dialogue, review of interim results, follow-up of corrective action, sharing of best practices, and identification of systems changes.

In addition to improved collaboration with the MCOs and other programs, there have also been ongoing partnerships with partner government agencies and stakeholder groups. These groups include DOH Chronic Disease branches, Tobacco Program, and Early Intervention Program, the American Academy of Pediatricians- Hawaii Chapter, Child Protective Services, the Nutrition and Physical Activity Coalition, among others. Projects have included improved education of providers and clients, better coordination of care for MCO clients, and development of policies and guidelines with local stakeholder input and support.

Also for the first time, public reporting and financial incentives/disincentives are being implemented. These activities support measures specific to MQD goals and objectives.

## **CHALLENGES AND FUTURE PLANS**

Since this Quality Strategy is in the beginning stages of development and implementation, there will be modifications to the process at various steps of implementation. It will be important to continuously assess and revise the quality process to ensure the successful implementation of the Quality Strategy. In addition, performance measures and targets will also need to be continuously evaluated to ensure that the measures meet appropriate populations and domains of care. Plans for the future include the establishment of performance measures and improvement activities for Inpatient Hospitals, Long-term Care, and Mental Health.

MQD has been scattered in previous quality activities, with each branch or program implementing its own quality activities and forming silos within MQD. The Quality Strategy will focus quality activities for the whole division, informed from analyses of previous performance data and input from a variety of sources, breaking down barriers to promote quality efforts within MQD.

In the past, monitoring reports and performance measures have been reviewed but not acted upon. As a result, sustained improvement was not brought forth by corrective action, and systems changes were not identified. With the Quality Strategy, the hope is to be able to ensure the implementation of quality improvement process from reporting to systems improvement.

## **Attachment D**

**FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT**



State Code	Fiscal Year								
	2010	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1a. Total individuals eligible for EPSDT	CN:	152,233	8,813	19,198	25,773	29,783	32,126	24,700	11,840
	MN:	2	1	0	1	0	0	0	0
	Total:	152,235	8,814	19,198	25,774	29,783	32,126	24,700	11,840
1b. Total Individuals eligible for EPSDT for 90 Continuous Days	CN:	135,927	5,919	17,663	23,746	27,340	29,548	22,429	9,282
	MN:	0	0	0	0	0	0	0	0
	Total:	135,927	5,919	17,663	23,746	27,340	29,548	22,429	9,282
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	26,659	168	1,621	3,280	6,079	7,722	6,407	1,382
	MN:	0	0	0	0	0	0	0	0
	Total:	26,659	168	1,621	3,280	6,079	7,722	6,407	1,382
2a. State Periodicity Schedule			5	4	3	2	3	2	1
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule			5.00	2.00	1.00	0.50	0.60	0.50	0.50
3a. Total Months of Eligibility	CN:	1,555,614	46,391	203,621	276,806	321,026	348,529	263,892	95,350
	MN:	1	0	0	1	0	0	0	0
	Total:	1,555,615	46,391	203,621	276,807	321,026	348,529	263,892	95,350
3b. Average Period of Eligibility	CN:	0.95	0.65	0.96	0.97	0.98	0.98	0.98	0.86
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.95	0.65	0.96	0.97	0.98	0.98	0.98	0.86
4. Expected Number of Screenings per Eligible	CN:		3.25	1.92	0.97	0.49	0.59	0.49	0.43
	MN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:		3.25	1.92	0.97	0.49	0.59	0.49	0.43
5. Expected Number of Screenings	CN:	121,995	19,237	33,913	23,034	13,397	17,433	10,990	3,991
	MN:	0	0	0	0	0	0	0	0
	Total:	121,995	19,237	33,913	23,034	13,397	17,433	10,990	3,991
6. Total Screens Received	CN:	117,218	27,540	37,902	17,816	11,199	12,488	8,880	1,393
	MN:	0	0	0	0	0	0	0	0
	Total:	117,218	27,540	37,902	17,816	11,199	12,488	8,880	1,393
7. SCREENING RATIO	CN:	0.96	1.00	1.00	0.77	0.84	0.72	0.81	0.35
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.96	1.00	1.00	0.77	0.84	0.72	0.81	0.35
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	92,427	5,919	17,663	23,034	13,397	17,433	10,990	3,991
	MN:	0	0	0	0	0	0	0	0
	Total:	92,427	5,919	17,663	23,034	13,397	17,433	10,990	3,991



**FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT**



State Code	Fiscal Year								
	2010	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	70,061	7,099	15,320	16,136	10,497	11,703	8,061	1,245
	MN:	0	0	0	0	0	0	0	0
	Total:	70,061	7,099	15,320	16,136	10,497	11,703	8,061	1,245
10. PARTICIPANT RATIO	CN:	0.76	1.00	0.87	0.70	0.78	0.67	0.73	0.31
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.76	1.00	0.87	0.70	0.78	0.67	0.73	0.31
11. Total Eligibles Referred for Corrective Treatment	CN:	34,045	4,627	8,375	6,682	4,423	5,028	3,932	978
	MN:	0	0	0	0	0	0	0	0
	Total:	34,045	4,627	8,375	6,682	4,423	5,028	3,932	978
12a. Total Eligibles Receiving Any Dental Services	CN:	68,884	157	9,975	17,218	16,225	15,277	8,519	1,513
	MN:	0							
	Total:	68,884	157	9,975	17,218	16,225	15,277	8,519	1,513
12b. Total Eligibles Receiving Preventive Dental Services	CN:	53,514	101	7,302	13,579	13,404	12,229	6,088	811
	MN:	0							
	Total:	53,514	101	7,302	13,579	13,404	12,229	6,088	811
12c. Total Eligibles Receiving Dental Treatment Services	CN:	32,522	43	2,848	8,406	8,068	7,433	4,815	909
	MN:	0							
	Total:	32,522	43	2,848	8,406	8,068	7,433	4,815	909
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	4,693				2609	2084		
	MN:	0							
	Total:	4,693				2,609	2,084		
12e. Total Eligibles Receiving Dental Diagnostic Services	CN:	56,536	113	8,149	14,130	13,597	12,637	6,773	1,137
	MN:	0							
	Total:	56,536	113	8,149	14,130	13,597	12,637	6,773	1,137
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	0	0	0	0	0	0	0	0
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12g. Total Eligibles Receiving Any Dental Or Oral Health Service	CN:	68,884	157	9,975	17,218	16,225	15,277	8,519	1,513
	MN:	0							
	Total:	68,884	157	9,975	17,218	16,225	15,277	8,519	1,513
13. Total Eligibles Enrolled in Managed Care	CN:	149,281	8,753	18,981	25,445	29,219	31,417	24,049	11,417
	MN:	0	0	0	0	0	0	0	0
	Total:	149,281	8,753	18,981	25,445	29,219	31,417	24,049	11,417
14. Total Number of Screening Blood Lead Tests	CN:	8,943	674	6,821	1,448				
	MN:	0							
	Total:	8,943	674	6,821	1,448				

\* Includes 12-month visit

Note: "CN" = Categorically Needy, "MN"= Medically Needy

**FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT**



State Code HI	Fiscal Year								
		Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1a. Total individuals eligible for EPSDT	CN:	158,910	9,032	19,489	27,616	31,697	34,075	25,494	11,507
	MN:	0	0	0	0	0	0	0	0
	Total:	158,910	9,032	19,489	27,616	31,697	34,075	25,494	11,507
1b. Total Individuals eligible for EPSDT for 90 Continuous Days	CN:	144,843	5,894	18,091	25,780	29,855	32,084	23,875	9,264
	MN:	0	0	0	0	0	0	0	0
	Total:	144,843	5,894	18,091	25,780	29,855	32,084	23,875	9,264
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	26,234	175	1,546	3,304	6,119	7,714	6,174	1,202
	MN:	0	0	0	0	0	0	0	0
	Total:	26,234	175	1,546	3,304	6,119	7,714	6,174	1,202
2a. State Periodicity Schedule			5	4	3	2	3	2	1
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule			5.00	2.00	1.00	0.50	0.60	0.50	0.50
3a. Total Months of Eligibility	CN:	1,594,086	46,768	202,980	289,167	335,878	360,982	268,298	90,013
	MN:	0	0	0	0	0	0	0	0
	Total:	1,594,086	46,768	202,980	289,167	335,878	360,982	268,298	90,013
3b. Average Period of Eligibility	CN:	0.92	0.66	0.93	0.93	0.94	0.94	0.94	0.81
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.92	0.66	0.93	0.93	0.94	0.94	0.94	0.81
4. Expected Number of Screenings per Eligible	CN:		3.30	1.86	0.93	0.47	0.56	0.47	0.41
	MN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:		3.30	1.86	0.93	0.47	0.56	0.47	0.41
5. Expected Number of Screenings	CN:	124,092	19,450	33,649	23,975	14,032	17,967	11,221	3,798
	MN:	0	0	0	0	0	0	0	0
	Total:	124,092	19,450	33,649	23,975	14,032	17,967	11,221	3,798
6. Total Screens Received	CN:	121,192	28,205	37,766	18,865	12,147	13,488	9,431	1,290
	MN:	0	0	0	0	0	0	0	0
	Total:	121,192	28,205	37,766	18,865	12,147	13,488	9,431	1,290
7. SCREENING RATIO	CN:	0.98	1.00	1.00	0.79	0.87	0.75	0.84	0.34
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.98	1.00	1.00	0.79	0.87	0.75	0.84	0.34
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	94,978	5,894	18,091	23,975	14,032	17,967	11,221	3,798
	MN:	0	0	0	0	0	0	0	0
	Total:	94,978	5,894	18,091	23,975	14,032	17,967	11,221	3,798

\* Includes 12-month visit

Note: "CN" = Categorically Needy, "MN"= Medically Needy

**FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT**



State Code	Fiscal Year								
HI	2011	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	73,900	7,294	15,605	17,227	11,420	12,612	8,585	1,157
	MN:	0	0	0	0	0	0	0	0
	Total:	73,900	7,294	15,605	17,227	11,420	12,612	8,585	1,157
10. PARTICIPANT RATIO	CN:	0.78	1.00	0.86	0.72	0.81	0.70	0.77	0.30
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.78	1.00	0.86	0.72	0.81	0.70	0.77	0.30
11. Total Eligibles Referred for Corrective Treatment	CN:	33,890	4,331	8,344	6,518	4,369	5,271	4,152	905
	MN:	0	0	0	0	0	0	0	0
	Total:	33,890	4,331	8,344	6,518	4,369	5,271	4,152	905
12a. Total Eligibles Receiving Any Dental Services	CN:	73,868	129	6,005	15,981	19,062	18,212	11,561	2,918
	MN:	0							
	Total:	73,868	129	6,005	15,981	19,062	18,212	11,561	2,918
12b. Total Eligibles Receiving Preventive Dental Services	CN:	57,337	26	3,682	12,350	15,566	14,920	8,854	1,939
	MN:	0							
	Total:	57,337	26	3,682	12,350	15,566	14,920	8,854	1,939
12c. Total Eligibles Receiving Dental Treatment Services	CN:	45,208	84	2,374	9,775	12,642	10,638	7,605	2,090
	MN:	0							
	Total:	45,208	84	2,374	9,775	12,642	10,638	7,605	2,090
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	6,075				3461	2614		
	MN:	0							
	Total:	6,075				3,461	2,614		
12e. Total Eligibles Receiving Dental Diagnostic Services	CN:	60,822	46	4,520	13,000	15,772	15,308	9,759	2,417
	MN:	0							
	Total:	60,822	46	4,520	13,000	15,772	15,308	9,759	2,417
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	0	0	0	0	0	0	0	0
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12g. Total Eligibles Receiving Any Dental Or Oral Health Service	CN:	73,868	129	6,005	15,981	19,062	18,212	11,561	2,918
	MN:	0							
	Total:	73,868	129	6,005	15,981	19,062	18,212	11,561	2,918
13. Total Eligibles Enrolled in Managed Care	CN:	154,597	9,027	19,372	26,765	30,683	32,880	24,651	11,219
	MN:	0	0	0	0	0	0	0	0
	Total:	154,597	9,027	19,372	26,765	30,683	32,880	24,651	11,219
14. Total Number of Screening Blood Lead Tests	CN:	8,949	647	6,900	1,402				
	MN:	0	0	0	0				
	Total:	8,949	647	6,900	1,402				

\* Includes 12-month visit

Note: "CN" = Categorically Needy, "MN"= Medically Needy

## **Attachment E**

- 5) The Benefit Specifications and Qualifications forms are completed for the following benefits that will be provided under the 1115 demonstration that differ from the Medicaid or CHIP State Plan.

The State included this information in the respective Long Term Services Benefit Specifications and Provider Qualifications forms instead:

- 1) Counseling and training services;
- 2) Skilled nursing (private duty nursing); and
- 3) Specialized medical equipment and supplies.

**BENEFIT CHART**

<b>Benefit</b>	<b>Description of Amount, Duration and Scope</b>	<b>Reference</b>
Counseling	Counseling services are provided to eligible recipients with limitations under the State Plan.	Att. 3.1-A – Item 6. d.
Skilled Nursing	Skilled nursing services are provided to eligible recipients with limitations under the State Plan.	Att. 3.1-A – Item 7.a.
Durable Medical Equipment and Medical Supplies	Durable medical equipment and medical supplies are provided to eligible recipients with limitations under the State Plan.	Att. 3.1-A – Items 4.c, 7.c. and 12.

**BENEFITS  
NOT PROVIDED**

<b>Benefit</b>	<b>Description of Amount, Duration and Scope</b>	<b>Reference</b>
Training	Training services are not provided under the State plan.	
Private Duty Nursing	Private duty nursing services are not provided under the State Plan.	Att. 3.1-A – Item 8.

## Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

**Name of Benefit or Service:** Clubhouse

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

- a. *A Clubhouse is a local community center that offers individuals who have mental illness opportunities to achieve their full potential by forming a community of individuals who are working together to achieve a common goal. A Clubhouse is organized to support individuals living with mental illness.*
- b. *Clubhouse is an organization accredited by International Center for Clubhouse Development (ICCD). ICCD is an organization that provides resources for communities to create solutions for individuals with mental illness. Clubhouse is provided to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:** Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; monthly assessments are performed to ensure medically necessary.*

### Provider Specifications and Qualifications

Provider Category(s): *Agencies*

☐ Individual (list types)

☒ Agency (list types of agencies)

*Agencies accredited by ICCD*

The service may be provided by a:      N/A  
☐ Legally Responsible Person      ☐ Relative/Legal Guardian

**Description of allowable providers:**

*Providers of Clubhouse shall be accredited by ICCD as a center that promotes recovery for individuals with mental illness.*

Specify the types of providers for this benefit or service and their required qualifications:

<b>Provider Type:</b>	<i>Accredited Clubhouse</i>	
License Required:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Certificate Required:	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No

**Describe:**

*All agencies that provide Clubhouse benefits shall be accredited by International Center for Clubhouse Development (ICCD). Each Clubhouse shall meet the standards of ICCD for accreditation. Accreditation is awarded for either a one- or three-year period, subject to the degree of adherence by the Clubhouse to the ICCD International Standards. The accreditation process is both evaluative and consultative. It is conducted by members of the ICCD Faculty for Clubhouse Development (made up of veteran members and staff from certified ICCD Clubhouses from around the world).*

*Accreditation components include:*

- *A Clubhouse self-study;*
- *A site visit by members of the ICCD Faculty for Clubhouse Development;*
- *A findings presentation and dialogue with Clubhouse leadership focusing on improvement opportunities;*
- *A written report;*
- *The award of accredited status; and*
- *Ongoing consultation with ICCD.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

**Name of Benefit or Service:** Peer Specialist

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

- a. *The peer specialist works in collaboration with interdisciplinary team members to assist beneficiaries to:*
  - i. *Understand recovery and the value of every individual's recovery experience;*
  - ii. *Identify strengths and needs for recovery;*
  - iii. *Understand and set goals for recovery;*
  - iv. *Determine the objectives needed to reach beneficiary-centered recovery goals; and*
  - v. *Help beneficiaries create, maintain and utilize their own recovery plan.*
- b. *These providers help individuals with SMI or SPMI by providing support to others who are facing a similar situation that they have faced in the past. Peer specialists promote self-determination, personal responsibility, and community integration for beneficiaries.*
- c. *Providers of peer specialist services are certified peer specialists.*
- d. *Peer specialists may provide services to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:** Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; monthly assessment to ensure medically necessary.*



## Provider Specifications and Qualifications

Provider Category(s):

☒ Individual (list types)

*Certified Peer Specialist*

☒ Agency (list types of agencies)

*Certified Mental Health providers*

The service may be provided by a: *N/A*

☐ Legally Responsible Person

☐ Relative/Legal Guardian

## Description of allowable providers:

*Peer specialists shall be certified by Department of Health, Adult Mental Health Division (AMHD) as part of their Hawaii Certified peer specialist (HCPS) program. Peer specialists are persons who have self-identified themselves as receiving (or previously received) mental health services for their own personal recovery. Certified mental health providers may utilize certified peer specialists as part of the IDT in the individual's plan of care.*

Specify the types of providers for this benefit or service and their required qualifications:

### Provider Type:

*Certified Peer Specialist*

License Required:

☐ Yes

☒ No

Certificate Required:

☒ Yes

☐ No

### Describe:

*All individuals or agencies that provide certified peer specialist benefits shall be certified by the Department of Health, Adult Mental Health Division to provide the services described above.*

### Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

**Name of Benefit or Service:** Representative Payee

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

- a. *The representative payee service is provided by an organization that is chosen for a beneficiary that cannot manage or direct someone else to manage his or her money. This benefit is only for those without access to the social security representative payee program.*
- b. *The main responsibilities of a representative payee are to use the beneficiary's income to pay for the current and foreseeable needs of the beneficiary and properly save any income not needed to meet current needs. A payee must also keep records of expenses. Reports shall be provided quarterly on each beneficiary's account.*
- c. *Providers of representative payee services are agencies that are certified mental health providers by the Department of Health, Adult Mental Health Division. Representative payee services may provide services to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:** Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; monthly assessments are performed to ensure medically necessary.*

### Provider Specifications and Qualifications

Provider Category(s):

☐ Individual (list types)

☒ Agency (list types of agencies)  
*Certified Mental Health provider*

The service may be provided by a:

*N/A*

☐ Legally Responsible Person

☐ Relative/Legal Guardian

**Description of allowable providers:**

*Certified Mental Health providers are agencies that are certified by the Department of Health, Adult Mental Health Division (AMHD) to provide services to individuals with SMI or SPMI who have a plan of care developed with participation by a psychiatrist or psychologist requiring this as a medically necessary service.*

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:**

*Certified Mental Health provider*

License Required:

☐ Yes

☒ No

Certificate Required:

☒ Yes

☐ No

**Describe:**

*All agencies that provide representative payee benefits shall be certified by DOH, AMHD to provide the services described above.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

**Name of Benefit or Service:** *Substance Abuse Treatment*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*Substance abuse treatment services will also be provided by certified substance abuse counselors. In contrast, the Medicaid State Plan limits those services to be provided by psychiatrists, psychologists, licensed social workers in behavioral health, and advance practice registered nurses in behavioral health.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:** Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; monthly assessments are performed to ensure medically necessary.*

### Provider Specifications and Qualifications

Provider Category(s):

☒ Individual (list types)

☐ Agency (list types of agencies)

*Certified substance abuse counselors may provide services as an individual provider or as an employee of an agency.*

The service may be provided by a: *N/A*

☐ Legally Responsible Person

☐ Relative/Legal Guardian

**Description of allowable providers:**

*Certified substance abuse counselors are trained to provide medically necessary substance abuse treatment services. Often, certain licensed providers are also certified substance abuse counselors. However, some certified substance abuse counselors are not otherwise licensed. Allowing these qualified providers to provide services to Medicaid beneficiaries expands access to medically necessary substance abuse treatment services.*

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:**

License Required:

☐ Yes☒ No

Certificate Required:

☒ Yes☐ No**Describe:**

*Certified substance abuse counselors must be certified by the International Certification and Reciprocity Consortium and meet the requirements of HAR§11-177.1-16.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

### **Name of Benefit or Service:** Supportive Employment

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

- a. *Supportive employment includes activities needed to obtain and sustain paid work within the general workforce by beneficiaries and includes assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the beneficiary, transitioning the beneficiary from volunteer work to paid employment, and assisting the beneficiary in maintaining an individual job in the general workforce at or above the state's minimum wage.*
- b. *Supportive employment support is conducted in a variety of settings to include self-employment. With regard to self-employment, individual employment support services may include:*
  - i. *Aiding the beneficiary to identify potential business opportunities;*
  - ii. *Assisting in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business;*
  - iii. *Identifying the supports that are necessary in order for the beneficiary to operate the business; and*
  - iv. *Providing ongoing assistance, counseling and guidance once the business has been launched.*
- c. *Providers of supportive employment services are agencies that are certified mental health providers by the Department of Health, Adult Mental Health Division.*
- d. *Supportive employment services may be provided to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

### **Amount of Benefit/Service**

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### **Duration of Benefit/Service:**

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

**Name of Benefit or Service:** Supportive Housing

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

- a. *This is housing-based care management focused on ensuring housing stability, recognizing housing's role as an essential platform for recovery and improved health.*
- b. *This service will include assisting individuals with finding and retaining housing such as Section 8, Section 811, other Housing and Urban Development (HUD) programs, and public housing. This service is available to previously homeless individuals or others in public housing.*
- c. *Providers of supportive housing are agencies that are certified mental health providers by the Department of Health, Adult Mental Health Division.*
- d. *Supportive housing services may provide services to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:** Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; monthly assessments are performed to ensure medically necessary.*

### Provider Specifications and Qualifications

Provider Category(s):



☐ Individual (list types)

☒ Agency (list types of agencies)  
*Certified Mental Health provider*

The service may be provided by a:

*N/A*

☐ Legally Responsible Person

☐ Relative/Legal Guardian

**Description of allowable providers:**

*Certified Mental Health providers are agencies that are certified by Department of Health, Adult Mental Health Division (AMHD) to provide services to individuals with SMI or SPMI that have a plan of care developed with participation by a psychiatrist or psychologist requiring this as a medically necessary service.*

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:**

*Certified Mental Health provider*

License Required:

☐ Yes

☒ No

Certificate Required:

☒ Yes

☐ No

**Describe:**

*All agencies that provide supportive housing benefits shall be certified by DOH, AMHD to provide the services described above.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:**      *Adult Day Care*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*Adult day care provides regular supportive care 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.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; and quarterly assessment is completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per                      ☐ Day            ☐ Week            ☐ Month            ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

☐ Day(s)

☐ Week(s)

☐ Month(s)

☐ (Other)

### Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

### Provider Specifications and Qualifications

Provider Category(s): *Agencies*  
☐ Individual (list types) ☒ Agency (list types of agencies)  
*Licensed Adult Day Care centers*

The service may be provided by a: N/A

☐ Legally Responsible Person ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Adult Day Care*

License Required: ☒ Yes ☐ No

Certificate Required: ☐ Yes ☒ No

**Describe:**

*All agencies are licensed by the Department of Human Services (DHS) to meet the requirements provided in Hawaii Administrative Rule 17-1417. Agencies that provide adult day care programs include Federally Qualified Health Centers, nursing facilities, and independent free-standing facilities.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Adult Day Health (ADH)*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*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 §11-94.1-47. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community.*

*Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall 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, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; and quarterly assessment is completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

☐ Day(s)

☐ Week(s)

☐ Month(s)

☐ (Other)

**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization as required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *Licensed Adult Day Health Centers*

☐ Individual (list types) ☒ Agency (list types of agencies)

The service may be provided by a: *N/A*

☐ Legally Responsible Person ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Adult Day Health Centers*

License Required: ☒ Yes ☐ No

Certificate Required: ☐ Yes ☒ No

**Describe:**

*All agencies are licensed by the Department of Health, Office of Health Care Assurance, Medicare Certification Section (OHCA) to meet the requirements provided in Hawaii Administrative Rule 11-94.1-47 and 11-96. Agencies that provide adult day health programs include nursing facilities, hospitals, and free-standing ADH programs.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

*Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.*

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Assisted Living Services*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*Assisted living services include personal care and supportive care services (homemaker, chore, companion services, and meal preparation) that are furnished to members who reside in an assisted living facility.*

*An assisted living facility, as defined in HRS 321-15.1, is licensed by the Department of Health. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall 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.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; quarterly assessments are performed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐  
Year

☒ Other, describe:  
*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

### Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *Licensed Assisted Living Facilities*

☐ Individual (list types) ☒ Agency (list types of agencies)

The service may be provided by a: *N/A*

☐ Legally Responsible Person ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Assisted Living Facilities*

License Required: ☒ Yes ☐ No

Certificate Required: ☐ Yes ☒ No

**Describe:**

*Licensing occurs by the Department of Health, Office of Health Care Assurance, Medicare Certification Section (OHCA) to meet the requirements provided in Hawaii Administrative Rule 11-90. Agencies that provide assisted living services are facilities that are dedicated to the provision of assisted living. Each building has minimal requirements for building, staffing, and services.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

*Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.*

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Community Care Foster Family Home (CCFFH)*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*CCFFH services are personal care and supportive services, homemaker, chore, companion services and medication oversight (to the extent permitted under State law) provided in a certified private home by a principal care provider who lives in the home. The number of adults receiving services in a CCFFH is determined by HAR, Title 17, Department of Human Services, Subtitle 9, Chapter 1454-43.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations; prior authorization is required; monthly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

☐ Day(s)

☐ Week(s)

☐ Month(s)

☐ (Other)

### Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; monthly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility LOC assessment is completed to ensure LOC is met.*

### Provider Specifications and Qualifications

Provider Category(s):



☒ Individual (list types)

☐ Agency (list types of agencies)

*Certified Community Care Foster Family Home (CCFFH) are operated by individuals (called caregivers) who are at least a nursing assistant (though some caregivers are certified nursing assistants (CNA), Licensed Practical Nurses (LPN), or registered nurses(RN)).*

The service may be provided by a: N/A

☐ Legally Responsible Person

☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

1. **Provider Type:** *Community Care Foster Family Home*

License Required: ☐ Yes ☒ No

Certificate Required: ☒ Yes ☐ No

**Describe:**

*CCFFHs are certified by the State, currently by the Department of Human Services in accordance with Hawaii Administrative Rule 17-1754, Subchapter 3; however, this function will transfer to the Department of Health. Each caregiver (that owns or operates a CCFFH) shall be at least a nurse assistant though some are a CNA, LPN, or RN. CCFFHs are small home that care for no more than three (3) clients with at least one being a Medicaid beneficiary. These homes are located throughout the state. Each home is certified annually and thereafter every two years. Each client in the home shall have a case manager (see Specialized Case Manager) that oversees care provided in the CCFFH. Assessments occur every month on clients. Adverse events are reported to the Department within 24 hours of the event. Adverse events are tracked for trends.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Counseling and Training*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*Counseling and training will be provided to family members/caregivers, professional and paraprofessional caregivers to support them in caring for members 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. In contrast, the Medicaid State Plan only provides counseling and training services for only eligible recipients with certain limitations and conditions as specified in the State Plan.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐  
Year

☒ Other, describe:  
*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s):

☒ Individual (list types)      ☐ Agency (list types of agencies)

The service may be provided by a:      N/A

☐ Legally Responsible Person      ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

*These individuals are licensed in the specialty needed to counsel or train the beneficiary or their family on the services they need.*

**Provider Type:**      *Individual*

License Required:      ☒ Yes      ☐ No

Certificate Required:      ☐ Yes      ☒ No

**Describe:**

- *Social Worker (LCSW)*
- *Psychiatrist (MD)*
- *Physician (MD or DO)*
- *Clinical Psychologist, PsyD*
- *Registered Nurse (RN)*
- *Registered Dietitian (RD)*
- *Physical Therapist (PT)*
- *Occupational Therapist (OT)*
- *Speech-Language Pathologist (SLP)*

**Other Qualifications Required for this Provider Type (please describe):**

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Environmental Accessibility Adaptations*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*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.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required to ensure benefits/services are medically necessary and nursing facility – level of care (LOC) is met prior to performing the adaptation.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

☐ Day(s)

☐ Week(s)

☐ Month(s)

☐ (Other)

### Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required to ensure medically necessary and nursing facility – level of care (LOC) is met prior to performing the adaptation.*

**Provider Specifications and Qualifications**

Provider Category(s): *Independent licensed contractors*  
☐ Individual (list types) ☒ Agency (list types of agencies)

The service may be provided by a: *N/A*  
☐ Legally Responsible Person ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Independent licensed contractors*  
License Required: ☒ Yes ☐ No  
Certificate Required: ☐ Yes ☒ No

**Describe:**

*Allowable providers are licensed contractors who are licensed under Hawaii Revised Statutes 444, 448E, or 464 by the Department of Commerce and Consumer Affairs (DCCA). All licensed contractors shall be confirmed with the Licensing and Business Registration Information Section of the DCCA. These agencies perform adaptation to beneficiary's homes when medically necessary. The licensed contractor may need to include licensed plumbers or electricians based upon scope of the project.*

**Other Qualifications Required for this Provider Type (please describe):**

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Home Delivered Meals*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*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.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

☐ Day(s)

☐ Week(s)

☐ Month(s)

☐ (Other)

### Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *Agencies*

☐ Individual (list types) ☒ Agency (list types of agencies)

*Agencies that produce and distribute meals to Medicaid beneficiaries and other low income seniors.*

The service may be provided by a: *N/A*

☐ Legally Responsible Person ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Home Delivered Meals*

License Required: ☐ Yes ☒ No

Certificate Required: ☐ Yes ☒ No

**Describe:**

*Providers shall be a registered business in the State of Hawaii. These agencies are typically either connected with a hospital or nursing facility or a non-for-profit business that supports low income seniors with obtaining meals. Meals are prepared and delivered mostly Monday through Saturday.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Home Maintenance*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*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.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*No limitations exists for this service but prior authorization is required to ensure that benefits/services are medically necessary; and assessment of nursing facility – level of care (LOC) is completed to ensure LOC is met prior to authorization of service. This service is typically provided only once until the living environment meets acceptable standards. Thereafter, additional HCBS are utilized to assure that environment continues to meet acceptable standards.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐  
Year

☒ Other, describe:  
*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_



**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; assessment is conducted prior to authorization of service to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed prior to authorization of service to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *House cleaning agencies or pest control companies*

☐ Individual (list types) ☒ Agency (list types of agencies)

The service may be provided by a: *N/A*

☐ Legally Responsible Person ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Agencies*

License Required: ☒ Yes ☐ No

Certificate Required: ☐ Yes ☒ No

*Pest control companies are licensed; house cleaning agencies are neither licensed nor certified. Both shall be a registered business in the State of Hawaii.*

**Describe:**

*Providers shall be a registered business in the State of Hawaii. Providers for pest control are licensed by the Department of Commerce and Consumer Affairs (DCCA) under Hawaii Administrative Rule 16-94. These agencies are responsible for performing heavy duty cleaning to bring the beneficiary's home up to a livable standard. A pest control company may need to be utilized. This service is a one-time service. Personal assistance services are added thereafter to maintain the cleanliness of the home going forward.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Moving Assistance*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

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; the member is no longer able to afford the home due to a rent increase; or relocation to receive ongoing medically necessary services. 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.

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required to ensure benefits/services are medically necessary; and nursing facility – level of care (LOC) assessment must be completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

☐ Day(s)

☐ Week(s)

☐ Month(s)

☐ (Other)

### Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization as required to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *Moving companies in the State of Hawaii.*  
☐ Individual (list types) ☒ Agency (list types of agencies)

The service may be provided by a: *N/A*  
☐ Legally Responsible Person ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Agency*  
License Required: ☒ Yes ☐ No  
Certificate Required: ☐ Yes ☒ No

**Describe:**

*Providers shall be a registered business in the State of Hawaii. Providers for moving assistance are licensed with the Federal Motor Carrier Safety Administration, US Department of Transportation (FMCSA) under 49 CFR Part 375. In addition, each employee of the moving company that drives the moving truck must contain a Public Utilities Commission (PUC) license in accordance with Hawaii Administrative Rule 6-62. These agencies will move the beneficiary from one location to the other in the rare instance where a beneficiary's health is impaired by their current living location.*

**Other Qualifications Required for this Provider Type (please describe):**

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Non-Medical Transportation*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*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 shall not replace them. Members shall receive the most appropriate modality of transportation based on their individual needs. 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.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

### Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *Transportation providers with a fleet of vans or taxi cabs.*

☐ Individual (list types)

☒ Agency (list types of agencies)

The service may be provided by a: *N/A*

☐ Legally Responsible Person

☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Agency*

License Required:

☒ Yes

☐ No

Certificate Required:

☐ Yes

☒ No

**Describe:**

*Providers shall be a registered business in the State of Hawaii. All drivers shall have a Public Utilities Commission (PUC) license in accordance with Hawaii Administrative Rule 6-62.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Personal Assistance Services*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*Personal assistance services Level I are provided to individuals requiring assistance with 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 consist of both companion and homemaker services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping/ errands, but do not perform these activities as discrete services. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. Homemaker services means any of the activities such as routine housekeeping, laundry, marketing, light yard work, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker services are of a routine nature and shall not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker services specified in this section shall cover only the activities that need to be provided for the beneficiary, and not for other members of the household.*

*Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance with performing ADLs and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency.*

*When personal assistance services Level II are provided, personal assistance services Level I identified on the care plan may also be provided, if they are essential to the health and welfare of the member. Personal assistance services Level II may be self-directed.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization as required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

**Duration of Benefit/Service:**

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *Individuals or Personal care agencies or home health agencies.*

- ☒ Individual (list types) ☒ Agency (list types of agencies)

The service may be provided by a:

- ☒ Legally Responsible Person ☒ Relative/Legal Guardian  
*Family or friends (through self-direction)*

*Providers include the following:*

- *Family or friends (through self-direction)*
- *Personal care agencies*
- *Home health agencies*

*Family or friends shall be trained to perform the necessary personal assistance services, if applicable. If an agency, they must be a registered business in Hawaii.*

*Oversight occurs through service planning, review of incident reports, and visiting the beneficiary without a prearranged visit.*

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

1. **Provider Type:** *Individual*
- License Required: ☐ Yes ☒ No
- Certificate Required: ☐ Yes ☒ No

**Describe:**

*These services may be self-directed to a family member or friend. If the beneficiary is unable to make their own decisions, a surrogate may be enacted for the beneficiary to self-direct personal care services. The self-directed service provider may be the legally responsible person or legal guardian but cannot be the surrogate as well.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

*Family or friends (through self-direction) are not required to be screened for criminal history record check or registry screening if waived by the beneficiary or their surrogate.*

2. **Provider Type:** *Personal Care Agency*

License Required: ☐Yes ☒No

Certificate Required: ☐Yes ☒No

**Describe:**

*Personal Care Agencies shall be a registered business in the State of Hawaii.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

3. **Provider Type:** *Home Health Agency*

License Required: ☒Yes ☐No

Certificate Required: ☐Yes ☒No

**Describe:**

*Home Health Agencies are licensed by Department of Health, Office of Health Care Assurance, Medicare Certification Section under Hawaii Administrative Rule 11-97.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*



*Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.*

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Personal Emergency Response System (PERS)*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*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.*

*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, or who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required to ensure that benefits/services are medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

☐ Day(s)

☐ Week(s)

☐ Month(s)

☐ (Other)

**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s):                      *Agencies*

☐ Individual (list types)                      ☒ Agency (list types of agencies)

*Those that have the capacity to issue an alarm that is worn by the beneficiary and monitor for any indications for “help” 24-hours per day.*

The service may be provided by a:                      *N/A*

☐ Legally Responsible Person                      ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:**                      *Agency*

License Required:                      ☐ Yes                      ☒ No

Certificate Required:                      ☐ Yes                      ☒ No

**Describe:**

*Providers shall be a registered business in the State of Hawaii. Providers shall have the qualifications to provide the benefit described above to the beneficiary.*

*Oversight occurs through service planning, review of incident reports by service coordinator, and beneficiary satisfaction.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Residential Care Services*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*Residential care services are personal care services, homemaker, chore, companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principle 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 with up to six (6) residents allowed at the discretion of the DHS, of which no more than two (2) may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, of which no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC and receive services in conjunction with residing in the home.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; monthly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐  
Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; monthly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s):

☒ Individual (list types)

☒ Agency (list types of agencies)

*Expanded Adult Residential Care Home (E-ARCH)- Type I that are operated by individuals (called caregivers) who are at least a nursing assistant (though some caregivers are certified nursing assistants (CNA), Licensed Practical Nurses (LPN), or registered nurses(RN)).*

*E-ARCH- Type II is a home that consists of six or more residents with no more than twenty (20) percent of the homes capacity at NF level of care. These homes are operated by licensed businesses in the State of Hawaii.*

*Only residents who meet NF level of care are included in the request for Medicaid covered services.*

The service may be provided by a: N/A

☐ Legally Responsible Person

☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**1. Provider Type:** E-ARCH Type I

License Required:

☒ Yes

☐ No

Certificate Required:

☐ Yes

☒ No

**Describe:**

*Licensing occurs by the Department of Health, Office of Health Care Assurance, State Licensing Section (OHCA) to meet the requirements provided in Hawaii Administrative Rule 11-100.1.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

*Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.*

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

2. **Provider Type:** *E-ARCH – Type II*

License Required: ☒ Yes ☐ No

Certificate Required: ☐ Yes ☒ No

**Describe:**

*Licensing occurs by the Department of Health, Office of Health Care Assurance, State Licensing Section (OHCA) to meet the requirements provided in Hawaii Administrative Rule 11-100.1.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

*Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.*

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:**      *Respite Care*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*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 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.*

**Amount of Benefit/Service**

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

**Duration of Benefit/Service:**

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessment is performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

### **Provider Specifications and Qualifications**

Provider Category(s):

☒ Individual (list types)

☒ Agency (list types of agencies)

The service may be provided by a:

☒ Legally Responsible Person

☒ Relative/Legal Guardian

### **Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

#### **1. Provider Type:** *Individual*

License Required: ☐ Yes

☒ No

Certificate Required: ☐ Yes

☒ No

#### **Describe:**

*These services may be self-directed. If the beneficiary is unable to make his or her own decisions, a surrogate may be utilized. The self-directed service provider may be a family member or friend, the legally responsible person or legal guardian, but cannot be the surrogate as well.*

#### **Other Qualifications Required for this Provider Type (please describe):**

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

*Family or friends (through self-direction) are not required to be screened for criminal history record check or registry screening if waived by the beneficiary or their surrogate.*

#### **2. Provider Type:** *Agency/Facility*

License Required: ☐ Yes

☐ No

Certificate Required: ☐ Yes

☐ No

#### **Describe:**

*The following providers can provide respite services. The HCBS provider requirements are described in other sections of this document. Nursing facilities are licensed by the Department of Health.*

Licensed providers that can provide respite services:

- *Adult day care facility*
- *Adult day health facility*
- *E-ARCH*



- *Home health agency*
- *Nursing facility*

Certified providers that can provide respite services:

- *CCFFH*

Providers that are not licensed or certified that can provide respite service:

- *Personal care agency*

**Other Qualifications Required for all of these Provider Types** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

*The following requirements are currently met for adult day care, CCFFH, and personal care agencies. Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met for all other licensed agencies.*

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Skilled Nursing (or Private Duty Nursing)*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*Skilled or 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.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; quarterly assessments completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐  
Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

### Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

## Provider Specifications and Qualifications

Provider Category(s):

☒ Individual (list types)

☒ Agency (list types of agencies)

The service may be provided by a:

N/A

☐ Legally Responsible Person

☐ Relative/Legal Guardian

### Description of allowable providers:

Specify the types of providers for this benefit or service and their required qualifications:

*Types of individuals: Registered Nurses*

*Types of agencies: Personal care agencies, Home health agencies.*

#### 1. Provider Type: Individual

License Required:

☒ Yes

☐ No

Certificate Required:

☐ Yes

☒ No

#### Describe:

*Individual: Licensing occurs by the Department of Commerce and Consumer Affairs (DCCA) to meet the requirements provided in Hawaii Administrative Rule 16-89.*

#### Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

#### 2. Provider Type: Personal Care Agency

License Required:

☐ Yes

☒ No

Certificate Required:

☐ Yes

☒ No

#### Describe:

*Agency: Personal care agencies shall be a registered business in the State of Hawaii. Agencies may only utilize Licensed Registered Nurses to perform this service.*

#### Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*

- *List of Excluded Individuals and Entities (LEIE)- annually*
- *Office of Inspector General exclusion list- annually*
- *Tuberculosis (TB)- annually*
- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

**3. Provider Type:** *Home Health Agencies*

License Required: ☒Yes ☐No

Certificate Required: ☐Yes ☒No

**Describe:**

*Agency: Home Health agency are licensed by Department of Health, Office of Health Care Assurance, Medicare Certification Section under Hawaii Administrative Rule 11-97. Agencies may only utilize Licensed Registered Nurses to perform this service.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

*Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.*

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Specialized Community Case Management (CCMA) Services*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. 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, 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. CCMA's 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,*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; monthly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐ Year

☒ Other, describe:

*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

☐ Day(s)

☐ Week(s)

☐ Month(s)

☐ (Other)

**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; monthly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *Licensed Case Management Agencies*

☐ Individual (list types) ☒ Agency (list types of agencies)

The service may be provided by a: *N/A*

☐ Legally Responsible Person ☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Agency*

License Required: ☒ Yes ☐ No

Certificate Required: ☐ Yes ☒ No

**Describe:**

*These agencies are specialized in the provision of case management services. Their employees who work with Medicaid beneficiaries are either licensed Registered Nurses or Licensed Social Workers. Agencies are licensed by the Department of Human Services in accordance with Hawaii Administrative Rule 17-1754, Subchapter 1 and 2. They see their beneficiaries monthly to perform an assessment to assure that their needs are being addressed in either a CCFFH or E-ARCH.*

**Other Qualifications Required for this Provider Type (please describe):**

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *Delegation oversight on-site review by health plan- annually*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

## Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

**Name of Service:** *Specialized Medical Equipment and Supplies*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

*Specialized medical equipment and supplies entails the purchase, rental, lease, warranty 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. The providers of these services are the same providers that offer Medicaid State Plan services for durable medical equipment and medical supplies. All items shall meet applicable standards of manufacture, design and installation.*

### Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

*There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.*

**Benefit Amount:** \_\_\_\_\_ per ☐ Day ☐ Week ☐ Month ☐  
Year

☒ Other, describe:  
*There are no limitations if the above requirements are met.*

### Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

*There are no limitations if the above requirements are met.*

- ☐ Day(s) \_\_\_\_\_
- ☐ Week(s) \_\_\_\_\_
- ☐ Month(s) \_\_\_\_\_
- ☐ (Other) \_\_\_\_\_

**Authorization Requirements:**

Describe any prior, concurrent or post-authorization requirements, if any:

*Prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility LOC assessment is completed to ensure LOC is met.*

**Provider Specifications and Qualifications**

Provider Category(s): *Durable Medical Equipment Suppliers*

☐ Individual (list types)

☒ Agency (list types of agencies)

The service may be provided by a: *N/A*

☐ Legally Responsible Person

☐ Relative/Legal Guardian

**Description of allowable providers:**

Specify the types of providers for this benefit or service and their required qualifications:

**Provider Type:** *Agency*

License Required: ☐ Yes

☐ No

Certificate Required: ☐ Yes

☐ No

**Describe:**

*All suppliers of specialized medical equipment and supplies shall be Durable Medical Equipment and Medical Supplies agencies. These agencies shall be accredited by a CMS-approved independent National Accreditation organization. All suppliers shall meet the CMS quality standards for DMEPOS as part of their accreditation as a Medicare provider.*

**Other Qualifications Required for this Provider Type** (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*



## **Attachment F**

## **Med-QUEST Division Behavioral Health Protocol**

### **I. OVERVIEW**

The Med-QUEST Division (MQD) is responsible for providing behavioral health services to all its beneficiaries. MQD provides standard behavioral health services to all beneficiaries and specialized behavioral health services to beneficiaries with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).

Regardless of the type of behavioral health service a beneficiary receives or where the beneficiary receives his/her behavioral health services, the beneficiary continues to have access to all of the other services for which he/she is eligible, including:

- Primary and acute care services from his/her health plan;
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services if he/she is under the age of 21;
- Home and community based services/long-term supports and services (HCBS/LTSS) services under the section 1115 demonstration waiver; and
- Services or under the Developmental Disabilities or Intellectual Disabilities (DD/ID) 1915(c) waiver.

All beneficiaries have access to standard behavioral health services through the contracted managed care health plans. The standard behavioral health services include inpatient psychiatric hospitalization, medications, medication management, psychiatric and psychological evaluation and management, and alcohol and drug dependency treatment services.

Beneficiaries with SMI, SPMI, or SEBD may be in need of specialized behavioral health services. For children (individuals <21), the SEBD services are provided through the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD); for adults (individuals ≥21) the SMI/SPMI services are provided through the DOH Adult Mental Health Division (AMHD), the MQD's behavioral health program Community Care Services (CCS), or the managed care health plans. Regardless of how adults with SMI/SPMI access specialized behavioral health services, all have access to the same services, and MQD ensures no duplication. The available specialized services include:

- For children: multidimensional treatment 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, and
- For adults: crisis management, crisis and specialized residential treatment, intensive care coordination/case management, psychosocial rehabilitation, clubhouse, peer

specialist, representative payee, supportive employment, supportive housing partial or intensive outpatient hospitalization, and therapeutic living supports.

See Addendum A for an overview of the behavioral health services delivery systems for individuals with SMI, SPMI, or SEBD; and see Addendum B for a detailed description of the services provided by CAMHD, AMHD, CCS, and the managed care health plans.

## **II. RECEIPT OF BEHAVIORAL HEALTH SERVICES BY CHILDREN (INDIVIDUALS <21 YEARS)**

### **A. Clinical Criteria**

Beneficiaries <21 years old with a diagnosis of SEBD are eligible for additional behavioral health services within CAMHD if meeting the following criteria:

- The beneficiary is age three through twenty (3-20) years;
- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least six (6) months or is expected to demonstrate the qualifying diagnosis for the next six (6) months; and
- The beneficiary's Child and Adolescent Functional Assessment Scale (CAFAS) score is > 80.
- Beneficiaries who do not meet the eligibility criteria, but based upon assessment by the CAMHD medical director that additional behavioral health services are medically necessary for the member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

### **B. Service Delivery**

MQD has a Memorandum of Understanding (MOU) with CAMHD to provide services to Medicaid beneficiaries. The CAMHD is responsible for providing SEBD services to all individuals age three through twenty (3-20) years who meet eligibility criteria. CAMHD provides services to approximately 900 children. CAMHD had previously functioned as a Pre-paid Inpatient Health Plan (PIHP) but changed to billing these services to MQD through a fee-for-service (FFS) process effective October 1, 2008.

The health plan can make a referral to CAMHD through use the SEBD Referral Form developed by CAMHD. The health plan will continue to provide behavioral health services even after CAMHD admits the individual into their program. In these cases, the health plan will not provide services offered by CAMHD, and CAMHD will not provide services offered by the health plan. The MQD informs the health plans, via the 834-transaction file, when an individual is receiving services through the CAMHD program. When a child is no longer eligible for services through CAMHD, CAMHD will coordinate transition of care with the child's health plan. The health plan will be notified that the individual is no longer receiving services via CAMHD via the 834-transaction file.

Referrals to CAMHD can also occur through the school, parent, child, or the health plan. CAMHD considers all referrals through an assessment process. Even if a child qualifies for SEBD services, parents can choose to have their children's behavioral health services provided through the child's health plan. However, the health plans are only able to provide the behavioral health services identified in their contract. CAMHD would need to be involved for any specialized behavioral health services. These additional behavioral health services include both intensive case management and targeted case management and are distinct from the services provided through the health plans.

### **III. RECEIPT OF SPECIALIZED BEHAVIORAL HEALTH SERVICES BY ADULTS (INDIVIDUALS $\geq$ 21 YEARS)**

#### **A. Clinical Criteria**

Beneficiaries  $\geq$ 21 years old with a SMI or SPMI are eligible for specialized behavioral health services if they meet the following criteria:

- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The beneficiary meets at least one of the criteria below demonstrating instability and/or functional impairment:
  - Global Assessment of Functioning (GAF)  $<$  50;
  - Clinical records demonstrate that the beneficiary is currently unstable under current treatment or plan of care (ex. multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable to include but not limited to consistently noncompliant with medications and follow-up, unengaged with providers, significant and consistent isolation, resource deficit causing instability, significant co-occurring medical illness causing instability, poor coping/independent living/problem solving skills causing instability, at risk for hospitalization); or
  - Beneficiary is under Protective Services or requires intervention by housing or law enforcement officials.
- Beneficiaries who do not meet the requirements listed above, but based upon an assessment by a programmatic medical director, that additional behavioral health services are medically necessary for the member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

#### **B. Service Delivery**

The current organization for the delivery of specialized behavioral health services is largely historical. Around the time that the QUEST program was implemented in the mid-1990's, for which specialized behavioral health services were carved out, the CCS program was created due to the lack of

behavioral health services for Medicaid beneficiaries with a SMI/SPMI. (AMHD had a limited service package at that time.) In the early 2000 timeframe, AMHD expanded its services significantly, largely modeling the CCS services, due to a mandated court decree that was withdrawn in 2006. However, MQD continued to offer its CCS program despite the expansion of services within AMHD.

CCS predominately served non-Aged, Blind and Disabled (ABD) individuals, and AMHD largely served ABDs. When QExA was implemented as managed care for the ABD population, specialized behavioral health services remained carved out. Over the years as individuals were offered choice, an increasing number of non-ABDs began to receive their services through AMHD, and an increasing number of ABDs began to receive their services through CCS.

In an effort to improve integration between medical and behavioral health care, effective July 1, 2010, the MQD transitioned all behavioral health services provided to QUEST adult beneficiaries by AMHD and the CCS program into the QUEST health plans. MQD observed that neither behavioral health outcomes nor medical outcomes were improved for this population, and the fragmentation among multiple health plans created confusion for patients and providers alike.

Effective March 1, 2013, CCS will be converted from primarily a third party administrator contract to a Pre-paid Inpatient Health Plan (PIHP), and MQD intends to transition all adults to receive their specialized behavioral health services through CCS. The following describes the current alternative service delivery options for adults until all adults can be transitioned to the CCS program to receive their specialized behavioral health services as described in this protocol.

#### 1. AMHD

MQD had a MOU with AMHD to provide services to Medicaid beneficiaries. Currently, AMHD provides specialized behavioral health services to approximately 1,200 Medicaid ABD adults, until this population can be transitioned to the CCS program. AMHD bills specialized behavioral health services to the MQD through a FFS process.

Referrals to AMHD occur through either the beneficiary (self-referral) by calling the AMHD access line, or by beneficiary choice after a health plan referral and determination of eligibility. AMHD considers all referrals through an assessment process and uses the same criteria as listed in section A above. If the individual meets criteria, AMHD will notify MQD, develop an individual service plan, and begin providing services.

Currently, the QExA health plans make referrals for adult members identified with a SMI/SPMI. All referrals are reviewed by a MQD

physician for eligibility. Eligible beneficiaries can choose to receive their specialized behavioral health services through AMHD or CCS, until the transition at which time they will only be able to receive the specialized behavioral health services through CCS.

The specialized behavioral health services provided by AMHD include both intensive case management and targeted case management. These services are distinct from the services provided through the managed care health plans.

2. CCS

The CCS program provides specialized behavioral health services to approximately 900 Medicaid ABD adults. MQD awards the CCS program to a contractor through a Request for Proposals (RFP) to provide specialized behavioral health services to eligible adults as a PIHP. Certain new services may be reimbursed on a fee-for-service basis until able to be incorporated into the capitation rates.

Currently, the QExA health plans make referrals for adult members identified with a SMI/SPMI. All referrals are reviewed by a MQD physician for eligibility. Eligible beneficiaries can choose to receive their specialized behavioral health services through AMHD or CCS, until the transition at which time they will only be able to receive the specialized behavioral health services through CCS. Once enrolled in CCS, CCS performs an assessment and develops an individual service plan.

3. Managed Care Health Plans

All managed care health plans provide all their beneficiaries with first line behavioral health services. Currently, the QUEST health plans also provide approximately 2,000 adults with specialized behavioral health services, until this population is transitioned to receive specialized behavioral health services through CCS. Payment to the health plans is incorporated into their capitation rates. The health plans identify adult members with a SMI/SPMI and perform an assessment to develop an individual service plan. Certain specialized services are provided by CCS instead of the health plan.

Regardless of the specialized behavioral health service delivery option an adult utilizes, the individual will have access to the same specialized behavioral health services. This will be clear, and the delivery system will be more integrated, once MQD successfully transitions all adults with SMI/SPMI to receive their specialized behavioral health services through the CCS program.

#### **IV. COVERED SPECIALIZED BEHAVIORAL HEALTH SERVICES**

The standard behavioral health services are State plan services. The covered specialized behavioral health services include those covered under the State plan and those covered under the section 1115 demonstration. These services may be provided through CAMHD or through AMHD, CCS, or health plans. The State plan services are listed below with details available in the State plan. The 1115 demonstration services are described in detail below, and these services are not available through the health plans. Individuals receiving specialized behavioral health services through the health plans in need of these additional services can receive them either through AMHD or CCS.

##### **A. State Plan Standard Behavioral Health Services**

1. Acute Psychiatric Hospitalization
2. Diagnostic/Laboratory Services
3. Electroconvulsive Therapy
4. Evaluation and Management
5. Methadone Treatment
6. Prescription Medications
7. Substance Abuse Treatment
8. Transportation

##### **B. State Plan Specialized Behavioral Health Services**

1. Assertive Community Treatment (intensive case management and community-based residential programs)
2. Biopsychosocial Rehabilitation
3. Crisis Management
4. Crisis Residential Services
5. Hospital-based Residential Programs
6. Intensive Family Intervention
7. Intensive Outpatient Hospital Services
8. Therapeutic Living Supports and Therapeutic Foster Care Supports  
(Addendum D includes the State plan pages for these Community Mental Health Rehabilitative Services)

##### **C. 1115 Demonstration Specialized Behavioral Health Services**

1. Clubhouse
  - a. A Clubhouse is a local community center that offers people who have mental illness opportunities to achieve their full potential by forming a community of people who are working together to achieve a common goal. A Clubhouse is organized to support people living with mental illness.
  - b. Clubhouse is an organization accredited by International Center for Clubhouse Development (ICCD). ICCD is an organization that provides resources for communities to create solutions for people with mental illness.



- c. MQD would reimburse this service utilizing half-day and full-days attending Clubhouse.
- 2. Peer Specialist
  - a. The peer specialist works in collaboration with interdisciplinary team members to assist beneficiaries to:
    - i. Understand recovery and the value of every individual's recovery experience;
    - ii. Identify strengths and needs for recovery;
    - iii. Understand and set goals for recovery;
    - iv. Determine the objectives needed to reach beneficiary-centered recovery goals; and
    - v. Help beneficiaries create, maintain and utilize their own recovery plan.
  - b. Peer specialists shall be certified by AMHD as part of their Hawaii Certified peer specialist (HCPS) program. Peer specialists are persons who have self-identified themselves as receiving (or previously received) mental health services for their own personal recovery.
  - c. These individuals help SMI beneficiaries by providing support to others who are facing a similar situation they have faced in the past. Peer specialists promote self-determination, personal responsibility, and community integration for beneficiaries.
- 3. Representative Payee
  - a. A representative payee is an individual or organization that is chosen for a beneficiary that cannot manage or direct someone else to manage his or her money. This benefit is only for those without access to the social security representative payee program.
  - b. The main responsibilities of a payee are to use the beneficiary's income to pay for the current and foreseeable needs of the beneficiary and properly save any income not needed to meet current needs. A payee must also keep records of expenses. Reports shall be provided quarterly on each beneficiary's account.
- 4. Supportive Employment
  - a. Supported employment includes activities needed to obtain and sustain paid work within the general workforce by beneficiaries and includes assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the beneficiary, transitioning the beneficiary from volunteer work to paid employment, and assisting the beneficiary in maintaining an individual job in the general workforce at or above the state's minimum wage.
  - b. Supported employment support is conducted in a variety of settings to include self-employment. With regard to self-employment, individual employment support services may include:
    - i. Aiding the beneficiary to identify potential business opportunities;
    - ii. Assisting in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business;



- iii. Identifying the supports that are necessary in order for the beneficiary to operate the business; and
- iv. Providing ongoing assistance, counseling and guidance once the business has been launched.

5. Supportive Housing

- a. This is housing-based care management focused on ensuring housing stability, recognizing housing's role as an essential platform for recovery and improved health.
- b. The service will include assisting individuals with finding and retaining housing such as Section 8, Section 811, other Housing and Urban Development (HUD) programs, and public housing.
- c. Available to previously homeless individuals or others in public housing.

## Addendum A. Overview of Behavioral Health Service Delivery

	Adults without SMI/SPMI	Non-ABD Adults with SMI/SPMI	ABD Adults with SMI/SPMI Enrolled in AMHD	ABD Adults with SMI/SPMI Enrolled in CCS	Children with SEBD Enrolled in CAMHD
<b>Standard Behavioral Health Services</b>					
Acute Psychiatric Hospitalization	HP	HP	HP	CCS	HP
Diagnostic/laboratory Services	HP	HP	HP	CCS	HP
Electroconvulsive Therapy	HP	HP	HP	CCS	HP
Evaluation and Management	HP	HP	HP	CCS	CAMHD/HP
Methadone Treatment	HP	HP	HP	CCS	HP
Prescription Medications	HP	HP	HP	CCS	HP
Substance Abuse Treatment	HP	HP	HP	CCS	HP
Transportation	HP	HP	HP	CCS	HP
<b>Specialized State Plan Behavioral Health Services</b>					
Biopsychosocial Rehabilitation	n/a	HP	AMHD	CCS	n/a
Community Based Residential Programs	n/a	n/a	n/a	n/a	CAMHD
Crisis Management	n/a	HP	AMHD	CCS	CAMHD
Crisis Residential Services	n/a	CCS	AMHD	CCS	CAMHD
Hospital-based Residential Services	n/a	n/a	n/a	n/a	CAMHD
Intensive Case Management	n/a	HP	AMHD	CCS	CAMHD
Intensive Family Intervention	n/a	n/a	n/a	n/a	CAMHD
Intensive Outpatient Hospital Services	n/a	HP	AMHD	CCS	CAMHD
Therapeutic Living Supports and Therapeutic Foster Care Supports	n/a	HP	AMHD	CCS	CAMHD
<b>Specialized 1115 Behavioral Health Services</b>					
Clubhouse	n/a	HP	AMHD	CCS	n/a

Peer Specialist	n/a	HP	AMHD	CCS	n/a
Representative Payee	n/a	CCS	AMHD	CCS	n/a
Supportive Employment	n/a	CCS	AMHD	CCS	n/a
Supportive Housing	n/a	CCS	AMHD	CCS	n/a

Legend:

ABD	Aged, Blind, or Disabled
AMHD	Adult Mental Health Division in the Department of Health
HP	Health Plan
CAMHD	Child and Adolescent Mental Health Division in the Department of Health
CCS	Community Care Services program
SEBD	Support for Emotional and Behavioral Development
SMI	Severe Mental Illness
SPMI	Serious and Persistent Mental Illness

## Addendum B. Details of Covered Behavioral Health Services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
<b>Payment methodology</b>	N/A	<b>Payment to health plans</b>  Capitation	<b>Payment to DOH-AMHD</b>  Billed FFS to MQD	<b>Payment to the Behavioral Health Organization</b>  Capitation/FFS	<b>Payment to DOH-CAMHD</b>  Billed FFS to MQD
<b>Standard Behavioral Health Services</b>					
Acute psychiatric hospitalization	Hospitals licensed to provide psychiatric services	Twenty-four (24) hour care for acute psychiatric illnesses including: <ul style="list-style-type: none"> <li>○ Room and board</li> <li>○ Nursing care</li> <li>○ Medical supplies and equipment</li> <li>○ Diagnostic services</li> <li>○ Physician services</li> <li>○ Other practitioner services as needed</li> <li>○ Other medically necessary services</li> <li>○ Pharmaceuticals</li> <li>○ Rehabilitation services, as needed</li> </ul>	Provided by health plan	Twenty-four (24) hour care for acute psychiatric illnesses including: <ul style="list-style-type: none"> <li>○ Room and board</li> <li>○ Nursing care</li> <li>○ Medical supplies and equipment</li> <li>○ Diagnostic services</li> <li>○ Physician services</li> <li>○ Other practitioner services, as needed</li> <li>○ Other medically necessary services</li> <li>○ Pharmaceuticals</li> <li>○ Rehabilitation services, as needed</li> </ul>	Provided by health plan
Diagnostic/laboratory services	Laboratories	Diagnostic/laboratory services including: <ul style="list-style-type: none"> <li>○ Psychological testing</li> <li>○ Screening for drug and alcohol problems</li> <li>○ Other medically necessary diagnostic services</li> </ul>	Provided by health plan	Diagnostic/laboratory services including: <ul style="list-style-type: none"> <li>○ Psychological testing</li> <li>○ Screening for drug and alcohol problems</li> <li>○ Other medically necessary diagnostic services</li> </ul>	Provided by health plan
Electro-	Acute Psychiatric	ECT	Provided by health plan	ECT	Provided by health plan

<b>Benefits</b>	<b>Providers</b>	<b>Health Plans</b>	<b>AMHD</b>	<b>CCS Program</b>	<b>CAMHD</b>
convulsive Therapy (ECT)	Hospital  Outpatient facility	<ul style="list-style-type: none"> <li>○ Medically necessary, may do more than one/day</li> <li>○ Inclusive of anesthesia</li> </ul>		<ul style="list-style-type: none"> <li>○ Medically necessary, may do more than one/day</li> <li>○ Inclusive of anesthesia</li> </ul>	
Evaluation and Management	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	Psychiatric or psychological evaluation  Individual and group counseling and monitoring	Psychiatric or psychological evaluation for SMI/SPMI  Individual and group counseling and monitoring for SMI/SPMI  HP provides individual and group counseling and monitoring for non-SMI/SPMI	Psychiatric, psychological or neuropsychological evaluation for SMI/SPMI  Individual and group counseling and monitoring for SMI/SPMI  HP provides individual and group counseling and monitoring for non-SMI/SPMI	Psychiatric, psychological or neuropsychological evaluation for SEBD  Individual and group counseling and monitoring for children requiring SEBD  HP provides individual and group counseling and monitoring for all other children
Methadone Treatment	Methadone clinics	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan
Prescription Medications	Providers licensed to prescribe (e.g. Psychiatrist and APRN Rx). Medications are dispensed by licensed pharmacies.	Prescribed drugs including medication management and patient counseling	Provided by health plan	Prescribed drugs including medication management and patient counseling	Provided by health plan

<b>Benefits</b>	<b>Providers</b>	<b>Health Plans</b>	<b>AMHD</b>	<b>CCS Program</b>	<b>CAMHD</b>
Substance Abuse Treatment	Certified substance abuse counselors*  Specialized residential treatment facilities  Facilities licensed to perform substance abuse treatment	Substance Abuse – Residential: <ul style="list-style-type: none"> <li>Medically necessary services based on American Society of Addiction Medicine (ASAM)</li> </ul> Substance Abuse – Out-patient: <ul style="list-style-type: none"> <li>Screening</li> <li>Treatment and treatment planning</li> <li>Therapy/counseling</li> <li>Therapeutic support &amp; education</li> <li>Homebound services</li> <li>Continuous treatment teams</li> <li>Other medically necessary</li> <li>Screening for drugs and alcohol</li> </ul>	Provided by health plan	Substance Abuse – Residential: <ul style="list-style-type: none"> <li>Medically necessary services based on American Society of Addiction Medicine (ASAM)</li> </ul> Substance Abuse – Out-patient: <ul style="list-style-type: none"> <li>Screening</li> <li>Treatment and treatment planning</li> <li>Therapy/counseling</li> <li>Therapeutic support &amp; education</li> <li>Homebound services</li> <li>Continuous treatment teams</li> <li>Other medically necessary</li> <li>Screening for drugs and alcohol</li> </ul>	Provided by health plan
Transportation	Approved transportation providers to include medical vans, taxi cabs, bus services, and handicap bus services.	Transportation <ul style="list-style-type: none"> <li>Air</li> <li>Ground for medically necessary services</li> </ul>	Provided by health plan	Transportation <ul style="list-style-type: none"> <li>Air</li> <li>Ground for medically necessary services</li> </ul>	Provided by health plan
<b>Specialized Behavioral Health Services</b>					
Biopsychosocial Rehabilitative Programs	AMHD  Qualified Mental Health Provider**	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Not provided

<b>Benefits</b>	<b>Providers</b>	<b>Health Plans</b>	<b>AMHD</b>	<b>CCS Program</b>	<b>CAMHD</b>
Clubhouse*	AMHD	Beneficiaries participate in programs that support them in obtaining employment, education and housing.	Beneficiaries participate in programs that support them in obtaining employment, education and housing.	Beneficiaries participate in programs that support them in obtaining employment, education and housing.	Not provided
Community Based Residential Programs	Small homes certified to perform community based residential programs. Each home is staffed with several qualified mental health professionals.	Not provided	Not provided	Not provided	These programs provide twenty-four (24) hour integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression, or deviance, which prevent the youth from taking part in family and/or community life.
Crisis Management	Qualified Mental Health Provider**	Crisis Management Services <ul style="list-style-type: none"> <li>○ 24-hour crisis hotline</li> <li>○ Mobile outreach services</li> <li>○ Crisis intervention/stabilization services</li> </ul>	Crisis Management Services <ul style="list-style-type: none"> <li>○ 24-hour crisis hotline</li> <li>○ Mobile outreach services</li> <li>○ Crisis intervention/stabilization services</li> </ul>	Crisis Management Services <ul style="list-style-type: none"> <li>○ 24-hour crisis hotline</li> <li>○ Mobile outreach services</li> <li>○ Crisis intervention/stabilization services</li> </ul>	Crisis Management Services <ul style="list-style-type: none"> <li>○ 24-hour crisis hotline</li> <li>○ Mobile outreach services</li> <li>○ Crisis intervention/stabilization services</li> </ul>
Crisis Residential Services	Qualified Mental Health Provider**	Not provided	Crisis Residential Services	Crisis Residential Services	Crisis Residential Services
Hospital based residential programs	Acute psychiatric hospital	Not provided	Not provided	Not provided	Hospital based residential treatment
Intensive Case Management	Qualified Mental Health Provider**	Care Coordination/Case Management	Intensive case management/community based case	Care Coordination/Case Management	Intensive case management/community based case

<b>Benefits</b>	<b>Providers</b>	<b>Health Plans</b>	<b>AMHD</b>	<b>CCS Program</b>	<b>CAMHD</b>
	Health plan	<ul style="list-style-type: none"> <li>○ Case assessment</li> <li>○ Case planning (service planning, care planning)</li> <li>○ Outreach</li> <li>○ Ongoing monitoring and service coordination</li> </ul>	<p>management</p> <p>Targeted Case Management</p>	<ul style="list-style-type: none"> <li>○ Case assessment</li> <li>○ Case planning (service planning, care planning)</li> <li>○ Outreach</li> <li>○ Ongoing monitoring and service coordination</li> </ul>	<p>management</p> <p>Targeted Case Management</p>
Intensive family intervention	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	Not provided	Not provided	Not provided	Intensive family intervention
Intensive Outpatient Hospital Services	<p>Acute psychiatric hospitals</p> <p>Qualified Mental Health Provider**</p>	<p>Intensive Outpatient Hospital Services</p> <ul style="list-style-type: none"> <li>○ Medication management</li> <li>○ Pharmaceuticals</li> <li>○ Medical supplies</li> <li>○ Diagnostic testing</li> <li>○ Therapeutic services including individual, family, and group therapy</li> </ul>	<p>Intensive Outpatient Hospital Services</p> <ul style="list-style-type: none"> <li>○ Medication management</li> <li>○ Pharmaceuticals</li> <li>○ Medical supplies</li> <li>○ Diagnostic testing</li> <li>○ Therapeutic services including individual, family, and group therapy</li> </ul>	<p>Intensive Outpatient Hospital Services:</p> <ul style="list-style-type: none"> <li>○ Medication management</li> <li>○ Pharmaceuticals</li> <li>○ Medical supplies</li> <li>○ Diagnostic testing</li> <li>○ Therapeutic services including individual, family, and group therapy</li> </ul>	<p>Intensive Outpatient Hospital Services:</p> <ul style="list-style-type: none"> <li>○ Medication management</li> <li>○ Pharmaceuticals</li> <li>○ Medical supplies</li> <li>○ Diagnostic testing</li> <li>○ Therapeutic services including individual, family, and group therapy</li> </ul>



<b>Benefits</b>	<b>Providers</b>	<b>Health Plans</b>	<b>AMHD</b>	<b>CCS Program</b>	<b>CAMHD</b>
		and aftercare ○ Other medically necessary services	and aftercare ○ Other medically necessary services	and aftercare ○ Other medically necessary services	and aftercare ○ Other medically necessary services
Peer Specialist*	Certified peer specialists	Structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community skills.	Not provided
Representative Payee*	Qualified Mental Health Provider**	Not provided	Assist beneficiary in managing their financial status.	Assist beneficiary in managing their financial status.	Not provided
Supportive Employment*	Qualified Mental Health Provider**	Not provided	Activities to obtain and sustain paid work by beneficiaries.	Activities to obtain and sustain paid work by beneficiaries.	Not provided
Supportive Housing*	Qualified Mental Health Provider**	Not provided	Housing-based care management focused on ensuring housing stability.	Housing-based care management focused on ensuring housing stability.	Not provided
Therapeutic Living Supports and Therapeutic Foster Care Supports	Specialized residential treatment facility	Specialized residential treatment facilities	Specialized residential treatment facilities	Specialized residential treatment facilities	Therapeutic living and therapeutic foster care supports

Legend:

*	Approved waiver services
**	Medicaid provider that offers multiple behavioral health services in one organization in order to provide continuity for the participants in the behavioral health program. Qualified providers are licensed or certified as required by Hawaii Revised Statutes.

## **Addendum C: Eligibility Diagnoses for Specialized Behavioral Health Services**

### **Support for Emotional and Behavioral Development**

#### *Eligible Diagnoses*

- Demonstrates the presence of a primary DSM (most current edition) Axis I diagnosis for at least six (6) months or is expected to demonstrate the diagnosis for the next six (6) months. See excluded diagnoses in the next section.

#### *Excluded Diagnoses\**

- Mental Retardation\*\* (317, 318.0, 318.1, 318.2, 319)
- Pervasive Developmental Disorders\*\* (299.0, 299.80, 299.10)
- Learning Disorders (315.0, 315.1, 315.2, 315.9)
- Motor Skills Disorders (315.3)
- Communication Disorders (315.31, 315.32, 315.39, 307.0, 307.9)
- Substance Abuse Disorders
- Mental Disorders Due to a General Medical Condition
- Delirium, Dementia, Amnestic, and other Cognitive Disorders
- Factitious Disorders
- Feeding Disorders of Infancy or Childhood
- Elimination Disorders
- Sexual Dysfunctions
- Sleep Disorders

\* If a diagnosis listed above is the **ONLY** DSM (most current edition) diagnosis, the child/youth is ineligible for SEBD services. However, these diagnoses may and often do co-exist with other DSM diagnoses, which would not make the child/youth ineligible for SEBD services.

\*\* Co-occurring diagnoses of Mental Retardation and Pervasive Developmental Disorders require close collaboration and coordination with State of Hawaii Department of Health (DOH) and State of Hawaii Department of Education (DOE) services. The health plan, with CAMHD, is responsible for coordinating these services. These diagnoses may be subject to a forty-five (45) day limit on hospital-based residential services, after which utilization review and coordination of services with DOE need to occur.

### **Severe Mental Illness/ Serious and Persistent Mental Illness**

#### *Eligible Diagnoses*

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)

- Delusional Disorders (297.1)
- Mood Disorders- Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders- Depressive Disorders (296.24, 296.33, 296.34)
- Post-traumatic stress disorder
- Substance induced psychosis

**Addendum D**  
**SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B**

12d. Same as 6b

Limitations on prescription eyeglasses are as follows:

Trifocal lenses are covered only for those currently wearing these lenses satisfactorily and for specific job requirements.

Tinted or coated lenses are excluded except for persons with aphakia, albinism, glaucoma, etc. exclusive of photophobia not associated with such conditions.

Oversize lenses are excluded.

Bilateral plano glasses covered as safety glasses for persons with one remaining eye.

Individuals with presbyopia who require no or minimal distance correction shall be fitted with ready made half glasses instead of bifocal. Contact lenses for cosmetic purposes and blended bifocals are excluded.

13a. Certain categories of diagnostic procedures or out-of-state procedures require prior authorization.

13d. Rehabilitative services are subject to the limitations specified on these supplement pages for particular services, i.e., physical therapy, speech therapy, etc.

**Community Mental Health Rehabilitative Services:** Medicaid Rehab Option

The covered Community Mental Health Rehabilitative Services will be available to all Medicaid eligibles who are medically determined to need mental health and/or drug abuse/alcohol services. These services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.

Individuals who are mentally retarded (MR) or developmentally delayed (DD) are not eligible for these services, including MR/DD individuals who are in Home & Community Based Waiver programs.

These services are to be provided by the following qualified mental health professionals: licensed psychiatrist, licensed psychologist, licensed clinical social worker (CSW) with experience in behavioral health, licensed advance practical nurse (APRN) in behavioral health, or a licensed Marriage and Family Therapist (LMFT) with experience in behavioral health. Additionally, provider qualifications must be in

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TN No. 01-010

Supersedes

TN No. 93-010

Approval Date: MAY 15 2002 Effective Date: 07/01/01

## SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B

compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

The services are defined as follows:

1. **Crisis Management.** This service provides mobile assessment for individuals in an active state of crisis (24 hours per day, 7 days per week) and can occur in a variety of community settings including the consumer's home. Immediate response is required. Included in Crisis Management services are an assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation. If necessary, this may include referral to licensed psychiatrist, licensed psychologist, or to an inpatient acute care hospital. The presenting crisis situation may necessitate that the services be provided in the consumer's home or natural environment setting. Thus, crisis management services may be provided in the home, school, work environment or other community setting as well as in a health care setting. These services are provided through JCAHO, CARF, or COA accredited agencies. In addition, agencies must have staff that includes one or more qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.
2. **Crisis Residential Services.** Crisis Residential Services are short-term, interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization or inpatient hospital based psychiatric care at levels of care below acute psychiatric inpatient. Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, and daily living skills training. Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting. All crisis residential programs will have less than 16 beds. The services do not include payment for room and board. The staff providing crisis residential services must be qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.
3. **Biopsychosocial Rehabilitative Programs :** A therapeutic day rehabilitative social skill building service which allows individuals with serious mental illness to gain the necessary social and communication skills necessary to allow them to remain in or return to naturally occurring community programs.

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TN No. 01-010

Supersedes

TN No.

Approval Date: MAY 15 2002

Effective Date: 07/01/01



## SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B

Services include group skill building activities that focus on the development of problem-solving techniques, social skills and medication education and symptom management. All services provided must be part of the individual's plan of care. The therapeutic value of the specific therapeutic recreational activities must be clearly described and justified in the plan of care. At a minimum the plan of care must define the goals/objectives for the individual, educate the individual about his/her mental illness, how to avoid complications and relapse, and provide opportunities for him/her to learn basic living skills and improve interpersonal skills. Services are provided by qualified mental health professionals or staff that are under the supervision of a qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

4. **Intensive Family Intervention.** These are time limited intensive interventions intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for children with serious emotional or behavioral disturbance or adults with serious mental illness. These services: 1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; 2) assess and monitor the service needs of the identified individual so that he/she can be safely maintained in the family; 3) ensure the clinical appropriateness of services provided; and 4) improve the individual's ability to care for self and the family's capacity to care for the individual. This service includes focused evaluations and assessments, crisis case management, behavior management, counseling, and other therapeutic rehabilitative mental health services toward improving the individual's ability to function in the family. Services are directed towards the identified individual within the family. Services can be provided in-home, school or other natural environment. Services are provided by a multidisciplinary team comprised of qualified mental health professionals. If the services are provided by staff other than that listed above, the staff must be supervised by one of the licensed disciplines noted above and at a minimum be a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).
5. **Therapeutic Living Supports and Therapeutic Foster Care Supports.** These are services covered in settings such as group living arrangements or therapeutic foster homes. Group living arrangements usually provide services for 3 to 6 individuals per home but not more than 15. Therapeutic foster homes provide services for a maximum of 15 individuals per home. Although these group living arrangements and therapeutic foster homes may provide 24 hour per day of residential care, only the therapeutic services provided are covered. There is no reimbursement of room and board charges. Covered

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TN No. 01-010

Supersedes

TN No.

Approval Date: MAY 15 2002

Effective Date: 07/01/01

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therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home. The identified individual must be either a child with serious emotional or behavioral disturbance or the adult with a serious mental illness. Services provided in therapeutic group homes and therapeutic foster homes include: supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training (individual, group, family), directed at the amelioration of functional and behavioral deficits and based on the individual's plan of care developed by a team of licensed and qualified mental health professionals. Services are provided in a licensed facility and are provided by a qualified mental health professional or staff under the supervision of a qualified mental health professional with 24-hour on-call coverage by a licensed psychiatrist or psychologist.

6. **Intensive outpatient hospital services.** These are outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. Services are provided to an individual who is either a child with serious emotional or behavioral disturbance or an adult with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) are unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The goals of service are clearly identified in an individualized plan of care. The short term and long term goals and continuing care plan are established prior to admission through a comprehensive assessment of the consumer to include a severity-adjusted rating of each clinical issue and strength. Treatment is time-limited, ambulatory and active offering intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Services are available at least 20 hours per week. All services are provided by qualified mental health professionals, or by individuals under the supervision of a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Registered nurses or licensed practical nurses must be available for nursing interventions and administration of medications. Licensed psychiatrists or psychologist must be actively involved in the development, monitoring, and modification of the plan of care. The services must be provided in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for

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coverage of partial hospitalization/day treatment. These services are not provided to individuals in the inpatient hospital setting and do not include acute inpatient hospital stays.

7. **Assertive Community Treatment (ACT)**. This is an intensive community rehabilitation service for individuals who are either children with serious emotional or behavioral disturbance or adults with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) is unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The ACT rehabilitative treatment services are to restore and rehabilitate the individual to his/her maximum functional level. Treatment interventions include crisis management (crisis assessment, intervention and stabilization); individual restorative interventions for the development of interpersonal, community coping and independent living skills; services to assist the individual develop symptom monitoring and management skills; medication prescription, administration and monitoring medication and self medication; and treatment for substance abuse or other co-occurring disorders. Services include 24 hours a day, 7 days a week coverage, crisis stabilization, treatment, and counseling. Also, individuals included in ACT receive case management to assist them in obtaining needed medical and rehabilitative treatment services within their ACT treatment plan. Services can be provided to individuals in their home, work or other community settings. ACT services are provided by agencies whose staffs include one or more licensed qualified mental health professionals. If the services are provided by staff other than a licensed qualified mental health professional, the staff must be supervised by a licensed qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Case management is an integral part of this service and reimbursement for case management as a separate service is not allowed. If biopsychosocial rehabilitation is part of the individual's plan of care under intensive case management, reimbursement for biopsychosocial rehabilitation as a separate service is not allowed.

13d. **Limitations continued**

The covered services are available only to Medicaid eligible recipients with a written plan of care developed with the participation of a licensed psychiatrist or psychologist. Services provided must be medically necessary. Prior approval is required.

TN No. 01-010

Supersedes

TN No. \_\_\_\_\_

Approval Date: \_\_\_\_\_

MAY 15 2002

Effective Date: \_\_\_\_\_

07/01/01



**SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B**

15a. Authorization by the department's medical consultant for the recommended level of  
& care is required.

15b.

16. **Psychiatric services for individuals under age 21.**

Provides secure locked residential treatment consisting of highly structured daily programming, close supervision, educational services, and integrated service planning designed for severely emotionally/behaviorally disturbed to function in a less restrictive setting. Services include multi-disciplinary assessment of the child, skilled milieu of services by trained staff who are supervised by a licensed professional on a 24 hour per day basis, individual psychotherapy and/or counseling, individualized adjunctive therapies, and substance abuse education and counseling, as appropriate and as part of an interdisciplinary treatment plan. Services are required to be staff secure at all times. Hospital-based residential services are provided in a licensed inpatient facility serving individuals who are under the age of 21 and are provided by a qualified mental health professional. If the services are provided by staff other than that listed above, the staff must be supervised by a qualified mental health professional.

Services are not limited and must be authorized.

In communities where a psychiatric facility is not readily available, emergency inpatient psychiatric services may be provided for up to forty-eight hours at the closest licensed general hospital.

17. Limited to nurse midwives sponsored by a physician.

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TN No. 01-010

Supersedes

TN No. \_\_\_\_\_

Approval Date: MAY 15 2002 Effective Date: 07/01/01

## **Attachment G**

State of Hawaii  
1115A Waiver Renewal  
Total Computable

			Trend Rates	DY20 Trended	1/2014-12/2014 DY21	1/2015-12/2015 DY22	1/2016-12/2016 DY23	1/2017-12/2017 DY24	1/2018-12/2018 DY25	5 Year Total
MEG										
WITHOUT WAIVER (WOW)										
PMPM										
Children 6-18 >100% to 133%	CHIP children up to 133%	4.00%		\$162.76	\$169.27	\$176.04	\$183.08	\$190.41	\$198.02	
Newly Eligible	QUEST NET/ACE and newly eligible	4.00%		\$292.52	\$304.22	\$316.39	\$329.05	\$342.21	\$355.90	
Childless to 100%	QUEST 100% and below	4.00%		\$393.75	\$409.50	\$425.88	\$442.92	\$460.63	\$479.06	
Foster Children to Age 25		4.00%		\$170.95	\$177.79	\$184.90	\$192.30	\$199.99	\$207.99	
State Plan Option up to 100%	GA Adults; Parents up to 100%	4.00%		\$463.80	\$482.35	\$501.65	\$521.71	\$542.58	\$564.28	
State Plan Adults		4.00%		\$769.25	\$800.02	\$832.02	\$865.30	\$899.91	\$935.91	
State Plan Children		4.00%		\$444.52	\$462.30	\$480.79	\$500.02	\$520.03	\$540.83	
Aged	Aged with/without Medicare	4.50%		\$1,643.48	\$1,717.44	\$1,794.72	\$1,875.48	\$1,959.88	\$2,048.08	
Blind/Disabled	Blind/Disabled with/without Medicare	4.50%		\$2,111.54	\$2,206.56	\$2,305.85	\$2,409.62	\$2,518.05	\$2,631.36	
Breast & Cervical Cancer		4.50%		\$2,390.74	\$2,498.32	\$2,610.75	\$2,728.23	\$2,851.00	\$2,979.30	
Member Months										
Children 6-18 >100% to 133%		3.0%			112,116	115,479	118,944	122,512	126,188	
Newly Eligible		3.0%			374,253	385,481	397,045	408,956	421,225	
Childless to 100%		3.0%	437,592		450,720	464,241	478,169	492,514	507,289	
Foster Children to Age 25		3.0%	2,376		2,447	2,521	2,596	2,674	2,754	
State Plan Option up to 100%		3.0%	125,596		129,364	133,245	137,242	141,359	145,600	
State Plan Adults		3.0%			492,138	506,902	522,109	537,772	553,906	
State Plan Children		3.0%			1,401,486	1,443,531	1,486,836	1,531,442	1,577,385	
Aged		1.2%			250,185	253,187	256,225	259,300	262,412	
Blind/Disabled		1.2%			298,231	301,810	305,431	309,097	312,806	
Breast & Cervical Cancer		1.2%			368	372	377	381	386	
Projected Without Waiver Expenditures										
Children 6-18 >100% to 133%					\$18,977,920	\$20,329,148	\$21,776,583	\$23,327,076	\$24,987,964	\$109,398,692
Newly Eligible					\$113,856,715	\$121,963,313	\$130,647,101	\$139,949,174	\$149,913,555	\$656,329,858
Childless to 100%					\$184,569,742	\$197,711,107	\$211,788,138	\$226,867,454	\$243,020,416	\$1,063,956,857
Foster Children to Age 25					\$435,097	\$466,076	\$499,261	\$534,808	\$572,886	\$2,508,128
State Plan Option up to 100%					\$62,398,926	\$66,841,730	\$71,600,861	\$76,698,842	\$82,159,800	\$359,700,159
State Plan Adults					\$393,720,243	\$421,753,124	\$451,781,946	\$483,948,821	\$518,405,977	\$2,269,610,111
State Plan Children					\$647,908,099	\$694,039,156	\$743,454,744	\$796,388,721	\$853,091,598	\$3,734,882,318
Aged					\$429,676,876	\$454,400,483	\$480,546,687	\$508,197,343	\$537,439,019	\$2,410,260,408
Blind/Disabled					\$658,064,387	\$695,929,411	\$735,973,190	\$778,321,087	\$823,105,682	\$3,691,393,757
Breast & Cervical Cancer					\$919,383	\$972,284	\$1,028,230	\$1,087,394	\$1,149,962	\$5,157,253
PCP Increase					\$44,500,000	\$47,000,000	\$49,600,000	\$52,300,000	\$55,300,000	\$248,700,000
Without Waiver Expenditures					\$2,555,027,387	\$2,721,405,833	\$2,898,696,740	\$3,087,620,721	\$3,289,146,861	\$14,551,897,541
DSH/UCC Ceiling					\$94,547,507	\$94,547,507	\$94,547,507	\$94,547,507	\$94,547,507	\$472,737,535
TOTAL WITHOUT WAIVER EXPENDITURES					\$2,649,574,894	\$2,815,953,340	\$2,993,244,247	\$3,182,168,228	\$3,383,694,368	\$15,024,635,076
WITH WAIVER (WW)										
PMPM										
Children 6-18 >100% to 133%		4.00%			\$169.27	\$176.04	\$183.08	\$190.41	\$198.02	
Newly Eligible		4.00%			\$304.22	\$316.39	\$329.05	\$342.21	\$355.90	
Childless to 100%		4.00%			\$409.50	\$425.88	\$442.92	\$460.63	\$479.06	
Foster Children to Age 25		4.00%			\$177.79	\$184.90	\$192.30	\$199.99	\$207.99	
State Plan Option up to 100%		4.00%			\$482.35	\$501.65	\$521.71	\$542.58	\$564.28	
State Plan Adults		4.00%	\$327.98		\$341.10	\$354.74	\$368.93	\$383.69	\$399.04	
State Plan Children		4.00%	\$188.57		\$196.11	\$203.96	\$212.12	\$220.60	\$229.42	
Aged		4.50%	\$1,568.19		\$1,638.76	\$1,712.50	\$1,789.57	\$1,870.10	\$1,954.25	
Blind/Disabled		4.50%	\$1,242.77		\$1,298.69	\$1,357.14	\$1,418.21	\$1,482.03	\$1,548.72	
Breast & Cervical Cancer		4.50%	\$2,390.74		\$2,498.32	\$2,610.75	\$2,728.23	\$2,851.00	\$2,979.30	
Caretaker to age 19		4.00%	\$277.40		\$288.50	\$300.04	\$312.04	\$324.52	\$337.50	
Member Months										
Children 6-18 >100% to 133%		3%	108850		112116	115479	118944	122512	126188	
Newly Eligible					374253	385481	397045	408956	421225	
Childless to 100%					450720	464241	478169	492514	507289	
Foster Children to Age 25					2447	2521	2596	2674	2754	
State Plan Option up to 100%					129364	133245	137242	141359	145600	
State Plan Adults					492138	506902	522109	537772	553906	
State Plan Children					1401486	1443531	1486836	1531442	1577385	
Aged					250185	253187	256225	259300	262412	
Blind/Disabled					298231	301810	305431	309097	312806	
Breast & Cervical Cancer					368	372	377	381	386	
Caretaker to age 19					4296	4348	4400	4453	4506	
Projected With Waiver Expenditures										
Children 6-18 >100% to 133%					\$18,977,920	\$20,329,148	\$21,776,583	\$23,327,076	\$24,987,964	\$109,398,692
Newly Eligible					\$113,856,715	\$121,963,313	\$130,647,101	\$139,949,174	\$149,913,555	\$656,329,858
Childless to 100%					\$184,569,742	\$197,711,107	\$211,788,138	\$226,867,454	\$243,020,416	\$1,063,956,857
Foster Children to Age 25					\$435,097	\$466,076	\$499,261	\$534,808	\$572,886	\$2,508,128
State Plan Option up to 100%					\$62,398,926	\$66,841,730	\$71,600,861	\$76,698,842	\$82,159,800	\$359,700,159
State Plan Adults					\$167,867,878	\$179,820,071	\$192,623,260	\$206,338,036	\$221,029,304	\$967,678,550
State Plan Children					\$274,849,344	\$294,418,617	\$315,381,222	\$337,836,365	\$361,890,315	\$1,584,375,863
Aged					\$409,992,808	\$433,583,794	\$458,532,206	\$484,916,149	\$512,818,224	\$2,299,843,180
Blind/Disabled					\$387,311,004	\$409,596,879	\$433,165,084	\$458,089,403	\$484,447,867	\$2,172,610,237
Breast & Cervical Cancer					\$919,383	\$972,284	\$1,028,230	\$1,087,394	\$1,149,962	\$5,157,253
Caretaker to age 19					\$1,239,379	\$1,304,421	\$1,372,877	\$1,444,926	\$1,520,756	\$6,882,360
PCP Increase					\$44,500,000	\$47,000,000	\$49,600,000	\$52,300,000	\$55,300,000	\$248,700,000
UCC					\$94,547,507	\$94,547,507	\$94,547,507	\$94,547,507	\$94,547,507	\$472,737,535
Total With Waiver Expenditures					\$1,761,465,702	\$1,868,554,948	\$1,982,562,329	\$2,103,937,134	\$2,233,358,557	\$9,949,878,671
Cost Share					-\$9,000,000	-\$9,000,000	-\$9,000,000	-\$9,000,000	-\$9,000,000	
Net Expenditures					\$1,752,465,702	\$1,859,554,948	\$1,973,562,329	\$2,094,937,134	\$2,224,358,557	
DY BN Savings					\$897,109,192	\$956,398,392	\$1,019,681,918	\$1,087,231,094	\$1,159,335,811	
Cumulative Savings					\$2,098,447,093	\$3,951,954,676	\$4,971,636,594	\$6,058,867,688	\$7,218,203,498	
Carryover										

State of Hawaii		FMAP		0.5185	0.5185	0.5185	0.5185	0.5185	
1115A Waiver Renewal		CHIP		0.663	0.663	0.663	0.663	0.663	
Federal Share		Newly Enrolled		1	1	1	0.95	0.94	
		Transitional		0.7593	0.8074	0.8556	0.8637	0.8979	
		Trend Rates	DY20 Trended	1/2014-12/2014 DY21	1/2015-12/2015 DY22	1/2016-12/2016 DY23	1/2017-12/2017 DY24	1/2018-12/2018 DY25	5 Year Total
MEG									
WITHOUT WAIVER (WOW)									
PMPM									
Children 6-18 >100% to 133%	CHIP children up to 133%	4.00%	\$162.76	\$169.27	\$176.04	\$183.08	\$190.41	\$198.02	
Newly Eligible	QUEST NET/ACE and newly eligible	4.00%	\$292.52	\$304.22	\$316.39	\$329.05	\$342.21	\$355.90	
Childless to 100%	QUEST 100% and below	4.00%	\$393.75	\$409.50	\$425.88	\$442.92	\$460.63	\$479.06	
Foster Children to Age 25		4.00%	\$170.95	\$177.79	\$184.90	\$192.30	\$199.99	\$207.99	
State Plan Option up to 100%	GA Adults; Parents up to 100%	4.00%	\$463.80	\$482.35	\$501.65	\$521.71	\$542.58	\$564.28	
State Plan Adults		4.00%	\$769.25	\$800.02	\$832.02	\$865.30	\$899.91	\$935.91	
State Plan Children		4.00%	\$444.52	\$462.30	\$480.79	\$500.02	\$520.03	\$540.83	
Aged	Aged with/without Medicare	4.50%	\$1,643.48	\$1,717.44	\$1,794.72	\$1,875.48	\$1,959.88	\$2,048.08	
Blind/Disabled	Blind/Disabled with/without Medicare	4.50%	\$2,111.54	\$2,206.56	\$2,305.85	\$2,409.62	\$2,518.05	\$2,631.36	
Breast & Cervical Cancer		4.50%	\$2,390.74	\$2,498.32	\$2,610.75	\$2,728.23	\$2,851.00	\$2,979.30	
Member Months									
Children 6-18 >100% to 133%		3.0%		112,116	115,479	118,944	122,512	126,188	
Newly Eligible		3.0%		374,253	385,481	397,045	408,956	421,225	
Childless to 100%		3.0%	437,592	450,720	464,241	478,169	492,514	507,289	
Foster Children to Age 25		3.0%	2,376	2,447	2,521	2,596	2,674	2,754	
State Plan Option up to 100%		3.0%	125,596	129,364	133,245	137,242	141,359	145,600	
State Plan Adults		3.0%		492,138	506,902	522,109	537,772	553,906	
State Plan Children		3.0%		1,401,486	1,443,531	1,486,836	1,531,442	1,577,385	
Aged		1.2%		250,185	253,187	256,225	259,300	262,412	
Blind/Disabled		1.2%		298,231	301,810	305,431	309,097	312,806	
Breast & Cervical Cancer		1.2%		368	372	377	381	386	
Projected Without Waiver Expenditures									
Children 6-18 >100% to 133%			\$0	\$12,582,361	\$13,478,225	\$14,437,875	\$15,465,851	\$16,567,020	\$72,531,333
Newly Eligible				\$113,856,715	\$121,963,313	\$130,647,101	\$132,951,716	\$140,918,742	\$640,337,586
Childless to 100%				\$140,143,805	\$159,631,948	\$181,205,931	\$195,945,420	\$218,208,032	\$895,135,135
Foster Children to Age 25				\$225,598	\$241,660	\$258,867	\$277,298	\$297,041	\$1,300,464
State Plan Option up to 100%				\$32,353,843	\$34,657,437	\$37,125,046	\$39,768,350	\$42,599,856	\$186,504,532
State Plan Adults				\$204,143,946	\$218,678,995	\$234,248,939	\$250,927,464	\$268,793,499	\$1,176,792,843
State Plan Children				\$335,940,349	\$359,859,302	\$385,481,285	\$412,927,552	\$442,327,994	\$1,936,536,482
Aged				\$222,787,460	\$235,606,651	\$249,163,457	\$263,500,323	\$278,662,131	\$1,249,720,021
Blind/Disabled				\$341,206,384	\$360,839,400	\$381,602,099	\$403,559,484	\$426,780,296	\$1,913,987,663
Breast & Cervical Cancer				\$609,551	\$644,624	\$681,716	\$720,942	\$762,425	\$3,419,259
PCP Increase				\$44,500,000	\$24,369,500	\$25,717,600	\$27,117,550	\$28,673,050	\$150,377,700
Without Waiver Expenditures				\$1,448,350,012	\$1,529,971,055	\$1,640,569,916	\$1,743,161,948	\$1,864,590,087	\$8,226,643,019
DSH/UCC Ceiling				\$94,547,507	\$94,547,507	\$94,547,507	\$94,547,507	\$94,547,507	\$472,737,535
TOTAL WITHOUT WAIVER EXPENDITURES				\$1,542,897,519	\$1,624,518,562	\$1,735,117,423	\$1,837,709,455	\$1,959,137,594	\$8,699,380,554
WITH WAIVER (WW)									
PMPM									
Children 6-18 >100% to 133%		4.00%		\$169.27	\$176.04	\$183.08	\$190.41	\$198.02	
Newly Eligible		4.00%		\$304.22	\$316.39	\$329.05	\$342.21	\$355.90	
Childless to 100%		4.00%		\$409.50	\$425.88	\$442.92	\$460.63	\$479.06	
Foster Children to Age 25		4.00%		\$177.79	\$184.90	\$192.30	\$199.99	\$207.99	
State Plan Option up to 100%		4.00%		\$482.35	\$501.65	\$521.71	\$542.58	\$564.28	
State Plan Adults		4.00%	\$327.98	\$341.10	\$354.74	\$368.93	\$383.69	\$399.04	
State Plan Children		4.00%	\$188.57	\$196.11	\$203.96	\$212.12	\$220.60	\$229.42	
Aged		4.50%	\$1,568.19	\$1,638.76	\$1,712.50	\$1,789.57	\$1,870.10	\$1,954.25	
Blind/Disabled		4.50%	\$1,242.77	\$1,298.69	\$1,357.14	\$1,418.21	\$1,482.03	\$1,548.72	
Breast & Cervical Cancer		4.50%	\$2,390.74	\$2,498.32	\$2,610.75	\$2,728.23	\$2,851.00	\$2,979.30	
Caretaker to age 19		4.00%	\$277.40	\$288.50	\$300.04	\$312.04	\$324.52	\$337.50	
Member Months									
Children 6-18 >100% to 133%		3%	108850	112116	115479	118944	122512	126188	
Newly Eligible				374253	385481	397045	408956	421225	
Childless to 100%				450720	464241	478169	492514	507289	
Foster Children to Age 25				2447	2521	2596	2674	2754	
State Plan Option up to 100%				129364	133245	137242	141359	145600	
State Plan Adults				492138	506902	522109	537772	553906	
State Plan Children				1401486	1443531	1486836	1531442	1577385	
Aged				250185	253187	256225	259300	262412	
Blind/Disabled				298231	301810	305431	309097	312806	
Breast & Cervical Cancer				368	372	377	381	386	
Caretaker to age 19				4296	4348	4400	4453	4506	
Projected With Waiver Expenditures									
Children 6-18 >100% to 133%			\$0	\$12,582,361	\$13,478,225	\$14,437,875	\$15,465,851	\$16,567,020	\$72,531,333
Newly Eligible				\$113,856,715	\$121,963,313	\$130,647,101	\$132,951,716	\$140,918,742	\$640,337,586
Childless to 100%				\$140,143,805	\$159,631,948	\$181,205,931	\$195,945,420	\$218,208,032	\$895,135,135
Foster Children to Age 25				\$225,598	\$241,660	\$258,867	\$277,298	\$297,041	\$1,300,464
State Plan Option up to 100%				\$32,353,843	\$34,657,437	\$37,125,046	\$39,768,350	\$42,599,856	\$186,504,532
State Plan Adults				\$87,039,495	\$93,236,707	\$99,875,160	\$106,986,272	\$114,603,694	\$501,741,328
State Plan Children				\$142,509,385	\$152,656,053	\$163,525,164	\$175,168,155	\$187,640,128	\$821,498,885
Aged				\$212,581,271	\$224,813,197	\$237,748,949	\$251,429,023	\$265,896,249	\$1,192,468,689
Blind/Disabled				\$200,820,756	\$212,375,982	\$224,596,096	\$237,519,355	\$251,186,219	\$1,126,498,408
Breast & Cervical Cancer				\$609,551	\$644,624	\$681,716	\$720,942	\$762,425	\$3,419,259
Caretaker to age 19				\$642,618	\$676,343	\$711,837	\$749,194	\$788,512	\$3,568,503
PCP Increase				\$44,500,000	\$24,369,500	\$25,717,600	\$27,117,550	\$28,673,050	\$150,377,700
UCC				\$49,022,882	\$49,022,882	\$49,022,882	\$49,022,882	\$49,022,882	\$245,114,412
Total With Waiver Expenditures				\$1,036,888,279	\$1,087,767,871	\$1,165,554,224	\$1,233,122,009	\$1,317,163,852	\$5,840,496,234
Cost Share				-\$4,666,500	-\$4,666,500	-\$4,666,500	-\$4,666,500	-\$4,666,500	
Net Expenditures				\$1,032,221,779	\$1,083,101,371	\$1,160,887,724	\$1,228,455,509	\$1,312,497,352	
DY BN Savings				\$510,675,740	\$541,417,191	\$574,229,699	\$609,253,947	\$646,640,242	
Cummulative Savings			Carryover	\$1,558,726,915	\$2,610,819,846	\$3,185,049,545	\$3,794,303,492	\$4,440,943,734	

## **Attachment H**

The Department of Human Services sent the following email and attachment on November 20, 2012, to the individuals listed below:

**E-Mail Content:**

The Med-QUEST Division (MQD) is seeking public comment on its section 1115 demonstration project application. You are receiving this email as a key stakeholder regarding the provision of care to Medicaid beneficiaries and have either participated in previous MQD community forums and/or indicated a desire to receive such notifications. Please see the attached full public notice that provides detailed information on how to access the application documents and how to provide comment. Thank you for your continuing support of MQD programs and our beneficiaries.

**Attachment**

**Notice of Request for a Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration (11-W-00001/9)**

The State of Hawaii, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 demonstration from the Centers for Medicare & Medicaid Services (CMS). This renewal, which will be effective January 1, 2014, will be entitled "QUEST Integration."

By November 20, 2012, a copy of the proposed renewal application will be available at the Department of Human Services, Med-QUEST Division, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707, or at <http://www.med-quest.us/> and [http://hawaii.gov/dhs/main/har/proposed\\_rules/](http://hawaii.gov/dhs/main/har/proposed_rules/). We are providing this notice pursuant to CMS requirements in 42 C.F.R. § 431.408.

**QUEST Integration Renewal Application**

The State's current demonstration, QUEST Expanded, is set to expire June 30, 2013, but the State expects it will be extended to December 31, 2013 pursuant to the extension request submitted in June 2012. QUEST Integration seeks to build on the successes of Hawaii's existing demonstration, while integrating the current programs to align with requirements in the Affordable Care Act (ACA) and deliver better health outcomes more efficiently.

***Program Description, Goals, and Historical Context***

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. The provision of benefits through managed care has saved hundreds of millions of dollars in State and federal funds and has

enabled the State to use some of the savings to provide coverage to individuals not otherwise eligible for Medicaid.

The Hawaii Medicaid program covers adults in certain categories and up to certain income levels, as well as all children up to 300% of the federal poverty level (FPL). In addition, through the demonstration, Hawaii has sought to provide coverage to Medicaid expansion populations through a variety of programs known as QUEST, QUEST-Net, and QUEST-ACE. The demonstration already covers non-pregnant, non-disabled adults up to and including 133% of the federal poverty level (FPL).

Further detail on the existing program is available at <http://www.med-quest.us/>. CMS also offers online resources regarding the QUEST Expanded Demonstration, which can be viewed at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=hawaii>

Under the “QUEST Integration” renewal, Hawaii seeks to continue to deliver services through managed care, while integrating the demonstration’s programs and benefits to create a more patient-centered healthcare delivery system and to align the demonstration with ACA’s new requirements. The State will eliminate all eligibility enrollment caps, and streamline its programs by consolidating the current programs under QUEST Integration. All eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be based on clinical criteria and medical necessity. Other renewal initiatives include:

- Incorporating the new simplified Medicaid eligibility structure and other changes in ACA.
- Offering new services to beneficiaries, including a home- and community-based services (HCBS) benefit to individuals who are assessed to be at risk of deteriorating to the institutional level of care (the “at risk” population).
- Expanding coverage of behavioral health services.
- Preparing for integration of care for Medicaid and Medicare enrollees.
- Modifying the health plan enrollment process.
- Covering certain Medicaid expansion populations.
- Expanding the qualified provider network to increase access to substance abuse treatment services.
- Modifying retroactive coverage.
- Changing the payment process when hospice care is furnished to individuals residing in nursing facilities.
- Eliminating the QUEST-ACE enrollment benchmarks for purposes of claiming FFP in uncompensated care costs.

The goals of QUEST Integration will be to:

- Improve the health and healthcare 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 state 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.

More detailed information about renewal initiatives and changes in QUEST Integration can be found in the draft application, which is available at <http://www.med-quest.us/> and [http://hawaii.gov/dhs/main/har/proposed\\_rules/](http://hawaii.gov/dhs/main/har/proposed_rules/), as well as in hard copy at the Department of Human Services, Med-QUEST, Policy and Program Development Office located at 601 Kamokila Blvd, Room 518, Kapolei, HI.

***Beneficiaries Impacted, Eligibility Methodology, and Eligibility Requirements***

QUEST Integration will utilize a new eligibility methodology called “modified gross adjusted income” (MAGI) to the extent required by ACA, which will not have an asset test. Other than the use of MAGI methodology, there will be no changes in eligibility methodology. Eligibility for the aged, blind, and disabled (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 individual enrolled on January 1, 2014 will lose his or her eligibility prior to March 31, 2014 because of the implementation of MAGI).

Hawaii plans to cover the following groups in QUEST Integration:

<b>Mandatory State Plan Groups</b>		
<b>Eligibility Group Name</b>	<b>Social Security Act and Code of Federal Regulations Citations</b>	<b>Income Level and Other Qualifying Criteria</b>
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
Children through the CHIP Medicaid expansion	Title XXI, § 2105	Title XIX limits up to and including 300% FPL and for whom the State is claiming Title XXI funding
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
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 need 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 adoption assistance payments

### ***Benefit Coverage***

Under QUEST Integration, Hawaii will combine the two benefit packages available under the current demonstration into one robust set of benefits available to all demonstration populations. Instead of offering different benefit packages to different eligibility groups, Hawaii will offer one package consisting of full primary and acute service State plan benefits and certain additional benefits based on clinical eligibility 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 HCBS and long-term services and supports (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 the 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.

Hawaii also plans to include in the QUEST Integration benefit package the following benefits, subject to clinical criteria and/or 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; and
- Specialized behavioral health services (Clubhouse, Supportive Employment, Peer Specialist, Supportive Housing and Representative Payee) for qualified individuals with a Serious and Persistent Mental Illness (SPMI), Severe Mental Illness (SMI), or Serious Emotional or Behavioral Disorder (SEBD) (either through the demonstration or the state plan).

### ***Delivery System***

Under QUEST Integration, the State will continue to provide most benefits through managed care, which will help ensure access to high-quality, cost-effective care. A discrete set of benefits will be provided fee-for-service.

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

<b>Benefit(s)</b>	<b>Delivery System</b>	<b>Authority</b>
State plan services	Managed Care - MCO	1115
QUEST Integration HCBS and long-term care benefits	Managed Care - MCO	1115
Cognitive rehabilitation therapy	Managed Care - MCO	1115 or State plan
Medical services to medically needy individuals who are aged, blind or disabled	Managed Care - MCO	1115
Medical services to medically needy individuals who are not aged, blind or disabled	Fee-for-service	1115
Long-term care services for individuals with developmental disabilities (DD) or intellectual disabilities (ID)	Fee-for-service	Section 1915(c) waiver
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 State of Hawaii Organ and Tissue Transplant (SHOTT) program	Fee-for-service	State plan
Dental services	Fee-for-service	State plan
Targeted Case 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
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### ***Cost Sharing***

The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan. The State plans to seek authority to continue to charge an enrollment fee to health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate (for the Medically Needy Aged, Blind, and Disabled), in the amount equal to the estimated spend-down or cost share amount.

### ***Annual Enrollment and Annual Expenditures***

From July 1, 2011 to June 30, 2012, state and federal expenditures in the demonstration totaled approximately \$1.3 billion, and 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 changes effective since June 30, 2012 and other State-requested changes to the demonstration, to result in approximately \$700 million in increased State and federal annual expenditures during the renewal period.

### ***Hypotheses and Evaluation Parameters***

In QUEST Integration, 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.

The State will also measure the outcomes in QUEST Integration based on 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.

### ***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)(17)

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 have 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 (including services for the "at risk" population). No waiting list is permissible for other services for health plan enrollees.

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

***Expenditure Authority***

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 within 60 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 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 CFR § 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 adoption assistance.
4. Hospital 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 in the list below, will apply to the demonstration beginning January 1, 2014, through December 31, 2018, except those waived or listed below as not applicable.

### ***Medicaid 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.

### **Comments**

We invite comments on this proposal. Please submit any comments or questions to Noreen Moon-Ng by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at [nmoon-ng@medicaid.dhs.state.hi.us](mailto:nmoon-ng@medicaid.dhs.state.hi.us).

Comments will be accepted for consideration between November 20, 2012, and December 21, 2012 (30 days from the date of this notice).

### **Public Hearings**

The State will hold two public hearings to seek public input on this demonstration renewal 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. to 12:00 p.m.:

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

Interested parties may alternatively participate by teleconference in the December 7, 2012 public hearing. Should you be interested in participating in the teleconference, please call 808-692-8056 by close of business on December 5, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (*e.g.*, sign or foreign language or wheelchair accessibility), please contact:

Oahu            Jeri Kido (808) 692-8056  
Hawaii          Ann Stephenson (808) 933-0046  
Kauai           Iris Venzon (808) 241-3582  
Maui            Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

### **Email List of Individuals**

NAME	ORGANIZATION
A. Garrett	HIPAA Online
Alan Matsunami	CCMC
Phocused Hawaii	Phocused Hawaii Administration
A. Ige	DCCA
Aiona I. Rose	State of Hawaii Courts

A. Johnson	Hina Mauka
Amgoyal	Queens
A. Muraoka	Honolulu
Andreas Cravalho	HMSA
Anne Holton	DOH Hawaii
Antonette Torres	DOH Hawaii
Arendora	Hawaii
Arnold Villafuerte	DOH Hawaii
A. Tashiro	DHS Hawaii
A. Y. Onemoto	HHSC
B. Brown	Queens
Brian	Arc of Maui
B. Ogawa	HLTCA
Brian D. Cade	Hawaii
B. Stanton	AARP
B. Marsh	HSAG
Candice Calhoun	DOH Hawaii
Carol Ganiron	KP
Cash Lopez	DOH Hawaii
Catherine J. Bailey	KP
Catherine Sorensen	DOH Hawaii
Charlie Schlather	MYFSs
Christina K.	Pacificil
C. Stewart	Outreach Services
C. Y. Hara	Queens
C. Young	Hawaii
Dana	C. C. Maui
Dara Rampersad	DOH Hawaii
David W. Heywood	UHC
Chun Oakland	Yahoo
C. Kelsey	Queens
C. L. Yee	Queens
C. Mehau	Bay Clinic
C. Meyer-Uyehara	HHSC
C. O. Liu	Lashaw
Cristina A.	Stop the Violence
C. Flanders	HMSA-ASSN
David Kanno	DOH Hawaii
Dawn Mendiola	DOH Hawaii
D. Derauf	KKV
Dean T.	Kapiolani.
Debbie Shimizu	Hawaii
Deja	LEJ Hawaii
Diana Lee	HMSA
D. Mahi	KKV

D. Tom	Good Beginnings
D. Ulima	Epic Ohana
E. Kealoha	Capitol Hawaii
E. Ching	Easter Seals Hawaii
Edna Azada	Gmail
Eileen Matsumoto	DOH Hawaii
E. Kintu	KPHC
Ellen Matoi	DOH Hawaii
Fenny Esther	Hotmail
F. Jack	Bay Clinic
Flanderscd	Gmail
Flick W. J.	AH
Florentina Salvail	DOH Hawaii
Frank P. Richardson	NSMTP KP
G. Greene	HAH
Ginny P.	Kapiolani
G. L. Wideman	Hotmail
G. Oconnor	Queens
Ohtahpha	Yahoo
Grace Miyata	DOH Hawaii
Gretchen	Arc of Kona
Guinan	Hawaii Education
Hali	Hawaii Education
	Hawaii Down Syndrome
	Hawaii Lobbyist
H. Dela Cruz	WCCHC
Heidi M. Rian	Hawaii
Helene Kaiwi	DOH Hawaii
H. Koop	CFS Hawaii
H. Spoehr	Papa Ola Lokahi
J. Kawasaki	Queens
Kerita	Queens
info	NASWHI
J. Adams, Esq	AOL
Jan Tateishi	DOH Hawaii
Anenamikonakama	Gmail
Janelle Curnan	Meo Inc.
Jarkylik	Gmail
Jeffrey Torres	Wellcare
Jevans	Palama Settlement
J. Howard	HI Goodwill
J. Kakuno	MDX Hawaii
J. Kawamoto	HAH
J. Nakamura3	Honolulu
J. O'Donnell	Family Programs HI

J. Patricio	Hawaii Disability Rights
J. Tomoso	HNKOP
J. Wilhoite	Family Programs HI
Judc	Aloha
K. Hooser	Capitol Hawaii
Kanoe	Hawaii Health Connector
Karen	Scott Gardner Co.
Kathleen Tom	DOH Hawaii
Kathi	MFSS
Kathy	Hawaii Disability Rights
	Kauai DDC
K. Delahi	Hotmail
Keola Diaz	Gmail
Keolani	Hotmail
Kimberly Click	HMSA
K. Ishihara	DHS Hawaii
K. Liumd	Gmail
K. Louis	Hale Mahaolu
K. Suzuki	HPCA
L. Cook	Kualoha
Levie Gray	Yahoo
Lila C. King	Hawaii
Lila Ota	DOH Hawaii
Linda Takai	Gmail
Lisa Nakao	DOH Hawaii
Lisama	Kapiolani
Loren Y.	Kapiolani
Lorrin Kim	DOH Hawaii
Louis	Hawaii Disability Rights
L. Tochiki	Epic Ohana
L. Watanabe	Queens
Lynn.Fallin	DOH Hawaii
Mary Rydell	CMS
Maylyn Tallett	DOH Hawaii
M. Espinda,	Queens
Mihalke	Hawaii Education
M. Iwana	Bay Clinic
Marline	WHW Maui
M. Kobayashi	HHSC
	MLPC Hawaii
M. May	Queens
Moir T.Chin	Courts
M. Molina	Queens
Molokai Rep	Yahoo
N. Vierra	Bayada

Nishimura	Capitol
Norma Circle	CO Maui
O. Gonzaga	Kualoha
O. Wades	Hawaii Education
Pamela Cunningham	DOH Hawaii
Parcena	Alohacare
Paula	The Maui Farm
Pat	Arc of Maui
Phyllis Dendle	KP
P. Laenui	Hawaiian Perspectives
P. Young	HAH
Q. Ogawa	Kuakini
Racob	Rehab Hospital
R. Drake	Honolulu
Rep. Cabanilla	Capitol
Rep. Manahan	Capitol
Rhodorar	Pacificil
Richard Dusendschon	DOH Hawaii
River Run	Hawaii
R. Keene	Queens
R. Katsuda	Hale Mahaolu
R. Lorin	Catholic Charities Hawaii
Romala.Radcliffe	DOH Hawaii
R. Sato-Yuen	Queens
R. Wong	HAH
Ryan	Capitol
Sasha	Balancing Birth
S. Beckham	Waikiki Health Center
S. Bernadette	Gmail
S. B. Kemble	Hawaii
S. Catalan	Alohacare Hawaii
Scorse	Alohacare Hawaii
Scott	Scott Gardner, Co.
Shani Naleieha	Gmail
Shirley Kidani	DOH Hawaii
Shirley Robinson	DOH Hawaii
Suzanne Noland	DHS
S. Tone	Full life Hawaii
S. Yoro	SECOH
S. Young	HAH
Susan Jackson	Wellcare
Suzie Mig	Gmail
T. Gonsalves	WCCHC
T. J. Solid	AOI
Troy Freitas	DOH Hawaii

Trudy Murakami	DOH Hawaii
T. Wakasugi	Queens
Valerie	Arc of Maui
V. Geminiani	Gmail
V. Tomooka	Waimanalo Health
Waynette Cabral	DOH Hawaii
Wendy Nihoa	DOH Hawaii
Wendys Cortez	Yahoo
W. Villareal	HI Goodwill
Wendy Nihoa	DOH Hawaii
Wendy S. Cortez	Yahoo



## **Attachment I**

**Statement of Public Notice**  
**Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration**

The State of Hawaii, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 demonstration project from the Centers for Medicare & Medicaid Services (CMS). The State expects the current demonstration to expire on December 31, 2013. The State is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. §431.408(a)(2)(ii).

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. The demonstration covers Medicaid expansion populations through a variety of programs known as QUEST, QUEST-Net, and QUEST-ACE. The demonstration also covers aged, blind, or disabled Medicaid beneficiaries, including the provision of long-term supports and services, through the QUEST Expanded Access (QExA) program.

Under the "QUEST Integration" renewal, Hawaii seeks to continue to deliver services through managed care, while integrating the demonstration's programs and benefits to create a more patient-centered care delivery system and to align the demonstration with the Affordable Care Act's (ACA) new requirements. The State will eliminate all eligibility enrollment caps, and streamline its programs by consolidating the current programs under QUEST Integration. All eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be based on clinical criteria and medical necessity.

Other initiatives in the proposed renewal include:

- Incorporating the new simplified Medicaid eligibility structure, the modified adjusted gross income eligibility methodology, and other changes in ACA.
- Offering new services to beneficiaries, including a home and community-based services (HCBS) benefit to individuals who are assessed to be at risk of deteriorating to an institutional level of care (the "at risk" population).
- Expanding coverage of behavioral health services.
- Preparing for integration of care for Medicaid and Medicare enrollees.
- Modifying the health plan enrollment process.
- Covering certain Medicaid expansion populations.
- Expanding the qualified provider network to increase access to substance abuse treatment services.
- Modifying retroactive coverage.
- Changing the payment process when hospice care is furnished to individuals residing in nursing facilities.
- Eliminating the QUEST-ACE enrollment benchmarks for purposes of claiming federal financial participation in uncompensated care costs.

The draft renewal application and the State's full public notice, which describe the demonstration and the proposed renewal in more detail, can be found at <http://www.med->

quest.us/ and [http://hawaii.gov/dhs/main/har/proposed\\_rules/](http://hawaii.gov/dhs/main/har/proposed_rules/). Hard copies are available for review at the Department of Human Services, Med-QUEST, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707.

The State will hold two public hearings to solicit comments from interested parties on the proposed renewal:

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

Oahu            Keoni Ana Video Conference Center  
                  Keoni Ana Building  
                  1177 Alakea Street, Room 302  
                  Honolulu, Hawaii

Hawaii        Hilo Video Conference Center  
                  Hilo State Office Building  
                  75 Aupuni Street, Basement  
                  Hilo, Hawaii

Kauai          Lihue Video Conference Center  
                  Lihue State Office Building  
                  3060 Eiwa Street, Basement  
                  Lihue, Hawaii

Maui           Wailuku Video Conference 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

Interested parties may alternatively participate by teleconference in the December 7 hearing. Should you be interested in participating in the teleconference, please call 808-692-8056 by close of business on December 5, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (*e.g.*, sign or foreign language or wheelchair accessibility), please contact:

Oahu            Jeri Kido (808) 692-8056  
Hawaii        Ann Stephenson (808) 933-0046  
Kauai          Iris Venzon (808) 241-3582  
Maui           Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

STATE OF HAWAII  
COUNTY OF KAUAI  
AFFIDAVIT OF PUBLICATION

THE GARDEN ISLAND

DHS/MED-QUEST DIV/FINANCE OFFI  
601 KAMOKILA BLVD RM 518  
KAPOLEI HI 96707

REFERENCE: 113004  
7747476 SECTION 1115(a)  
RENEWAL OF HAWAII

Cheri Bagain, being duly sworn, deposes and says, that she is an employee of "The Garden Island," a newspaper published in Lihue, County of Kauai, State of Hawaii; that the NOTICE in the above entitled matter of which the annexed is a true and correct copy, was published 1 time(s) in "The Garden Island" aforesaid and that this affiant is not a party to or in any way interested in the above entitled matter.

Subscribed and sworn to me this 20 day of November, 2012.

Notary Public, Fifth Judicial Circuit  
State of Hawaii County of Kauai  
My Commission Expires: 04-05-15

Document Description: Affidavit of Publication  
No. of pages: 1 Document Date: 11-20-12

PUBLISHED ON: 11/20/2012



FILED ON: 11/20/12 es

**Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration**

The State of Hawaii, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 demonstration project from the Centers for Medicare & Medicaid Services (CMS). The State expects the current demonstration to expire on December 31, 2013. The State is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. § 431.408(a)(2)(ii).

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Under the "QUEST Integration" renewal, Hawaii seeks to continue to deliver services through managed care, while integrating the demonstration's programs and benefits to create a more patient-centered care delivery system and to align the demonstration with the Affordable Care Act's (ACA) new requirements. The State will eliminate all eligibility enrollment caps, and streamline its programs by consolidating the current programs under QUEST Integration. All eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be based on clinical criteria and medical necessity.

**Other initiatives in the proposed renewal include:**

- Incorporating the new simplified Medicaid eligibility structure, the modified adjusted gross income eligibility methodology, and other changes in ACA.
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The draft renewal application and the State's full public notice, which describe the demonstration and the proposed renewal in more detail, can be found at <http://www.med-quest.us/> and [http://hawaii.gov/dhs/main/har/proposed\\_rules/](http://hawaii.gov/dhs/main/har/proposed_rules/). Hard copies are available for review at the Department of Human Services, Med-QUEST, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707.

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Oahu: Jeri Kido (808) 692-8066  
Hawaii: Ann Stephenson (808) 933-0046  
Kauai: Iria Venzon (808) 241-3662  
Maui: Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

(November 20, 2012)

## AFFIDAVIT OF PUBLICATION

State of Hawaii )

) SS:

County of Hawaii )

LEILANI K. R. HIGAKI

, being first

duly sworn, deposes and says:

1. That she is the BUSINESS MANAGER of  
HAWAII TRIBUNE-HERALD, a  
newspaper published in the City of HILO,  
State of Hawaii.

2. That the "Statement of Public Notice Section 1115(a)  
Renewal of Hawaii's Section 1115 Demonstration...etc.,  
\_\_\_\_\_".

of which a clipping from the newspaper as published is attached hereto, was published in said newspaper on the following date(s) \_\_\_\_\_

November 20, 2012, (etc.).  
51892r1

Subscribed and sworn to before me

this 27th day of November, 2012.

SHARON H. P. OGATA

**Notary Public, Third Circuit, State of Hawaii**

My commission expires October 1, 2016

**Statement of Public Notice  
Section 1115(a) Renewal of  
Hawaii's Section 1115 Demonstration**

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Maui Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

(51892r1 Hawaii Tribune-Herald: November 20, 2012)

# AFFIDAVIT OF PUBLICATION

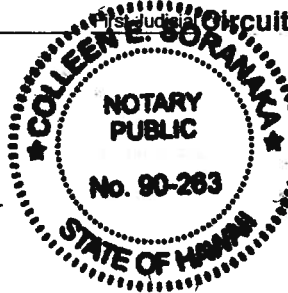
## IN THE MATTER OF Public Notice

STATE OF HAWAII

City and County of Honolulu

SS.

Doc. Date: <u>11/20/12</u>	# Pages: <u>1</u>
Notary Name: <u>COLLEEN E. SORANAKA</u>	
Doc. Description: <u>Affidavit of</u>	
Publication	
Notary Signature	Date <u>11/20/12</u>



Rose Rosales being duly sworn, deposes and says that she is a clerk, duly authorized to execute this affidavit of Oahu Publications, Inc. publisher of The Honolulu Star-Advertiser and MidWeek, that said newspapers are newspapers of general circulation in the State of Hawaii, and that the attached notice is true notice as was published in the aforementioned newspapers as follows:

Honolulu Star-Advertiser 1 times on:  
11/20/2012

Midweek Wed. 0 times on:

                     times on:

And that affiant is not a party to or in any way interested in the above entitled matter.

Rose Rosales /

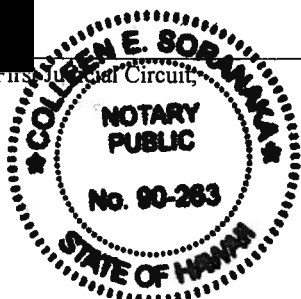
Subscribed to and sworn before me this 20<sup>th</sup> day

of Rov A.D. 2012

Colleen E. Soranaka, Notary Public of the First Judicial Circuit,  
State of Hawaii

My commission expires: Jan 06 2016

Ad # 0000470262



### Statement of Public Notice Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration

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Kauai	Iris Venzon (808) 241-3582
Maul	Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.  
(SA470262 11/20/12)



## AFFIDAVIT OF PUBLICATION

State of Hawaii                    )  
  ) SS:  
County of Hawaii                 )

M. R. Chavez, being first duly sworn, deposes and says:

1. That she is the Classified Accountant of WEST HAWAII TODAY, a newspaper published in the City of Kailua Kona, State of Hawaii.

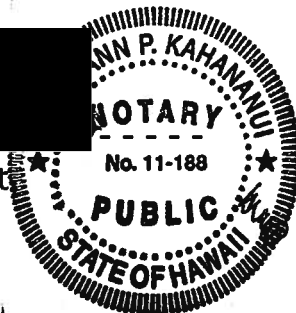
2. That "Statement of Public Notice Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration" of which a clipping from the newspaper is attached hereto, was published in said newspaper on the following date(s) November 20, 2012 (etc.)

[REDACTED]

Subscribed and sworn to before me  
This 20th day of November, 2012

[REDACTED]

Notary Public, Third Circuit  
State of Hawaii



Henriann P. Kahananui

My Commission expires: June 6, 2015

# Page(s): 1

## Statement of Public Notice

### Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration

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at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

(No. 68469-West-Hawaii Today: November 20, 2012)

# AFFIDAVIT OF PUBLICATION

STATE OF HAWAII, } ss.  
County of Maui.

Rhonda M. Kurohara being duly sworn

deposes and says, that she is in Advertising Sales of  
the Maui Publishing Co., Ltd., publishers of THE MAUI NEWS, a  
newspaper published in Wailuku, County of Maui, State of Hawaii;  
that the ordered publication as to

Statement of Public Notice Section 1115(a)

of which the annexed is a true and correct printed notice, was  
published 1 times in THE MAUI NEWS, aforesaid, commencing  
on the 20th day of November, 2012, and ending  
on the 20th day of November, 2012, (both days  
inclusive), to-wit: on

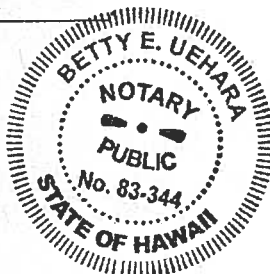
November 20, 2012

and that affiant is not a party to or in any way interested in the above  
entitled matter.

This 1 page Statement of Public Notice, dated  
November 20, 2012,

was subscribed and sworn to before me this 20th day of  
November, 2012, in the Second Circuit of the State of Hawaii,  
by Rhonda M. Kurohara

Notary Public, Second Judicial  
Circuit, State of Hawaii  
BETTY E. UEHARA  
My Commission expires 09-26-15



## Statement of Public Notice

Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration  
The State of Hawaii, Department of Human Services (the State), hereby  
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Kauai Iris Venzon (808) 241-3582  
Maui Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt  
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individuals and appropriate accommodations.

(MN: Nov. 20, 2012)

## **Attachment J**

## **Notice of Request for a Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration (11-W-00001/9)**

The State of Hawaii, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 demonstration from the Centers for Medicare & Medicaid Services (CMS). This renewal, which will be effective January 1, 2014, will be entitled "QUEST Integration."

By November 20, 2012, a copy of the proposed renewal application will be available at the Department of Human Services, Med-QUEST Division, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707, or at <http://www.med-quest.us/> and [http://hawaii.gov/dhs/main/har/proposed\\_rules/](http://hawaii.gov/dhs/main/har/proposed_rules/). We are providing this notice pursuant to CMS requirements in 42 C.F.R. §431.408.

### **QUEST Integration Renewal Application**

The State's current demonstration, QUEST Expanded, is set to expire June 30, 2013, but the State expects it will be extended to December 31, 2013 pursuant to the extension request submitted in June 2012. QUEST Integration seeks to build on the successes of Hawaii's existing demonstration, while integrating the current programs to align with requirements in the Affordable Care Act (ACA) and deliver better health outcomes more efficiently.

#### ***Program Description, Goals, and Historical Context***

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. The provision of benefits through managed care has saved hundreds of millions of dollars in State and federal funds and has enabled the State to use some of the savings to provide coverage to individuals not otherwise eligible for Medicaid.

The Hawaii Medicaid program covers adults in certain categories and up to certain income levels, as well as all children up to 300% of the federal poverty level (FPL). In addition, through the demonstration, Hawaii has sought to provide coverage to Medicaid expansion populations through a variety of programs known as QUEST, QUEST-Net, and QUEST-ACE. The demonstration already covers non-pregnant, non-disabled adults up to and including 133% of the federal poverty level (FPL).

Further detail on the existing program is available at <http://www.med-quest.us/>. CMS also offers online resources regarding the QUEST Expanded Demonstration, which can be viewed at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=hawaii>

Under the "QUEST Integration" renewal, Hawaii seeks to continue to deliver services through managed care, while integrating the demonstration's programs and benefits to create a more

patient-centered healthcare delivery system and to align the demonstration with ACA's new requirements. The State will eliminate all eligibility enrollment caps, and streamline its programs by consolidating the current programs under QUEST Integration. All eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be based on clinical criteria and medical necessity. Other renewal initiatives include:

- Incorporating the new simplified Medicaid eligibility structure and other changes in ACA.
- Offering new services to beneficiaries, including a home- and community-based services (HCBS) benefit to individuals who are assessed to be at risk of deteriorating to the institutional level of care (the "at risk" population).
- Expanding coverage of behavioral health services.
- Preparing for integration of care for Medicaid and Medicare enrollees.
- Modifying the health plan enrollment process.
- Covering certain Medicaid expansion populations.
- Expanding the qualified provider network to increase access to substance abuse treatment services.
- Modifying retroactive coverage.
- Changing the payment process when hospice care is furnished to individuals residing in nursing facilities.
- Eliminating the QUEST-ACE enrollment benchmarks for purposes of claiming FFP in uncompensated care costs.

The goals of QUEST Integration will be to:

- Improve the health and healthcare 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 state 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.

More detailed information about renewal initiatives and changes in QUEST Integration can be found in the draft application, which is available at <http://www.med-quest.us/> and [http://hawaii.gov/dhs/main/har/proposed\\_rules/](http://hawaii.gov/dhs/main/har/proposed_rules/), as well as in hard copy at the Department of Human Services, Med-QUEST, Policy and Program Development Office located at 601 Kamokila Blvd, Room 518, Kapolei, HI.

***Beneficiaries Impacted, Eligibility Methodology, and Eligibility Requirements***

QUEST Integration will utilize a new eligibility methodology called “modified gross adjusted income” (MAGI) to the extent required by ACA, which will not have an asset test. Other than the use of MAGI methodology, there will be no changes in eligibility methodology. Eligibility for the aged, blind, and disabled (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 individual enrolled on January 1, 2014 will lose his or her eligibility prior to March 31, 2014 because of the implementation of MAGI).

Hawaii plans to cover the following groups in QUEST Integration:

<b>Mandatory State Plan Groups</b>		
<b>Eligibility Group Name</b>	<b>Social Security Act and Code of Federal Regulations Citations</b>	<b>Income Level and Other Qualifying Criteria</b>
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
Children through the CHIP Medicaid expansion	Title XXI, § 2105	Title XIX limits up to and including 300% FPL and for whom the State is claiming Title XXI funding
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
<b>Optional State Plan Groups</b>		
<b>Eligibility Group Name</b>	<b>Social Security Act and Code of Federal Regulations Citations</b>	<b>Income Level and Other Qualifying Criteria</b>
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



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 need 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
<b>Expansion Population</b>		
<b>Eligibility Group Name</b>	<b>Federal Poverty Level and/or Other Qualifying</b>	
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 adoption assistance payments

### ***Benefit Coverage***

Under QUEST Integration, Hawaii will combine the two benefit packages available under the current demonstration into one robust set of benefits available to all demonstration populations. Instead of offering different benefit packages to different eligibility groups, Hawaii will offer one package consisting of full primary and acute service State plan benefits and certain additional benefits based on clinical eligibility 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 HCBS and long-term services and supports (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 the 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.

Hawaii also plans to include in the QUEST Integration benefit package the following benefits, subject to clinical criteria and/or 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; and
- Specialized behavioral health services (Clubhouse, Supportive Employment, Peer Specialist, Supportive Housing and Representative Payee) for qualified individuals with a Serious and Persistent Mental Illness (SPMI), Severe Mental Illness (SMI), or Serious Emotional or Behavioral Disorder (SEBD) (either through the demonstration or the state plan).

### ***Delivery System***

Under QUEST Integration, the State will continue to provide most benefits through managed care, which will help ensure access to high-quality, cost-effective care. A discrete set of benefits will be provided fee-for-service.

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

<b>Benefit(s)</b>	<b>Delivery System</b>	<b>Authority</b>
State plan services	Managed Care - MCO	1115
QUEST Integration HCBS and long-term care benefits	Managed Care - MCO	1115
Cognitive rehabilitation therapy	Managed Care - MCO	1115 or State plan
Medical services to medically needy individuals who are aged, blind or disabled	Managed Care - MCO	1115
Medical services to medically needy individuals who are not aged, blind or disabled	Fee-for-service	1115
Long-term care services for individuals with developmental disabilities (DD) or intellectual disabilities (ID)	Fee-for-service	Section 1915(c) waiver
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 State of Hawaii Organ and Tissue Transplant (SHOTT) program	Fee-for-service	State plan
Dental services	Fee-for-service	State plan
Targeted Case 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

### ***Cost Sharing***

The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan. The State plans to seek authority to continue to charge an enrollment fee to health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate (for the Medically Needy Aged, Blind, and Disabled), in the amount equal to the estimated spend-down or cost share amount.

### ***Annual Enrollment and Annual Expenditures***

From July 1, 2011 to June 30, 2012, state and federal expenditures in the demonstration totaled approximately \$1.3 billion, and 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 changes effective since June 30, 2012 and other State-requested changes to the demonstration, to result in approximately \$700 million in increased State and federal annual expenditures during the renewal period.

### ***Hypotheses and Evaluation Parameters***

In QUEST Integration, 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.

The State will also measure the outcomes in QUEST Integration based on 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.

### ***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)(17)

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 have 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 (including services for the “at risk” population). No waiting list is permissible for other services for health plan enrollees.

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

***Expenditure Authority***

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 within 60 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 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 CFR § 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 adoption assistance.
4. Hospital 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 in the list below, will apply to the demonstration beginning January 1, 2014, through December 31, 2018, except those waived or listed below as not applicable.



### ***Medicaid 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.

### **Comments**

We invite comments on this proposal. Please submit any comments or questions to Noreen Moon-Ng by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at [nmoon-ng@medicaid.dhs.state.hi.us](mailto:nmoon-ng@medicaid.dhs.state.hi.us).

Comments will be accepted for consideration between November 20, 2012, and December 21, 2012 (30 days from the date of this notice).

### **Public Hearings**

The State will hold two public hearings to seek public input on this demonstration renewal 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. to 12:00 p.m.:

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

Interested parties may alternatively participate by teleconference in the December 7, 2012 public hearing. Should you be interested in participating in the teleconference, please call 808-692-8056 by close of business on December 5, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (*e.g.*, sign or foreign language or wheelchair accessibility), please contact:

Oahu	Jeri Kido (808) 692-8056
Hawaii	Ann Stephenson (808) 933-0046
Kauai	Iris Venzon (808) 241-3582
Maui	Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

## **Attachment K**