CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00001/9**

TITLE: **QUEST Expanded Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Hawaii's QUEST Expanded (QEx) section 1115(a) Medicaid demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Hawaii Department of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. These amended STCs are effective from the date of the approval letter, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas: Program Description and Objectives, General Program Requirements, Eligibility, Enrollment, Benefits, Managed Care Plan Selection Processes, Cost Sharing, Delivery Systems, Hospital Uncompensated Care, Hawaii Premium Plus, General Reporting Requirements, General Financial Reporting Requirements for Defined Authorized Expenditures, Monitoring Budget Neutrality for the Demonstration, Evaluation and Schedule of State Deliverables During the Demonstration Extension Period.

In the event of a conflict between any provision of these STCs and any provision of an attachment to these STCs, the STCs shall control.

II. PROGRAM DESCRIPTION, OBJECTIVES AND HISTORICAL CONTEXT

The State of Hawaii implemented QUEST on August 1, 1994. QUEST is a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Assistance Program and its innovative State Health Insurance Program and offered benefits to citizens up to 300 percent 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 of:

- 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.

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 (Attachment F).

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.

In June 2012, the State requested to extend the QUEST demonstration under 1115(e) of the Social Security Act, which states, "the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection." Because the extension only allows for limited changes, revisions were made to the waiver and expenditure authorities to update the authorization period of the demonstration, along with a technical correction clarifying that the freedom of choice waiver is necessary to permit the state to mandate managed care, and updates to the budget neutrality trend rates.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or

CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, waiting list, sources of non-Federal share of funding, budget and/or allotment neutrality, and other comparable program elements that are not specifically described in the these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

    a. An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent

actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request Demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

   a. Demonstration Summary and Objectives: The State must provide a narrative summary of the Demonstration project, reiterate the objectives set forth at the time the Demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

   b. Special Terms and Conditions (STCs): The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

   c. Waiver and Expenditure Authorities: The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

   d. Quality: The State must provide: External Quality Review Organization (EQRO) reports; summaries of managed care organization (MCO) reports; State quality assurance monitoring; home and community based services discovery, remediation, and system improvement activities, and any other documentation that validates of the quality of care provided or corrective action taken under the Demonstration.

e. Compliance with the Budget Neutrality Cap: The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the Demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the Demonstration, a CHIP Allotment Neutrality worksheet must be included.

f. Draft report with Evaluation Status and Findings: 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. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

a) Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

b) Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all

appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; home and community-based services; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 Demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State.

In States with Federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal or renewal of this Demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **Federal Financial Participation (FFP).** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

16. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the State for premiums paid by beneficiaries shall not be used as a source of State match for FFP.

17. **Home and Community-Based Services (HCBS) Requirement.** The State will adhere to a continuous quality improvement process as applied to the following HCBS assurances: Level of Care; Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability.

IV. DEMONSTRATION SCOPE

18. **Overview.** QEx is a continuation and expansion of the State's ongoing demonstration, which is funded through title XIX, title XXI and the State. The four programs included in QEx, described below, use capitated managed care as a delivery system unless otherwise noted below.

    a) The **QUEST** component provides Medicaid State Plan benefits to the following populations:

        i. Families and children covered under the Medicaid State Plan;
        ii. Children in a Medicaid expansion under the State plan who are in families with income in excess of the March 31, 1997 Medicaid limits funded by title XXI .

    b) The **QUEST-Net** component uses title XIX funding to provide coverage to the following populations:

        i. **QUEST-Net Adults** previously enrolled in QUEST, QExA, or Medicaid fee-for-service, with income or assets in excess of the Medicaid limits:
            a. Effective through June 30, 2012: With income up to 200 percent of the FPL. Adults with incomes 201-300 percent FPL who were enrolled on or before January 1, 2008, will continue to have program eligibility as

long as they continue to meet their eligibility criteria as of January 1, 2008 and pay a premium;

b. Effective July 1, 2012 through December 31, 2013: With income up to 133 percent of the FPL.

c) The **QUEST-ACE** component provides the same benefits as the QUEST-Net coverage for adults whose income or assets exceed the QUEST-Net eligibility levels:

i. Effective through June 30, 2012: With income up to and including 200 percent of the FPL;

ii. Effective July 1, 2012 through December 31, 2013: With income up to 133 percent of the FPL.

Medically needy individuals whose income exceeds the Medicaid State Plan limits may elect QUEST-ACE coverage in lieu of spending down to the medically needy income level.

d) The **QExA** component will provide acute and primary care using managed care as well as institutional and home and community-based long-term-care services through comprehensive and specialized managed care plans to individuals eligible as ABD under the Medicaid State Plan.

i. The State will include the services of four of Hawaii's former 1915(c) HCBS waivers into the QEx demonstration authorized managed care plans. The former waivers include the Nursing Homes Without Walls (NHWW), the Residential Alternatives Community Care Program (RACCP), the Medically Fragile Community Care Program (MFCCP), and the HIV Community Care Program (HCCP). The State has now ceased operating these HCBS waivers, and all beneficiaries are receiving services through the State's QExA program.

ii. Primary and acute care services as well as institutional and HCBS long term care must be provided through capitated-managed care or through managed-fee-for-service delivery systems in certain circumstances.

iii. Beneficiaries enrolled in the States' Mentally Retarded/Developmentally Disabled (MR/DD) Home and Community Services for People with Developmental Disabilities and/or Mental Retardation Section 1915(c) waiver will receive capitated primary and acute care services through QExA. All other services for this group will continue to be provided under Section 1915(c) authority.

iv. HCBS Transitional Programs. At the time of the 2007 renewal, four of Hawaii's existing Section 1915(c) waivers (Nursing Homes Without Walls, Residential Alternatives Community Care Program, the Medically Fragile Community Care Program and the HIV Community Care Program) will cease operation. Until these individuals are enrolled in a QExA managed care plan, beneficiaries currently enrolled in these waivers will continue to receive HCBS through transitional programs under which the State will obtain services on a fee-for-service basis. Upon QExA implementation, these transitional HCBS programs will end and beneficiaries must receive HCBS through QExA as described below. The reporting and close out requirements for the transitioning programs will be required once the QExA program is implemented. On February 1, 2009,

the transitional program was completed. All beneficiaries who were served through the transitional programs now receive services through the QExA program.

19. **Specific Eligibility Criteria for populations affected by the Demonstration and populations eligible only through the Demonstration.** Mandatory and optional Medicaid and/or CHIP State Plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived under authority granted by this Demonstration. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid and/or CHIP laws, regulations and policies except as expressly identified as not applicable under expenditure authority granted by this Demonstration.

    Below is a chart that provides an overview of the eligibility groups. Eligibility will be determined by the Hawaii Medicaid State Plan, the Hawaii CHIP State Plan, or the definition(s) of demonstration eligible expansion populations.

Medicaid Mandatory State Plan Group(s) (Categorical Eligibility)	Eligibility Component	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Infants under age 1	Quest	Up to and including 185 percent FPL	Title XIX	State Plan Children
Pregnant women	Quest	Up to and including 185 percent FPL	Title XIX	State Plan Adults
Children 1-5	Quest	Up to and including 133 percent FPL	Title XIX	State Plan Children
Children 6-18	Quest	Up to and including 100 percent FPL	Title XIX	State Plan Children
AFDC-related family members eligible under Section 1931	Quest	Up to and including 100 percent FPL	Title XIX	State Plan Adults and Children
Section 1925 Transitional Medicaid	Quest	Coverage is for two 6-month periods due to increased earnings, or for 4 months due to receipt of child support, either of which would otherwise make an individual ineligible for continued coverage under section 1931. • In the second 6-month period, family income may not exceed 185 percent FPL.	Title XIX	State Plan Adults and Children
Aged, Blind, or Disabled	QExA	SSI related using SSI payment standard	Title XIX	Aged with Medicare **Or** Aged without Medicare **Or** Blind/Disabled

				without Medicare **Or** Blind/Disabled with Medicare
CHIP State Plan Groups	**Eligibility Component**	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
Children through the CHIP Medicaid expansion	QUEST	title XIX limits up to and including 300 percent FPL and for whom the State is claiming title XXI funding	Title XXI	Opt St Pl Children[1]
Optional Medicaid or CHIP State Plan Groups (Categorical Eligibility)	**Eligibility Component**	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	Quest	Up to and including 100 percent FPL	Title XIX	Foster Care (19-20)
Medically Needy AFDC-related Families and Children	Quest	Up to and including 300 percent FPL, if individuals otherwise eligible under State Plan groups described above spend down to Medicaid income limits.	Title XIX	Adults = Opt St Pl Adults Children = Opt St Pl Children
Breast and Cervical Cancer Treatment Program	QExA	Income at or below 250% of the FPL	Title XIX	BCCTP
Aged or Disabled Adults	QExA	SSI-related net income up to and including 100 percent FPL for family size	Title XIX	Aged with Medicare **Or** Aged without Medicare **Or** Blind/Disabled without Medicare **Or** Blind/Disabled with Medicare
Optional Medicaid or CHIP State Plan Groups (Categorical Eligibility)	**Eligibility Component**	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
Aged, Blind, and Disabled Medically Needy Adults and Children	QExA	Medically needy income standard for household size using SSI income methodology	Title XIX	Aged with Medicare **Or** Aged without Medicare **Or**

[1] Reported under Title XXI Allotment Neutrality if allotment is available.

				Blind/Disabled without Medicare **Or** Blind/Disabled with Medicare
Demonstration Eligibles	**Eligibility Component**	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
AFDC related family members who are TANF cash recipients who are otherwise ineligible for Medicaid	Quest	Up to and including 100 percent FPL (using TANF methodology)	Title XIX	Demo Elig Adults
Childless adults who are General Assistance (GA) cash recipients but are otherwise ineligible for Medicaid.	Quest-Net (recipients) or QUEST-ACE (applicants)	Up to and including 133 percent FPL (using GA methodology)	Title XIX	Demo Elig Adults
Adults in QUEST-Net-*	QUEST-Net	Up to and including 133 percent FPL. Must have been previously enrolled in QUEST, QUEST Expanded Access, or FFS, but have lost eligibility because income and/or assets now exceed Medicaid limits. Must meet QUEST-Net-Adult asset limit. As of February 1, 2008, the FPL for this group is changed from 300 percent to 200 percent. Individuals enrolled at that time were considered "grandfathered". Effective July 1, 2012, the FPL for this group is changed from 200 percent to 133 percent; all previously "grandfathered" individuals are no longer eligible as of this date.	Title XIX	Demo Elig Adults
Adults in Quest ACE *	QUEST ACE	Applicants up to and including 133 percent FPL and meet the QUEST-Net asset limits. Effective July 1, 2012, the FPL for this group is changed from 200 percent to 133 percent.	Title XIX	Demo Elig Adults
Individuals in the 42 CFR section 435.217 group who are receiving	QExA	Net income no more than 100 percent FPL using the institutional income rules	Title XIX	Aged with Medicare **Or** Aged without

home and community-based services (HCBS)				Medicare **Or** Blind/Disabled without Medicare **Or** Blind/Disabled with Medicare
Medically needy individuals receiving home-and community-based services	QExA	Medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income.	Title XIX	Aged with Medicare **Or** Aged without Medicare **Or** Blind/Disabled without Medicare **Or** Blind/Disabled with Medicare

*This demonstration eligible group excludes employed persons with access to employer-sponsored insurance unless they are receiving financial assistance or are self-employed.

Beneficiaries enrolled in Program for All-Inclusive Care for the Elderly (PACE) are excluded from this Demonstration. Beneficiaries enrolled in the State's Money Follows the Person (MFP) program are included in the Demonstration, and receive their services through the QExA program to better allow coordinated patient-centered care.

20. **Post-Eligibility Treatment of Income and Resources.** All individuals receiving nursing facility long-term care services must be subject to the post-eligibility treatment of income rules set forth in section 1924 and 42 CFR section 435.733. The application of patient income to the cost of care shall be made to the facility. Individuals receiving HCBS must be subject to the post-eligibility treatment of income rules set forth in section 1924 and 42 CFR section 435.735 if they are medically needy, with or without spend-down, or individuals who would be eligible for Medicaid if institutionalized as set forth in 42 CFR section 435.217.

21. **Financial Responsibility/Deeming.** The State must determine eligibility using the income of household members whose income may be taken into account under the related cash assistance program rules. If the household income so calculated exceeds QUEST limits, the State must determine eligibility using Medicaid financial responsibility and deeming rules, including institutional deeming for QExA participants.

22. **Retroactive Eligibility.** The State will limit retroactive eligibility for all individuals eligible under the State Plan or demonstration to a 5-day period prior to the date of application with the exception of individuals requesting long-term care services in which case up to three months of retroactive eligibility will be allowed.

23. **Quality Review of Eligibility.** The State must revise and submit to CMS for approval a Medicaid Eligibility Quality Control (MEQC) plan for reviewing eligibility determinations for Demonstration participants that is appropriate in scope to reflect the approved program design of the demonstration. On March 4, 2010 CMS approved the State's MEQC plan to reflect programmatic changes as a result of the QExA program implementation. The State shall remain relieved of any liability from disallowance for errors that exceed the 3 percent

tolerance. CMS permits the State to continue with its effort to implement administrative renewal and MEQC reviews shall take that policy into account.

V. ENROLLMENT

24. **Enrollment Limit and Priority Enrollment for QUEST.** Adult applicants with incomes below 100 percent of the FPL, who do not meet the qualifications for any other eligibility category, are subject to an enrollment limit for enrollment into the QUEST coverage group. The enrollment limit is set at 125,000 individuals for all QUEST programs.

    a) An adult applicant is not subject to the enrollment limit if:

        i. The individual's countable family income is less than or equal to the State Financial Assistance Payment Standard;
        ii. The individual meets the criteria for the General Assistance (GA) program. The GA program covers single adults, childless couples, and adults in 2-parent families, ages 18-64 years, who must be either temporarily disabled or meet work-search requirements;
        iii. The AFDC related family member(s) is covered by section 1931;
        iv. The individual has been covered by employer-sponsored insurance and has applied for QUEST benefits within 45 days of losing such coverage; and
        v. The individual has been covered under COBRA and has applied for QUEST benefits within 45 days of losing COBRA coverage.

    b) QUEST-Net enrollment shall include adults previously enrolled in QUEST, QUEST Expanded Access, or FFS who do not meet the requirements of STC 25 a) or whose income or assets exceed Medicaid limits, but are within QUEST-Net's limits.

    c) QUEST ACE enrollment shall include new adult applicants subject to the QUEST-ACE enrollment limit of 12,000 individuals. If the limit has not been reached, eligible adults will be enrolled. If the limit has been reached, the applicant may be denied enrollment.

    d) Provided receipt of identical benefits, recipients may remain in their current program until administratively switched into their new program.

25. **Spend-Down for Medically Needy Individuals**.

    a) **Members of AFDC-related Medically Needy State Plan groups** are eligible upon determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to subparagraph (d). Individuals in this group whose gross income exceeds 300 percent FPL are not eligible under QEx.

    b) **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is not expected to exceed the health plans' monthly capitation payment** will be enrolled in a QExA health plan upon the determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to subparagraph (d).

c) **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is expected to exceed the health plans' monthly capitation payment** will be eligible under the Demonstration subject to subparagraph (d) and an enrollment fee equal to the medically needy spend-down amount or, where applicable, the amount of patient income applied to the cost of long-term care. This group will receive all services through QExA health plans.

d) **Medically needy individuals who are expected to incur expenses sufficient to satisfy their spend-down obligation for less than a 3-month period** will not be enrolled in a QExA health plan and will be subject to an enrollment fee equal to the medically needy spend-down. They will receive services on a fee-for-service basis. (This category might include, for example, persons who become medically needy for a short-term period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically, and thus will not meet their spend-down obligations every month.)

VI. BENEFITS

26. **QUEST Expanded Benefits. QEx** provides benefits in three benefit package configurations. Benefits provided under authority of this Demonstration for QEx participants are as follows:

a) **Full Medicaid State Plan.** Benefits are delivered through mandatory managed care and include all services as defined in the Medicaid State Plan. Populations eligible for the Full Medicaid State Plan benefits include:

i. QUEST Families, Children, and Pregnant Women
ii. QUEST-Net Adults
iii. QUEST-ACE Adults
iv. QExA Adults and Children

b) **QExA Benefit Package.** This benefit package varies significantly from others in the Demonstration as follows:

i. **Full Medicaid State Plan Primary and Acute Care.** All individuals eligible for Medicaid or QExA who are aged, blind, or disabled will receive their primary and acute care benefits through managed care plans contracted specifically for these populations. In addition to the Medicaid State Plan services, these individuals will receive the following services when medically necessary:

- Inpatient services (without limitation);
- Optometry services;
- Hospice services (without limitation for children); and
- Rehabilitation services (including physical and occupational therapy, speech-language pathology, and audiology).

ii. **Medicaid State Plan Long-Term Care and HCBS.** QExA health plans will also have the flexibility to provide customized benefit packages for enrollees. The customized benefit packages must cover all benefits in the Medicaid State Plan, except for intermediate care facility for mentally retarded (ICF/MR). In addition, they will cover HCBS, including those services offered in the State's 1915(c) waivers as referenced in the overview of this section of the STCs. The service definitions and provider types which are identical to those found in the transitioning 1915(c) waiver programs are found in Attachment C of these STCs. The amount, duration, and scope of all covered services may vary to reflect the needs of the individual in accordance with the prescribed Care Coordination Plan. The long-term care benefits that will be provided through QExA health plans include:

- Specialized case management;
- Home maintenance;
- Personal assistance;
- Adult day health;
- Respite care;
- Adult day care;
- Attendant care;
- Assisted living facility;
- Community care foster family homes;
- Counseling and training;
- Environmental accessibility adaptations;
- Home delivered meals;
- Medically fragile day care;
- Moving assistance;
- Non-medical transportation;
- Nursing facility;
- Personal emergency response system,
- Private duty nursing;
- Residential care; and
- Specialized medical equipment and supplies (including gloves, diapers, and specialized wheelchairs, etc.).

c) **Cost of Room and Board Excluded from Capitation Rate Calculations.** For purposes of determining capitation rates, the cost of room and board is not included in non-institutional care costs.

d) **Benefits Provided to the MR/DD Population.** Medicaid eligibles with developmental disabilities will receive the full Medicaid State Plan primary and acute health care benefit package through QExA managed care plans. Case management, section 1915(c) HCBS and ICF/MR benefits for this group will remain carved out of the capitated benefit package. All QExA health plans will be required to coordinate the primary and acute health care benefits received by the DD/MR population with the HCBS that are provided

on a fee-for-service basis from the Department of Health's (DOH) Developmental Disabilities Division.

e) **Benefits for Neurotrauma Survivors.** HCBS for individuals who have been diagnosed with traumatic brain injury will be provided through QExA health plans. The services will encompass residential care, if necessary; intensive rehabilitative services, including cognitive and speech therapy, to be provided during such time as cognitive function can reasonably be expected to be restored; and less intensive, long-term-care services to assist in the maintenance of cognitive function.

f) **Behavioral Health Benefits.** All QEx and QExA plans will provide a full array of basic behavioral health benefits to members who may need such services. In addition, some members may opt to receive additional, specialized behavioral health services that are not available through the capitated managed care program as described below. Expenditures for beneficiaries who exercise this option will be paid fee for service by the State. By November 1, 2008 the State is required to provide and maintain a Behavioral Health Benefits protocol (future attachment E) that provides the following:

(i) Services provided by the DOH Child and Adolescent Mental Health Division (CAMHD) to children with serious emotional behavioral disorders (SEBD).
(ii) Services provided by the DOH Adult Mental Health Division (AMHD) to adults with serious mental illness (SMI).
(iii) Behavioral health and substance abuse services provided fee-for-service to individuals who are SEBD or SMI but who are not receiving services through AMHD or CAMHD.
(iv) A memorandum of agreement (MOA) that reflects the current interagency agreement for behavioral health services provided by the DOH to demonstration eligibles.
(v) The process and protocol used for referral between MCOs and the DOH, as well as the DOH and MCOs.

Any revisions to the QEx or QExA delivery system for Behavioral Health Services as defined in this sub-paragraph shall require a revision to Attachment E.

g) **Functional Level of Care (LOC) Assessment.** Access to both institutional and HCBS long-term care services will be based on a functional LOC assessment to be performed by the QExA managed care plans or those with delegated authority. Individuals who meet the institutional level of care (NF, hospital) may access institutional care and/or HCBS through QExA managed care plans. QExA plans will be responsible for performing a functional assessment for each enrollee. The State's delegated contractor will review the assessments and make a determination as to whether the beneficiary meets an institutional (hospital or nursing facility) level of care. LOC Assessments will be performed at least every twelve months or more frequently, when there has been a significant change in the member's condition or circumstances.

h) **Access to Long-Term Care Services.** The ultimate objective of the QEx Demonstration is that QExA beneficiaries meeting an institutional level of care shall have a choice of institutional services or HCBS. The HCBS provided must be sufficient to meet the needs identified in the functional assessment, taking into account family and other supports available to the beneficiary. In order to move toward the objective of providing beneficiaries with a choice of services, the State must require the following from QExA health plans:

i. If the individual has previously received services under a Section 1915(c) waiver and continues to meet an institutional level of care, the individual must continue to receive HCBS appropriate to his or her needs. Based upon the functional assessment at the time of QExA program implementation, the services need not be identical to the ones previously received under the Section 1915(c) waiver, but any change must be based upon the functional assessment.

ii. For all other beneficiaries, if the estimated costs of providing necessary HCBS to the beneficiary are less than the estimated costs of providing necessary care in an institution (hospital or nursing facility), the plan must provide the HCBS to an individual who so chooses, subject to the limitations described in paragraph (c). Health plans will be required to document good-faith efforts to establish a cost-effective, person-centered plan of care in the community using industry best practices and guidelines. If the estimated costs of providing necessary HCBS to the beneficiary exceed the estimated costs of providing necessary care in an institution (hospital or nursing facility), a plan may refuse to offer HCBS if the State or its independent oversight contractor so approves. In reviewing such a request, the State must take into account the plan's aggregate HCBS costs as compared to the aggregate costs that it would have paid for institutional care.

iii. A plan is not required to provide HCBS if the individual chooses institutional services, if he or she cannot be safely served in the community, if there are not adequate or appropriate providers for the services, or if there is an exceptional increase in the demand for HCBS. An exceptional increase in demand is defined as an increase beyond annual thresholds to be established by the State. In the case of an exceptional increase, the State shall be responsible for monitoring any wait for services as set forth below and reporting its findings to CMS.

iv. Plans may offer HCBS personal care services to individuals who do not meet an institutional level of care in order to prevent a decline in health status and maintain individuals safely in their homes and communities. The plans may have a waiting list for the provision of such services. Waiting list policies should be based on objective criteria and applied consistently in all geographic areas served.

v. The State will be responsible for monthly monitoring of the HCBS wait list by requiring health plans to submit the following information relevant to the waiting list:

    1. The names of the members on the waiting list;
    2. The date the member's name was placed on the waiting list;

3. The specific service(s) needed by the member; and
4. Progress notes on the status of providing needed care to the member.

The State shall meet with the health plans on a quarterly basis to discuss any issues associated with management of the waiting list. The purpose of these meetings will be to discuss the health plan's progress towards meeting annual thresholds and any challenges with meeting the needs of specific members on the waiting list. In addition, members who are on the waiting list may opt to change to another health plan if it appears that HCBS are available in the other plan.

VII. MANAGED CARE PLAN SELECTION PROCESSES

27. **QUEST, QUEST-Net, and QUEST-ACE** eligible individuals will be enrolled in a managed care plan upon initial eligibility. Eligible individuals will choose from among participating health plans offered to provide the full range of primary and acute services. Eligible individuals must be provided with brochures on the available health plans by the State. The State must ask each applicant to select a health plan upon determination of eligibility. If an eligible individual does not make a selection within 10 days, they are automatically assigned to a plan that operates on the island of residence. If more than one plan is available and meets the needs of the applicant, the assignment process provides preferential treatment to the plan with the lowest capitation rate. A QUEST-Net-Adult applicant who is required to pay a premium and who does not choose a plan is not eligible to participate. The State may place an enrollment limit on health plans in order to assure adequate capacity and sufficient enrollment in all participating health plans.

28. **QExA** eligible individuals will choose from among participating health plans offered to provide the full range of primary, acute and long-term care services to the ABD populations. The State may place an enrollment limit on health plans in order to assure adequate capacity and sufficient enrollment in all participating health plans.

    a) **Enrollment Counselor Assistance.** To better serve the QExA population, which may require additional assistance in navigating the enrollment process, the State will contract with an Enrollment Counselor for Demonstration Years (DYs) 15 and 16, when the largest number of new enrollees will enroll in the health plans. After the first 2 years, should the State choose to exercise the option to discontinue these special Enrollment Counselor tasks, the State must provide a report and transition plan to CMS for approval. The discontinuation plan must be approved by CMS no later than six (6) months prior to cancellation of the service to all beneficiaries. On May 22, 2012, CMS approved the termination of the Enrollment Counselor with an effective date of July 1, 2012.

        i. **Enrollment Counselor Tasks.** Assisting people determined eligible for QExA with selection of a health plan that best meets their needs; educating new members about how to use their chosen managed care delivery system; and educating new members about their rights and responsibilities including but not limited to access to care and appeal rights in adverse decisions.

ii. **Enrollment Counselor's Role in Enrollment Process.** The State will mail individuals determined eligible for QExA a packet of information explaining the program, the available health plan(s), and enrollment. Each week, the Enrollment Counselor will be provided with a list of individuals the State has determined to be eligible for a QExA plan. Enrollment Counselors will perform outreach to those individuals and assist them with any questions about health plan selection, primary care provider (PCP) selection, and enrollment.

b) **Enrollment During the Transition Period Prior to the QExA Program Start Date.** The State anticipates that the majority of QExA eligibles enrolling during the initial QExA implementation period will select a health plan within 60 days with the help of their Enrollment Counselors. In the event that a recipient does not make a health plan selection by the end of the 60-day period, the State will auto-assign the person to a health plan, taking into account the recipient's residence in a long-term-care facility, including community care foster family homes or residential care facilities, and historical claims based on an established provider relationship with providers in a given health plan's network.

c) **Enrollment after the QExA Program Begins.** After the initial QExA implementation period, the State will maintain a 15-day ongoing enrollment period.

29. **Enrollment and Disenrollment Processes.**

a) **QUEST, QUEST-Net, and QUEST-ACE Programs.** The State must maintain a managed care enrollment and disenrollment process that complies with 42 CFR Part 438, except that disenrollment without cause from a MCO will be more limited in cases where the enrollee was not auto-assigned to the MCO. If the enrollee was not auto-assigned to the MCO, the State must maintain a process by which the enrollee may change MCOs only if both MCOs agree to the change. The State must track and report to CMS these requests on an annual basis; along with MCO choice rates and MCO change rates that occur during the annual open enrollment period.

b) **QExA Program**. The State will enroll each eligible individual in a managed care plan for a full range of acute and long-term care services. The initial enrollment offering period is anticipated to be from October 1, 2008, to December 1, 2008. The QExA program is scheduled to begin on February 1, 2009.

c) **Disenrollment With and Without Cause**. The provisions of 42 CFR section 438.56(c), relating to disenrollment with and without cause, must apply to individuals enrolled in QExA health plans. Individuals who have been enrolled in a plan within the last 60 days will be reassigned to the prior plan unless the beneficiary exercises his/her option to disenroll for cause.

30. **Service Coordination Model.** After a recipient selects a health plan, the health plan will assign a licensed or qualified professional as the beneficiaries' service coordinator. The following are required to ensure QExA program integrity.

a) **Service Coordinator Responsibilities.**

i. Assuring that the health plan promptly conducts a face-to-face health and functionality assessment (HFA) for each QExA member. During the initial period of QExA enrollment, all QExA enrollees who are under age 21 years, or who are receiving HCBS, will receive an HFA within 90 days of the date QExA plans begin providing services. All other individuals will receive an HFA within 270 days of the date QExA plans begin providing services. Any QExA enrollee who has an emergency room visit, hospital visit, or any change in condition, will receive an HFA within 15 days of this event. Members who enroll more than 9 months after QExA plans begin providing services will receive a face-to-face HFA within 15 days of their enrollment.;

ii. Referring any member appearing to need a nursing facility level of care to the State's Contractor for a functional eligibility review;

iii. Providing options counseling regarding institutional placement and HCBS alternatives;

iv. Coordinating services with other providers such as physician specialists, Medicare fee-for-service and/or Medicare Advantage health plans and their providers, mental health providers at DOH, and MR/DD case managers;

v. Facilitating and arranging access to services;

vi. Seeking to resolve any concerns about care delivery or providers;

vii. Leading a team of decision-makers to develop a care plan for those members meeting functional eligibility. The care planning team may include the PCP (who may be a specialist); the beneficiary, family members, and significant others (when appropriate); legal guardians, a QExA Ombudsman if so requested by the beneficiary; and other medical care providers relevant to the beneficiary needs; and

viii. For those members meeting functional eligibility, leading the care planning team in the development of a case-specific, person-centered, cost-effective plan of care in the community, using industry best practices and guidelines established in subparagraph (b) below.

b) **Written Comprehensive Care Plans.** For each enrollee in a QExA plan who meets the functional Level of Care (LOC) assessment for long-term care, the MCOs will develop and implement a person-centered written care plan that analyzes and describes the medical, social, HCBS, and/or long-term care institutional services that the member will receive. In developing the care plan, the MCO will consider appropriate options for the beneficiary related to his/her medical, behavioral health, psychosocial, case-specific needs at a specific point in time, as well as for longer term strategic planning and will be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. Service plans will be updated annually or more frequently in conjunction with the health and functional assessment.

c) **Ombudsman Program.** An Ombudsman Program will be available to all members of QExA. The purpose of the program is to ensure access to care, to promote quality of

care, and to strive to achieve recipient satisfaction with QExA. The Department of Human Services (DHS) will seek a qualified independent organization to assist and represent members in the resolution of problems and conflicts between the health plan and its members regarding QExA services to act as the Ombudsman prior to the initial date for delivery of services. Issues regarding a member's health plan enrollment prior to the initiation of services will be handled by the enrollment counselor described in STC 28.

i. **Delivery of Ombudsman Services.** The Ombudsman will assist in the resolution of issues/concerns about access to, quality of, or limitations to, services for members of the QExA plans. The contracting organization must not be affiliated with any of the QExA health plans contracted by DHS.

ii. **Services Offered by Ombudsman Program.** Ombudsman services will be available to QExA members. The State intends to provide these services for a 1-year period; however, the State must demonstrate via reported data to CMS that such services are no longer needed in the community prior to terminating the program. Approval of program termination must be granted by CMS 90 days in advance.

iii. **Scope of the Ombudsman Program.** The Ombudsman Program will not replace the grievance and appeals process that all health plans that contract with the State must have in place, nor replace the right of a recipient to an Administrative Hearing. The Ombudsman may assist and represent members up to the point of an Administrative Hearing under State law. They may also assist a member during the hearing process but must not represent the member in an Administrative Hearing. The QExA member may file a grievance or appeal with the QExA health plan. An Administrative Hearing may be filed once the health plan's appeal process has been exhausted.

VIII. COST SHARING

31. **Cost Sharing**

a. **Premiums** – within the demonstration are charged to individuals as follows:

Population	Premiums/Cost Sharing
QUEST-Net Adults with family income greater than 200 percent of the FPL enrolled on or before January 1, 2008 with continuous program eligibility until December 31, 2013	$60 per person per month
Medically Needy with Spend-down	An enrollment fee equal to the spend-down obligation or, where applicable, the amount of patient income applied to the cost of long-term care.

b. **Copayments** – within the demonstration may be imposed as set forth in the Medicaid State Plan.

IX. DELIVERY SYSTEMS

32. **Contracts.** All contracts and contract modifications of existing contracts between the State and MCOs must be prior approved by CMS. The State will provide CMS with a minimum of 45 days to review changes for consideration of approval.

33. **Transition to Home and Community-Based Services.** A key objective of the QExA program is to develop capacity within the community so that all recipients can be served in the most appropriate, least restrictive cost-effective setting. Contracts may contain financial incentives, as allowed by title XIX and CMS regulations, which expand capacity for HCBS beyond the annual thresholds established by the State. Contracts may also contain sanctions penalizing plans that fail to expand community capacity at an appropriate pace. Should health plans be awarded financial incentives for health plans that expand community capacity such plan will be required, as determined appropriate by Federal and State law, to share a portion of any bonuses with providers in order to ensure that provider capacity is maintained and improved. However, the plans may not pass sanctions along to the providers.

34. **Statewideness.** If there are Islands on which only one health plan is available, the health plan will be required to assure that members have a choice of PCPs.

35. **Dual-eligible Beneficiaries.** These individuals may select a PCP and will be assigned a service coordinator to assure coordination of Medicare and Medicaid services.

36. **Special Requirements for QExA Plans.** For QExA plans, bidders were requested to provide information on the minimum number of beneficiaries that they believe to be cost effective to cover in order to assure that the selected plan(s) will be able to operate given the existing population size. Additionally, QExA health plans will be expected to contract with primary and specialist physicians who have established relationships with beneficiaries, including specialists who may also serve as PCPs.

X. UNCOMPENSATED CARE

37. **Overview.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a FY 2007 disproportionate share hospital (DSH) allotment for Hawaii. The DSH program established in Hawaii pursuant to TRHCA 2006 must be a State Plan program that is not part of QUEST Budget Neutrality. Federal financial participation for hospital uncompensated care (UCC) payments described in this section are separate from the State Plan DSH program, will be provided as set forth below and must be reported under budget neutrality as a demonstration expenditure. The State must make DSH and UCC payments directly to the providers of the services as specified at section 1923(i) of the Act.

    If Congress establishes a DSH allotment for Hawaii for any subsequent Federal fiscal year, DSH payments made by the State must be made on the basis of a State Plan amendment approved by CMS. Any future statutory DSH allotments will require reconsideration of the budget neutrality agreement. When determining hospital specific DSH limits and DSH payments, the State must take into account all Medicaid State Plan payments including Demonstration projects including UCC amounts paid to hospitals under this section, as well as any payments by or on behalf of individuals with no source of third-party coverage.

38. **Available FFP for UCC.** Annually, FFP is authorized to pay for hospital UCC during this extension period. The State must be limited to no more than the total of actual UCC incurred in any given year, up to the amount defined in the QUEST ACE enrollment benchmark. Expenditures may be made for hospital UCC costs in private hospitals, as well as governmentally owned and operated hospitals, provided paragraphs 39 and 40 are met.

39. **QUEST ACE Enrollment Benchmarks**. In order for the State to access an increase in UCC funding, the following benchmarks must be obtained. The benchmarks reflect increases over the baseline QUEST-ACE enrollment recorded as 1700, as of December 31, 2007. Should the State fail to meet the benchmark as designated, the State must submit a corrective action plan to CMS detailing the actions it will undertake to increase enrollment.

    a) DY 14 (SFY 2008) December 31, 2007 through June 30, 2008- benchmark of increase by 300 beneficiaries, for a total enrollment of at least 2000 beneficiaries.

    b) DY 15 (SFY 2009) – enrollment of at least 2750 beneficiaries.

    c) DY 16 (SFY 2010) - enrollment of at least 3500 beneficiaries.

    d) DY 17 (SFY 2011) - enrollment of at least 4250 beneficiaries.

    e) DY 18 (SFY 2012) - enrollment of at least 5000 beneficiaries.

40. **Availability of UCC Funds.** To the extent that in any Demonstration Year the State has a DSH allotment under 42 U.S.C. section 1396r-4, any expenditures of that allotment must be made pursuant to an approved State Plan amendment and the UCC payments authorized under this Demonstration must be in addition to any such expenditures. Combined payments may not exceed a hospital's uncompensated care costs.

41. **Coverage of Uncompensated Care Costs.** The State will be permitted to make payments to governmentally-operated (as detailed in Attachment D), governmentally-operated nursing facilities (as detailed in Attachment D, Supplement 1) and private hospitals to cover UCCs for furnished hospital and long-term care services as follows. UCC payments will be made directly to the providers who incur uncompensated care costs:

    a) **Governmentally-operated Hospitals.** The costs are limited to the following:

        i. The costs of providing hospital services to the uninsured, reduced by any applicable uninsured hospital inpatient and outpatient revenues, and any payments made by or on behalf of the uninsured for the provision of said services to this population (Uninsured shortfall);
        ii. The costs of providing inpatient and outpatient hospital services to QEx and QExA enrollees, reduced by any applicable Medicaid managed care revenues for the provision of said services to this population (QEx and QExA shortfall); and

iii. The costs of providing outpatient hospital services to Medicaid fee-for-services (FFS) beneficiaries, reduced by any applicable Medicaid outpatient revenues for the provision of said services to this population (FFS Outpatient shortfall).

b) **For Governmentally-operated Hospitals.** UCCs ***must not include***:

i. Inpatient Medicaid FFS shortfall, as governmental hospitals already receive inpatient payments only up to cost;
ii. The costs of providing non emergency care to unqualified aliens, qualified aliens subject to a 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S; and
iii. The costs of providing drugs to individuals eligible for Medicare Part D.

c) **For Governmentally-Operated Hospitals.** DSH and UCC payments to governmentally operated hospitals will be funded with certified public expenditures (CPE). The State must submit a cost-certification CPE protocol for CMS approval which articulates the procedures and methods the State will use to determine those Hospital Uncompensated Care costs eligible for Federal matching under DSH through the Medicaid State Plan. The UCC payments described in this section must follow the cost determination in the protocol.

The CPE method in the protocol must prescribe CPE procedures and methods that follow CMS CPE standards, and are consistent with the CPE procedures and methods approvable by CMS for CPE-funded Medicaid State Plan payments (including hospital Medicaid State Plan supplemental payments and DSH payments). In addition, the CPE method must be updated or changed to come into compliance with any future legislation or CMS regulation or policy change.

The CPE method will be in effect for all Demonstration CPE-funded claims (including interim payments, reconciliations to as-filed cost reports, and reconciliations to finalized cost reports) made on or after the approval date of these Special Terms and Conditions. The CPE protocol must be submitted to CMS no later than October 1, 2008 for review and consideration for approval.

d. Governmentally-Operated Hospital-Based and Governmentally-Operated Freestanding Nursing Facilities. The UCCs are limited to:

i. The costs of providing routine long term care services to QEx and QExA enrollees, reduced by any applicable Medicaid managed care revenues for the provision of said services to this population (QEx and QExA shortfall).

UCCs *must not include*:

ii. Medicaid FFS shortfall, as governmentally-operated nursing facilities hospitals already receive payments only up to cost under the State plan;

iii. The costs of providing routine long term care services to the uninsured;
iv. The costs of providing non emergency care to unqualified aliens, qualified aliens subject to a 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S; and
v. The costs of providing drugs to individuals eligible for Medicare Part D.

UCC payments to governmentally operated nursing facilities will be funded with certified public expenditures (CPE). The State must follow the CPE protocol in Attachment D, Supplement 1. The UCC payments described in this section must follow the cost determination in the protocol.

The CPE method in the protocol prescribes CPE procedures and methods that follow CMS CPE standards, and are consistent with the CPE procedures and methods approvable by CMS for CPE-funded Medicaid State Plan payments (including nursing facility Medicaid State Plan supplemental payments). In addition, the CPE method must be updated or changed to come into compliance with any future legislation or CMS regulation or policy change.

The CPE method will be in effect for all Demonstration CPE-funded claims (including interim payments, reconciliations to as-filed cost reports, and reconciliations to finalized cost reports) made on or after the approval date of these Special Terms and Conditions.

e) **Privately-operated Hospitals.** For private hospitals, direct payments may cover UCCs up to the amount of funds made available by the State for this purpose. UCCs for private hospitals will include the following:

i. The Uninsured shortfall as described above;
ii. QEx shortfall as described above;
iii. FFS outpatient shortfall as described above; and
iv. The costs of providing inpatient services to Medicaid FFS enrollees reduced by the amount of payments received from Med-QUEST for the provision of said services to this population (FFS inpatient shortfall).

f) **For Privately-operated Hospitals.** UCCs ***must not include***:

i. The costs of providing non-emergency care to unqualified aliens, qualified aliens subject to the 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S; and
ii. The costs of providing drugs to individuals eligible for Medicare Part D.

g) **Eligible Providers.** The State may pay governmentally-operated hospitals, governmentally-operated freestanding and hospital-based nursing facilities, and private hospitals listed in Attachment A UCC payments. Any changes to Attachment A must be approved by CMS. The State must report to CMS any changes to the ownership and/or operational status of any hospital listed in Attachment A.

h) **Reporting UCC Payments to Hospitals and Nursing Facilities.** The State will report all expenditures for UCC payments to hospitals and nursing facilities under this Demonstration on the Forms CMS-64.9 Waiver and/or 64.9P Waiver under the appropriate waiver name. In addition, the State must provide CMS with an annual report that identifies all hospital UCC and DSH payments and nursing facility UCC payments paid in that demonstration period, by provider.

42. **Aggregate Annual Limit of UCC and DSH Payments -** In any given year, the aggregate of federal share of the waiver UCC payments made under this section, combined with the federal share of aggregate DSH payments made pursuant to Hawaii's DSH allotment and under its State plan DSH methodology, should not exceed the amount equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project (paragraph 76(e)). Furthermore, in any given DSH State plan year, each hospital's DSH payments cannot exceed its hospital-specific uncompensated care cost limit pursuant to Section 1923(g) of the Social Security Act. Each hospital's uncompensated care cost is net of the waiver UCC payments received under this section. Any excess waiver UCC payments made to an individual private hospital above its uncompensated care costs will be recouped and redistributed to other private hospitals, using the same methodology as the original private hospital UCC payments, which are distributed proportionately based on the hospitals' uncompensated care costs. The redistribution will only be made to the extent that such redistribution does not result in any hospital receiving UCC payments in excess of its uncompensated care costs.

XI. GENERAL REPORTING REQUIREMENTS

43. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX and title XXI set forth in section XIV entitled, Monitoring Budget Neutrality in the Demonstration.

44. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in these STCs.

45. **Corrected Budget Neutrality Information.** The State must submit corrected budget neutrality data upon request.

46. **Compliance With Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR section 438 *et. seq.,* except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

47. **Monthly Calls.** CMS must schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant, actual or anticipated, developments affecting the Demonstration. Areas to be addressed include, but are not limited to MCO operations (such as contract amendments and rate certifications), quarterly reports, health care delivery,

enrollment, including the State's progress on enrolling individuals into the QUEST-ACE and QExA groups, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS must update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) must jointly develop the agenda for the calls.

48. **Monthly Enrollment Data.** The State must provide monthly enrollment data for each eligibility group as specified in Attachment B.

49. **Quarterly Reports.** The State must submit quarterly progress reports in the format specified by CMS in Attachment B, no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas.

50. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State must submit the draft annual report no later than March 31 each year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted. The annual report must include programmatic information, as well as expenditures for UCCs and expenditures made for all programs included in the Demonstration, including CHIP expenditures.

    In addition, as required by 42 CFR 457.750(a), the State must report by January 1 following the end of each Federal fiscal year, the results of the State's assessment of the operation of the title XXI State Plan. This data shall be submitted to CMS through the CHIP Annual Report Template System (SARTS).

51. **Title XIX and title XXI Enrollment Reporting.** Each month the State must provide CMS with enrollment figures by Demonstration population using the quarterly report format as defined in Attachment B. In addition, each quarter the State must provide CMS with an enrollment report by demonstration population showing the end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System (SEDS) by the State within 30 days after the end of each quarter.

XII. GENERAL FINANCIAL REPORTING REQUIREMENTS FOR DEFINED AUTHORIZED EXPENDITURES

General Financial Requirements under title XIX

52. **Quarterly Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the

Demonstration period. CMS must provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section XIV entitled, Monitoring Budget Neutrality in the Demonstration**.**

53. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures under the Demonstration:

    a) In order to track expenditures under this Demonstration, Hawaii must report Demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered, or for which capitation payments were made).

    b) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, the QEx premium collections (both total computable and Federal share) must also be reported on the Form CMS-64 Narrative.

    c) For monitoring purposes, cost settlements must be recorded on Line 10.b., in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments must be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual.

    d) For each Demonstration year, 23 separate waiver forms, using Forms CMS-64.9 Waiver and/or 64.9P Waiver, must be completed, using the waiver names in parentheses below, to report expenditures for individuals enrolled in the Demonstration and for hospital and long-term care facility uncompensated care payments as follows:

        i. Mandatory Title XIX Children (State Plan Children) (CMS-64.9 Waiver and/or 64.9P Waiver);
        ii. Mandatory Title XIX Adults, excluding Pregnant Immigrants/COFAs (State Plan Adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
        iii. Mandatory Title XIX Pregnant Immigrants/COFAs (State Plan Adults-Pregnant Immigrants/COFAs) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
        iv. Optional Title XIX Children (Optional State Plan Children) , including title XXI children if title XXI allotment is exhausted (CMS-64.9 Waiver and/or 64.9P Waiver);
        v. Optional Title XIX Children (Foster Care Children, 19-20 years old) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
        vi. Medically Needy Children (Optional State Plan Children) (CMS 64.9 Waiver and/or 64.9P Waiver);

vii. Medically Needy Adults (Medically Needy Adults) (CMS 64.9 Waiver and/or 64.9P Waiver);
viii. QUEST Adults (Demonstration eligible adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
ix. QUEST-Net Adults (Demonstration eligible adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
x. QUEST-Adult-Coverage-Expansion (Demonstration eligible adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
xi. Hospital payments to governmentally-operated hospitals (UCC-Governmental) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
xii. Long term care payments to governmentally-operated nursing facilities (UCC-Governmental LTC);
xiii. Hospital payments to private hospitals (UCC-Private) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
xiv. Aged with Medicare (Aged w/Mcare)(CMS 64.9 Waiver and/or CMS 64.9P Waiver);
xv. Aged without Medicare (Aged w/o Mcare)(CMS 64.9 Waiver and/or CMS 64.9P Waiver);
xvi. Blind/Disabled with Medicare (B/D w/Mcare)(CMS 64.9 Waiver and/or CMS 64.9P Waiver); and
xvii. Blind/Disabled without Medicare (B/D w/o Mcare)(CMS 64.9 Waiver and/or CMS 64.9P Waiver).
xviii. Breast and Cervical Cancer Treatment Program (BCCCTP))(CMS 64.9 Waiver and/or CMS 64.9P Waiver);and
xix. Hawaii Premium Plus (Premium Plus) (CMS 64.9 Waiver and/or CMS 64.9P Waiver).

54. **Expenditures Subject to the Budget Neutrality Ceiling.** For purposes of this section, the term "expenditures subject to the budget neutrality ceiling" must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration and for hospital uncompensated care payments as described in section XII, entitled General reporting Requirements of these STCs. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

55. **Premium Collection Adjustment.** The State must include section 1115 Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis on the CMS-64 Summary Sheet.

56. **Administrative Costs.** Administrative costs must not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

57. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the

State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

58. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:

    a) For the purpose of calculating the budget neutrality expenditure cap, and for other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member months for all Medicaid and Demonstration Eligibility Groups (EGs) defined in section XIV, entitled Monitoring Budget Neutrality in the Demonstration. This information must be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report. To permit full recognition of "in-process" eligibility, reported counts of member months must be subject to minor revisions for an additional 180 days after the end of each quarter. For example, the counts for the quarter ending September 30, 2008, due to be reported by November 30, 2008, are permitted to be revised until June 30, 2009.

    b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

    c) For the purposes of this Demonstration, the term "Demonstration Eligibles" refers to the eligibility groups described in section XIV, entitled Monitoring Budget Neutrality in the Demonstration. The term "Demonstration Eligibles" specifically excludes unqualified aliens, including aliens from the Compact of Free Association countries.

59. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. Hawaii must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS must make Federal funds available, based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS must reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

60. **Extent of Federal Financial Participation.** Subject to CMS approval of the source(s) of the

non-Federal share of funding, CMS must provide FFP at the applicable Federal matching rates for the following, subject to the limits described in section XIV, entitled Monitoring Budget Neutrality in the Demonstration .

a) Administrative costs, including those associated with the administration of the Demonstration;
b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and
c) Net expenditures made with dates of service during the operation of the Demonstration.

61. **State Certification of Funding Conditions.** The State certifies that matching funds for the Demonstration are State/local appropriations. The State further certifies that such funds must not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval.
    a) CMS may review the sources of the non-Federal share of funding and distribution methods for Demonstration funding at any time. All funding sources and distribution methodologies deemed unacceptable by CMS must be addressed within the time frames set by CMS.
    b) Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

62. **Medicaid Statistical Information System (MSIS) Data Submission.** The State must submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State must ensure, within 120 days after approval of the Demonstration, that all prior reports are accurate and timely.

63. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame. Within 6 months of the date of the award of this demonstration, the State will implement appropriate controls approved by CMS to ensure oversight of demonstration claiming and expenditures.

General Financial Requirements under title XXI

Beginning January 1, 2008, the State will not receive FFP under title XXI for expenditures for QUEST-Net children who are not authorized in the CHIP State Plan. For QUEST-Net children above 200 percent up to and including 300 percent FPL, who received demonstration services during the demonstration approval period ending January 31, 2008, the State will follow the financial reporting procedures outlined in paragraphs 64 (Quarterly Expenditure Reporting MBES/CBES) and 65 (Claiming Period) until all claims for expenditures for services provided prior to January 1, 2008 are made, including prior period adjustments.

64. **Expenditures Subject to the Allotment Neutrality Limit.** Eligible Title XXI Demonstration expenditures subject to the allotment neutrality agreement are expenditures for services provided through this Demonstration to Title XXI children with FPL levels

within the approved CHIP State Plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the State's available Title XXI funding.

65. **Quarterly Expenditure Reporting through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES).** In order to track title XXI expenditures under this Demonstration, the State must report quarterly Demonstration expenditures through the MBES/CBES, following routine CMS-64.21 and CMS-21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual.

    Title XXI Medical Assistance Payment (MAP) expenditures for immigrant/COFA title XXI children (HI-02) and non-immigrant/non-COFA title XXI children (HI-01) must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered, or for which capitation payments were made—e.g., 11-W00001/DY). Once the appropriate waiver form is selected for reporting expenditures, the State is required to identify the program code and coverage (i.e., children).

    Title XXI Administration expenditures for immigrant/COFA title XXI children and non-immigrant/non-COFA title XXI children must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver; identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which administration services were rendered) .

66. **Claiming Period.** All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

67. **Standard Medicaid Funding Process.** The standard CHIP funding process will be used during the Demonstration. Hawaii must estimate matchable Medicaid expansion CHIP (M-CHIP) expenditures on the quarterly Form CMS-37. for Medical Assistance Payments (MAP), and separately estimate State and Local Administrative Costs (ADM) on the quarterly Form CMS-21B. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver, and Forms CMS-21 Waiver and/or CMS-21P Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21U and CMS-21 Waiver forms with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

68. **Administrative Costs.** All administrative costs are subject to the title XXI 10 percent

administrative cap described in section 2105(c)(2)(A) of the Act.

69. **State Certification of Funding Conditions.** The State will certify that State/local monies are used as matching funds for the Demonstration. The State further certifies that such funds must not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS must be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

70. **Limitation on Title XXI Funding.** Hawaii will be subject to a limit on the amount of Federal title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the Demonstration children until the next allotment becomes available.

71. **Exhaustion of Title XXI Funds.** After the State has exhausted title XXI funds, expenditures for optional targeted low-income children within the CHIP State Plan approved income levels, may be claimed as title XIX expenditures, as approved in the Medicaid State Plan. The State shall report expenditures for these children, identified as "Optional State Plan Children," as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with the instructions that can be found in section XIII, paragraph 53 entitled Reporting Expenditures Under the Demonstration.

72. **Exhaustion of Title XXI Funds Notification**. The State must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures. The State must follow Hawaii Medicaid State Plan criteria for the beneficiaries unless specific waiver and expenditure authorities are granted through this demonstration.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

73. **Limit on Title XIX Funding.** The State must be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a combined per capita cost method and aggregate DSH method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration.

74. **Risk.** Hawaii must be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles in the EGs 1 through 4 as described below under this budget neutrality agreement, but not for the number of Medicaid eligibles in each of the groups. By providing FFP for all eligibles in the specified EGs, Hawaii must not be at risk for changing

economic conditions that impact enrollment levels. However, by placing Hawaii at risk for the per capita costs for Medicaid eligibles in each of the EGs under this agreement, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

75. **Eligibility Groups (EG) Subject to the Budget Neutrality Agreement.** The 5 EGs subject to this budget neutrality agreement are:

EG 1 – Children	**Income Level**
Infants under 1	Up to and including 185 percent FPL
Children 1-5	Up to and including 133 percent FPL
Children 6-18	Up to and including 100 percent FPL
Foster children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	Up to and including 100 percent FPL
EG 2 - Adults	
Pregnant women	Up to and including 185 percent FPL
Section 1931 Adults	Up to and including 100 percent FPL
Section 1925 Transitional Medicaid	Coverage is for two 6-month periods due to increased earnings, or for four months due to receipt of child support, either of which would otherwise make an individual ineligible for continued coverage under Section 1931. In the second 6-month period, family' total earned income may not exceed 185 percent
EG 3 - Aged	
Aged	Includes aged beneficiaries both with and without Medicare Includes Dually eligible beneficiaries who are Aged
EG 4 – Blind/Disabled	
Blind/Disabled	Includes blind and disabled beneficiaries both with and without Medicare Includes Dually eligible beneficiaries who are Blind/Disabled Includes beneficiaries screened and found to be in need of treatment for breast and/or cervical cancer
EG 5– HCBS	
HCBS	Includes beneficiaries enrolled in community support provided through NHWW, RAACP, MFCCP or HCCP during transition to managed care delivery system.

76. **Budget Neutrality Ceiling:** The following describes the method for calculating the budget

neutrality ceiling:

a) For each year of the budget neutrality agreement an annual limit is calculated for the 5 EGs described above. The annual limit for the Demonstration is the sum of the projected annual limits for the 4 EGs, plus a DSH adjustment for that year described in subparagraph (e) below and the HCBS adjustment for that year described in subparagraph (d) below.

b) For each EG 1 through 4, the annual limit for the EG must be calculated as a product of the number of eligible member months reported by the State under paragraph 86 for that EG, times the appropriate estimated per member per month (PMPM) cost from the table in subparagraph (g) below.

c) The PMPM costs in subparagraph (g) were determined by applying the growth rate for each EG (the PMPM costs for EG 3 and 4 were aged from State fiscal year 2006 using 1.7 percent for the Aged and 5.5 percent for the Blind/Disabled EG.

d) The budget neutrality ceiling is the sum of the annual PMPM limits for the Demonstration period plus the sum of the adjustments, plus the amount of unused budget authority carried over from prior Demonstration years. In DY 14 and DY 15, actual HCBS service expenditures during the transitional months will be added to the budget neutrality ceiling as described in subparagraph (f). The Federal share of the budget neutrality ceiling represents the maximum amount of FFP that the State may receive for expenditures on behalf of eligibles described in paragraph 64 during the Demonstration period.

e) The DSH adjustment is based upon Hawaii's DSH allotment for 1993 and calculated in accordance with current law. The DSH adjustment for July 1, 2005, through June 30, 2006, is $80,364,047. The total computable DSH for each subsequent year must be the previous Demonstration year's adjustment trended by the policy contained in current law. In this manner, Hawaii will have available funding for DSH adjustments similar to other states. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation that impacts the calculation of DSH allotments.

f) The HCBS EG will be represented as *actual* expenditures for the four (4) transitioning HCBS waivers in DY14 and DY15, will be claimed as title XIX expenditures as previously approved under the Secretary's section 1915(c) authority, and must be reported as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver.

g) The following are the ceiling PMPM costs for the calculation of the budget neutrality expenditure ceiling for the Demonstration enrollees under this section 1115 Demonstration. The PMPM costs below must be the net of premiums paid by QUEST Expanded eligibles.

Eligibility Group	Growth Rate	DY 15 PMPM	DY 16 PMPM	DY 17 PMPM	DY 18 PMPM	DY 19 PMPM	Growth Rate DY 20	DY 20 PMPM
		FYY 2009	FYY 2010	FFY 2011	FYY 2012	FFY 2013		FFY 2014
EG 1 - Children	1.066	$322.62	$343.98	$366.75	$391.03	$416.92	1.010	$421.09
EG 2 - Adults	1.064	$564.90	$600.88	$639.18	$679.87	$723.18	1.037	$749.94
EG 3 - Aged	1.064	$1204.63	$1281.84	$1364.01	$1451.44	$1544.48	1.034	$1,596.99
EG 4 – Blind/Disabled	1.072	$1489.42	$1597.11	$1712.58	$1836.40	$1969.17	1.045	$2,057.78

77. **Reporting Actual Member Months.** For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the State must provide a report to CMS in the format provided by CMS in Attachment B, identifying the State's actual member months for each EG and corresponding actual expenditures for each EG, less the amount of premiums paid by QEx eligibles.

78. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 15	Cumulative budget neutrality limit plus:	1,0 percent
Years 16 through 18	Cumulative budget neutrality limit plus:	0.5 percent
Year 19 and 20	Cumulative budget neutrality limit plus:	0 percent

In addition, the State may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the Demonstration will exceed the cap during this extension.

79. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the budget neutrality limit has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test must be based on the time elapsed through the termination date.

XIV. EVALUATION OF THE DEMONSTRATION

80. **State Must Evaluate the Demonstration.** The evaluation report as approved by CMS for the prior extension is due no later than June 30, 2008. In addition, the State must submit to CMS for approval a draft evaluation design with appropriate revisions to accommodate programmatic changes no later than June 30, 2008. 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.

81. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft design within 60 days of receipt, and the State must submit a final design within 60 days of receipt of CMS comments. The State must implement the evaluation design and submit its progress in the quarterly reports. The State must submit to CMS a draft of the evaluation report 120 days prior to the expiration of the Demonstration. CMS must provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.

82. **HCBS and LTC Baseline Data and Reporting**. After collaboration between the State and Federal governments to establish the baseline data appropriate for monitoring programmatic and beneficiary trends in the HCBS and LTC program, the State must report to CMS quarterly and annual reporting on these data elements. These data must be established no later than October 31, 2008.

83. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration.

XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION PERIOD

Due Date	Deliverable
30 days from approval letter date	State Acceptance of Demonstration Extension, STCs, Waivers, and Expenditure Authorities.
30 days from approval letter date	Medicaid State Plan amendment for CPE protocol and method.
30 days from approval letter date	Medicaid State Plan amendment to add children above 200 percent FPL up to and including 300 percent FPL to the plan.
30 days from approval letter date	CHIP State Plan amendment to add children above 200 percent FPL up to and including 300 percent FPL to the plan.
June 30, 2008	Evaluation Report for Demonstration to DY14
June 30, 2008	Submit Draft Evaluation Design
October 31, 2008	Deadline for Baseline HCBS and LTC Data Elements
October 31, 2008, and each subsequent year	Submit Draft Annual Report
January 1, 2009 and each subsequent year	SARTS report for previous fiscal year

Quarterly	Deliverable
	Requirements for Quarterly Reports Attachment B
	Title XXI Enrollment Reporting (SEDS)
	Expenditure Reports title XXI

ATTACHMENT A
HOSPITALS AND LONG-TERM CARE FACILITIES THAT MAY RECEIVE PAYMENTS FOR UNCOMPENSATED CARE COSTS

Governmental Hospitals

Hale Ho'ola Hamakua
Hilo Medical Center
Kau Hospitals
Kauai Veterans Hospital
Kohala Hospital
Kona Community Hospital
Kahuku Hospital
Kula Hospital & Clinic
Lanai Community Hospital
Maui Memorial Hospital
Samuel Mahelona Memorial

Private Hospitals

Castle Medical Center
Hawaii Medical Center - East
Hawaii Medical Center - West
Kahi Mohala
Kaiser Permanente Medical Center
Kapiolani Medical Center at Pali Momi
Kapiolani Medical Center for Women and Children
Kuakini Medical Center
Molokai General Hospital
North Hawaii Community Hospital
Rehabilitation Hospital of the Pacific
Straub Clinic & Hospital
The Queen's Medical Center
Wahiawa General Hospital
Wilcox Memorial Hospital

Nursing Facilities

Hilo Medical Center
Kona Community Hospital
Leahi Hospital
Maluhia

Attachment B
Quarterly Report Format

Under Section XII, paragraph 58, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Hawaii QUEST
Title Line Two - Section 1115 Quarterly Report
Date Submitted to CMS

Demonstration/Quarter Reporting Period:
Demonstration Year:
Federal Fiscal Quarter:

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This is likely to be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The State must indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State must indicate that by "0".

Enrollment Counts

Note: Enrollment counts must be person counts, not member months.

Expenditure Reporting Groups (as hard coded in the CMS 64)	**Current Enrollees** (to date)
State Plan Adults	
State Plan Children	
Optional State Plan Children	
Optional State Plan Children MCHP	
Foster Care Children	
Medically Needy Adults	
Demonstration Eligible Adults (Quest & Quest-Net Adults)	
Demonstration Eligible Adults (Quest ACE)	

UCC - Governmental	
UCC - Private	
NHWW - (Demonstration Years 14 and 15 only)	
RAACP - (Demonstration Years 14 and 15 only)	
MFCCP - (Demonstration Years 14 and 15 only)	
HCCP - (Demonstration Years 14 and 15 only)	
Aged with Medicare	
Aged without Medicare	
Blind/Disabled with Medicare	
Blind/Disabled without Medicare	
Breast and Cervical Cancer Treatment Program	
Hawaii Premium Plus	

And

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	
Title XXI funded State Plan	
Title XIX funded Expansion	
Title XXI funded Expansion	
DSH Funded Expansion	
Other Expansion	
Pharmacy Only	
Family Planning Only	
Enrollment Current as of	Mm/dd/yyyy

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Expenditure Containment Initiatives

Identify all current activities, by program and or demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Aged				
Blind/Disabled				
Children (EG1)				
Adults (EG2)				
HCBS				

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
State Plan Adults				
State Plan Children				
Optional State Plan Children				
Optional State Plan Children MCHP				
Foster Care Children				
Medically Needy Adults				
Medically Needy Children				
Demonstration Eligible Adults (Quest & Quest-Net Adults)				
Demonstration Eligible Adults (Quest ACE)				
UCC - Governmental				
UCC - Private				
NHWW - (Demonstration Years 14 and 15 only)				
RAACP - (Demonstration Years 14 and 15 only)				
MFCCP - (Demonstration Years 14 and 15 only)				
HCCP - (Demonstration Years 14 and 15 only)				
Aged with Medicare				
Aged without Medicare				
Blind/Disabled with Medicare				
Blind/Disabled without Medicare				
Breast and Cervical Cancer Treatment Program				
Hawaii Premium Plus				

Benchmarks for QUEST ACE

The State must report on accomplishments related to the enrollment benchmark for the QUEST ACE expansion population, as described in STC 42. In addition, the State must report all programmatic activities performed in the quarter to assist in reaching this enrollment benchmark, including any programmatic changes as corrective action to assist in reaching this goal.

Attachment B
Quarterly Report Format

QUEST Expanded Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also, discuss feedback received from the MCARP and other consumer groups.

QExA Enrollment

A summary and detail of the number of beneficiaries assisted monthly by the enrollment counselor. The monthly auto assignment rate including MCO information and island of residence. The number of requests to change plans, the outcome of the request, and the monthly disenrollment requests both granted and declined over monthly MCO enrollment.

QExA Consumer Issues

A summary and detail of all consumer complaints or problems related to the QExA program must be reported. Corrective actions and the number of outstanding issues that remain unresolved must be included.

Behavioral Health Programs Administered by the DOH

Upon QExA implementation, a summary of the programmatic activity for the quarter for Demonstration eligibles. This shall include a count of the point in time Demonstration eligibles receiving MQD FFS services through the DOH CAMHD and AMHD Programs.

QExA HCBS Waiting List

Should the need for a State sponsored waiting list for HCBS services be required, a summary and detail of beneficiaries currently on waiting lists. This information must include a minimum of information including the MCO the beneficiary is enrolled in, the geographic area or region that services will be rendered in when available, as well as discussion of how all possible options for HCBS were exhausted prior to being placed on the waiting list.

HCBS Expansion and Provider Capacity

A summary and detail of State and MCO activities performed during the quarter, or long-term planning items in progress that are performed with the goal of expansion of HCBS by plan and island or geographic area/region.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

An up-to-date-budget neutrality worksheet must be provided as a supplement to the quarterly report. In addition, any items identified as pertinent by the State may be attached. Documents must be submitted by title along with a brief description in the quarterly report of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Attachment C
Home and Community-Based Services (HCBS) and Long-Term Care
Provider Guidelines and Service Definitions

The following are the provider guidelines and service definitions for HCBS provided by section 1915(c) waivers, as well as the Quest Expanded Access (QExA) program upon implementation.

Service/Provider Term	Service Definition
Adult Day Care Center	Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants in accordance with HAR§17-1417. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services. Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency. Adult Day Care Centers are licensed by the Department of Human Services and maintained and operated by an individual, organization, or agency.
Adult Day Health Center	Adult Day Health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96 and HAR §11-94-5. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community. Each program 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, meals which do not constitute a full nutritional program, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services. Adult Day Health Centers are licensed by the Department of Health.
Assisted Living Facility	Assisted living services include personal care and supportive care services (homemaker, chore, attendant services, and meal preparation) that are furnished to members who reside in an assisted living facility. Assisted living facilities are home-like, non-institutional settings. Payment for room and board is prohibited. Section 30.200 describes Assisted Living Facilities as a facility, as defined in HRS 321-15.1, that is licensed by the Department of Health. This facility 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.
Pediatric Attendant Care	Attendant care is the hands-on care, both supportive and health-related in nature, provided to medically fragile children. The service includes member supervision specific to the needs of a medically stable, physically handicapped child. Attendant care may include skilled or nursing care to the extent permitted by law. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Supportive services, a component of attendant care, are those services that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant care services may be self-directed.
Community Care	CCMA services are provided to members living in Community Care Foster Family Homes and

Service/Provider Term	Service Definition
Management Agency (CCMA)	other community settings, as required. A health plan may, at its option, demonstrate the ability to provide CCMA services by contracting with an entity licensed under HAR subchapters 1 and 2. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of members; ongoing face-to-face monitoring and implementation of the member's care plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. CCMAs shall (1) communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders, (2) work with families regarding service needs of member and serve as an advocate for their members, and (3) be accessible to the member's caregiver twenty-four (24) hours a day, seven (7) days a week. CCMA's are agencies licensed by the DHS or its designee under HAR chapter 17-1454, subchapters 1 and 2, to engage in locating, coordinating and monitoring comprehensive services to residents in community care foster family homes or members in E-ARCHS and assisted living facilities. A health plan may be a community care management agency.
Community Care Foster Family Home (CCFFH)	CCFFH services is personal care and supportive services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted under State law) provided in a certified private home by a principal care provider who lives in the home. The number of adults receiving services in CCFFH is determined by HAR, Title 17, Department of Human Services, Subtitle 9, Chapter 1454-43. CCFFH services are currently furnished to up to three (3) adults who receive these services in conjunction with residing in the home. All providers must provide individuals with their own bedroom. Each individual bedroom shall be limited to two (2) residents. Both occupants must consent to the arrangement. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four (4). In accordance with HAR, Title 17, Department of Human Services, Subtitle 9, Chapter 1454-42, members receiving CCFFH services must be receiving ongoing CCMA services. A CCFFH is a home issued a certificate of approval by the DHS to provide, for a fee, twenty-four (24) hour living accommodations, including personal care and homemaker services. The home must meet all applicable requirements of HAR §17-1454-37 through HAR §17-1454-56.
Counseling and Training	Counseling and training activities include the following: member care training for members, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling. Counseling and training is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member.
Environmental Accessibility Adaptations	Environmental accessibility adaptations are those physical adaptations to the home, required by the individual's care plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member.

Service/Provider Term	Service Definition
	Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.
Expanded Adult Residential Care Home (E-ARCH) or Residential Care Services	Residential care services are personal care services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principal care provider who lives in the home. Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH), allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the DHS to live in a Type I home with no more than two (2) of whom may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. An E-ARCH's is a facility, as defined in HAR §11-100.1.2 and licensed by the Department of Health, that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of expanded care ARCHs in accordance with HRS § 321-1562 as described above.
Home Delivered Meals	Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization.
Home Maintenance	Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.
Medically Fragile Day Care	Medically fragile day care is a non-residential service for children who are medically and/or technology dependent. The service includes activities focused on meeting the psychological as well as the physical, functional, nutritional and social needs of children. Services are furnished four (4) or more hours per day on a regular scheduled basis for one (1) or more days per week in an outpatient setting encompassing both health and social services needed to ensure the optimal function of the individual.
Moving Assistance	Moving assistance is provided in rare instances when it is determined through an assessment by the care coordinator that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.

Attachment C
Home and Community-Based Services (HCBS) and Long-Term Care
Provider Guidelines and Service Definitions

Service/Provider Term	Service Definition
Non-Medical Transportation	Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.
Personal Assistance Services (Level I)	Personal assistance services Level I is the only service in this Attachment C that requires less than institutional level of care for the member to receive the service. Personal assistance services Level I are provided to individuals requiring assistance with instrumental activities of daily living (IADLs) who do not meet an institutional LOC in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I may be self-directed and consist of companion services and homemaker services. Homemaker services include • Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish; • Care of clothing and linen by washing, drying, ironing, mending; • Marketing and shopping for household supplies and personal essentials (not including cost of supplies); • Light yard work, such as mowing the lawn; • Simple home repairs, such as replacing light bulbs; • Preparing meals; • Running errands, such as paying bills, picking up medication; • Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available; • Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer; • Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate; and • Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service.
Personal Assistance Services (Level II)	Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform activities of daily living (ADLs) and health maintenance activities. Personal assistance services Level II 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. The following activities may be included as a part of personal assistance services Level II: • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing; • Assistance with bowel and bladder care; • Assistance with ambulation and mobility; • Assistance with transfers; • Assistance with medications, which are ordinarily self-administered when ordered by member's physician; • Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician; • Assistance with feeding, nutrition, meal preparation and other dietary activities;

Service/Provider Term	Service Definition
	• Assistance with exercise, positioning, and range of motion; • Taking and recording vital signs, including blood pressure; • Measuring and recording intake and output, when ordered; • Collecting and testing specimens as directed; • Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, Hawaii Administrative Rules; • Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished; • Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and • Maintaining documentation of observations and services provided. When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the care plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may also be provided. Personal assistance services Level II may be self-directed. Personal Assistance is care provided when a member, member's parent, guardian, family member or legal representative employs and supervises a personal assistant who is certified by the health plan as able to provide the designated services whose decision is based on direct observation of the member and the personal assistant during the actual provision of care. Documentation of this certification will be maintained in the member's individual plan of care.
Personal Emergency Response Systems	PERS is a twenty-four (24) hour emergency assistance service which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items: • 24-hour answering/paging; • Beepers; • Med-alert bracelets; • Intercoms; • Life-lines; • Fire/safety devices, such as fire extinguishers and rope ladders; • Monitoring services; • Light fixture adaptations (blinking lights, etc.); • Telephone adaptive devices not available from the telephone company; and • Other electronic devices/services designed for emergency assistance. All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible.

Service/Provider Term	Service Definition
	PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting.
Private Duty Nursing	Private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses (as defined in HAR § 16-89) within the scope of State law.
Respite Care	Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; foster home/expanded-care adult residential care home; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the State. Respite care services are authorized by the member's PCP as part of the member's care plan. Respite services may be self-directed.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation and may include: • Specialized infant car seats; • Modification of parent-owned motor vehicle to accommodate the child (i.e., wheelchair lifts); • Intercoms for monitoring the child's room; • Shower seat; • Portable humidifiers; • Electric bills specific to electrical life support devices (ventilator, oxygen concentrator); • Medical supplies; • Heavy duty items including, but not limited to, patient lifts or beds that exceed $1,000 per month; • Rental of equipment that exceeds $1,000 per month such as ventilators; and • Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month. Items reimbursed shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies shall be recommended by the member's PCP.

Attachment D
Certified Public Expenditure (CPE)/ Government-Owned Hospital
Uncompensated Care Cost (UCC) Protocol

Introduction

This document serves as an attachment to the Quest Expanded section 1115 Demonstration special terms and conditions (STCs). The State must modify this protocol in accordance with Section III of these STCs to reflect any changes in CPE regulations or generally applicable policy adopted by the Centers for Medicare & Medicaid Services (CMS).

This protocol directs the method that must be used to determine uncompensated care (UCC) payments to government-owned hospitals as allowed by Section X of the STCs.

Summary of Medicare Cost Report Worksheets

Expenditures will be certified according to costs reported on the hospitals' 2552 Medicare cost reports, as follows:

Worksheet A
The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:

(i) overhead;
(ii) routine;
(iii) ancillary;
(iv) outpatient;
(v) other reimbursable; and,
(vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B
Allocates overhead (originally identified as General Service Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C
Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the hospitals records. The cost to charge ratios are used in the Worksheet D series to determine program costs.

The cost-to-charge ratio for inpatient and outpatient service to be used in making the interim quarterly expenditure payments are from the Medicare cost report worksheets as follows:

Attachment D
Certified Public Expenditure (CPE)/ Government-Owned Hospital
Uncompensated Care Cost (UCC) Protocol

1. Inpatient Cost to Charge Ratio:

[Worksheet C, Part I, Column 1, Line 103 (Total Cost) - all LTC components and non-hospital components and outpatient-only components)]/ [Worksheet C, Part I, Column 8 line 103(Total Charges) -all LTC components, non-hospital components and outpatient-only components)]

2. Outpatient Cost to Charge Ratio:

[Worksheet C, Part I, Column 1 Line 103 (Total Cost) -Line 25 through 35 (Routine Cost), and all non- hospital cost components and all inpatient-only components] / [Worksheet C, Part I, Column 8 line 103 (Total Charges) -Lines 25 through 35 (Routine Charges) and all non-hospital components and all inpatient-only components]

The governmentally-operated hospital's (hospital) will utilize the Medicare cost report to determine uncompensated care costs described in the subsequent instructions. The above Medicare cost- to- charge ratio will be applied to the uncompensated care population program charges to determine cost. The cost will be reduced by actual payments received to determine the hospital's uncompensated care cost. Any direct payments to hospitals by State related to this CPE computation will not be reflected in the payment received to determine hospital's uncompensated care cost. Non-Medicaid payments, funding and subsidies made by a state or unit of local government shall not be offset (e.g., state- only, local-only, or state-local health programs).

NOTES:

For the purpose of utilizing the Medicare cost report to determine uncompensated care costs described in the subsequent instructions, the following terms and methodology are defined as follows:

The term "filed Medicare cost report" refers to the cost report that is submitted by the hospital to Medicare Fiscal Intermediary and is due 5 months after the end of the hospitals fiscal year end period.

The term "finalized Medicare cost report" refers to the cost report that is settled by the Medicare Fiscal Intermediary with the issuance of Notice of Program Reimbursement (NPR).

The "Uncompensated care costs (UCC)" includes covered inpatient and outpatient hospital services costs from the Medicaid Fee for Services (Medicaid FFS), Medicaid Quest Expanded (QEx), and Uninsured population, less payments received from Medicaid FFS, QEx, and from uninsured patients, and excluding costs attributable to services to unqualified aliens. However, UCC are subject to the limitations as set forth in STC section X. Specifically, STC #44b, for government-operated hospitals, excludes

inpatient Medicaid FFS shortfall, non-emergency care to unqualified aliens, and costs of drugs for individuals eligible for Part D.

Nothing in this document shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicare program. Any revision to the finalized Audit Report as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

Certified Public Expenditures -Determination of Allowable Payments to cover Uncompensated Care Costs (UCC)

To determine governmentally operated hospital's (hospital) allowable UCC when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation (FFP) as defined with limitations in the STCs:

Interim Quarterly Expenditure Payment

The purpose of the interim quarterly expenditure payment is to identify the UCC from hospitals eligible for FFP claimed through the CPE process. The interim quarterly expenditure payment funded by CPEs is the State's initial claim for the drawing Federal funds in a manner consistent with the instructions below.

The process of determining the CPEs to cover UCC eligible for FFP begins with the use of each hospital's most recently filed Medicare cost report for purposes of obtaining cost to charge ratios for inpatient and outpatient services using the methodology described in this document. The inpatient cost to charge ratio is applied to the inpatient program charges for the current quarter to determine inpatient costs. The outpatient cost to charge ratio is applied to the outpatient program charges for the current quarter to determine outpatient costs. The service period for inpatient is determined by the discharge date and for outpatient it is the service date. UCC is the cost of providing inpatient and outpatient services as computed above, reduced by an appropriate adjustment for the cost of undocumented aliens and any applicable revenue collected for the provision of services. Only inpatient and outpatient program charges related to medical services that are eligible under the UCCs will be used to compute inpatient and outpatient program costs for this CPE process. Payments that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments. Direct UCC waiver payments, computed in this protocol, to hospitals by the State will not be included in the total program payments. Non-Medicaid payments, fundings, and subsidies made by a state or unit of local government shall not be offset.

Charges and payments for Medicaid FFS originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured charges and payments will originate from the provider's auditable records.

Annual Reconciliation Payment

Each hospital's interim quarterly payments will be reconciled to its filed Medicare cost reports

for the spending year in which CPE payments were made. If, at the end of the annual reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government. The annual reconciliation payment is based on the recalculation of inpatient and outpatient program costs using the cost center per diems and cost-to-charge ratios derived from its filed Medicare cost report for the service period. Days, charges and payments for Medicaid FFS services originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges and payments will originate from the provider's auditable records.

For each inpatient hospital routine cost center, a per diem is calculated by dividing total costs of the cost center (from ws B, Part I, column 25) by total days of the cost center (from ws S-3, Part I, column 6). For each ancillary hospital cost center, a cost to charge ratio is calculated by dividing the total costs of the cost center (from ws B, Part I, column 25) by the total charges of the cost center (from ws C, Part I, column 8). The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

For inpatient UCC cost computation, each routine hospital cost center per diem is multiplied by the cost center's number of eligible UCC days, and each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible inpatient charges. Eligible UCC days and charges pertain only to the UCC populations and services as defined in the STCs and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's inpatient hospital UCC cost is the hospital's inpatient UCC cost prior to the application of payment/revenue offsets and an appropriate adjustment of one percent to remove the unallowable cost of services to undocumented aliens.

For outpatient UCC cost computation, each ancillary hospital cost center cost-to-charge ratio is multiplied by the cost center's UCC-eligible outpatient charges. Eligible UCC charges pertain only to the UCC populations and services as defined in the STCs and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's outpatient hospital UCC cost is the hospital's outpatient UCC cost prior to the application of payment/revenue offsets and an appropriate adjustment of one percent to remove the unallowable cost of services to undocumented aliens.

The cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim quarterly UCC payments made.

Payments that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, including payments from managed care entities, for serving QEx enrollees, will be included in the total program payments under this annual initial reconciliation process. Non-Medicaid payments, fundings, and subsidies made by a state or unit of local government will not be included in the total program payment

offset.

The interim annual reconciliation described above will be performed and completed within 12 months after the filing of the hospital Medicare cost report.

Final Reconciliation Payment

Each hospital's annual reconciliation payment in a spending year will also be subsequently reconciled to its finalized Medicare cost report for the respective cost reporting period. The hospital will adjust, as necessary, the aggregate amount of UCC reported on the CPE determined under the final reconciliation payment. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, such overpayment or underpayment will be properly reported to the federal government. The same methodology detailed in the annual reconciliation payment will be used for the final reconciliation payment. The final reconciliation payments are based on the recalculation of program costs using the cost center per diems and cost-to-charge ratios from the finalized Medicare cost report for the service period. The hospital will update the program charges to include only paid claims from Medicaid FFS, QEx in computing program costs for the reporting period. For the uninsured population, the hospital will update any payment made by or on behalf of the uninsured through the quarter prior to the receipt of all of the finalized government-owned hospital Medicare cost reports for each respective fiscal year. Days, charges and payments for Medicaid FFS originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges and payments will originate from the provider's auditable records. The hospital will report inpatient and outpatient UCC based on program data related to medical services that are eligible for Federal financial participation for the uncompensated care costs under this CPE process and Section X of the STCs.

The inpatient and outpatient cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim quarterly UCC payments and any interim annual reconciliation payments made.

Payments that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments under this final reconciliation process. Non-Medicaid payments, fundings, and subsidies made by a state or unit of local government shall not be offset. Using CPEs as a funding source, federal matching funds may be claimed for UCCs up to the hospitals eligible uncompensated costs as determined in this process.

The final reconciliation described above will be performed and completed within 6 months after the issuance of all of the finalized government-owned hospital Medicare cost reports for each respective fiscal year. The State is responsible to ensure the accuracy of the CPE amounts used for federal claiming.

Attachment D: Supplement 1
Certified Public Expenditure (CPE)/Governmental Hospital-based or Freestanding Long Term Care Facility
Uncompensated Care Cost (UCC) Protocol

Introduction

This document serves as an attachment to the Quest Expanded section 1115 Demonstration special terms and conditions (STCs). The State must modify this protocol in accordance with Section III of these STCs to reflect any changes in CPE regulations or generally applicable policy adopted by the Centers for Medicare & Medicaid Services (CMS).

This protocol directs the method that must be used to determine payments for uncompensated care cost (UCC) to government-owned nursing facilities as allowed by Section X of the STCs.

For governmental nursing facilities, uncompensated care costs include covered routine nursing facility services costs pertaining to Medicaid Quest Expanded (QEx) population, less payments received for Medicaid QEx patients. UCC are subject to the limitations as set forth in STCs section X.

To determine a governmental hospital-based or freestanding nursing facility's allowable Medicaid uncompensated care costs, the following steps must be taken to ensure Federal financial participation (FFP):

(1) *Interim Payment*

The State will make quarterly interim payments to approximate actual Medicaid uncompensated care costs for the expenditure period. The uncompensated care cost for any given period is the difference between the nursing facility's allowable routine cost pertaining to Medicaid services furnished to the Medicaid population and all revenues received by the facility for those same services.

(a) The process of determining allowable Medicaid nursing facility uncompensated routine costs eligible for FFP begins with the use of each governmental nursing facility's most recently filed cost report (the last cost report filed to the Medicare contractor). For hospital-based nursing facilities, such costs are reported on the CMS-2552. For freestanding nursing facilities, such costs are reported on the CMS-2540.

(b) On the latest as-filed Medicare cost report, the allowable hospital-based nursing facility routine per diem cost is identified on the CMS-2552-10, worksheet D-1, Part III, line 71 (or the equivalent line on any later version of the 2552). This amount represents the allowable NF cost from worksheet B, Part I, line 44 and/or 45 column 26; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part I; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 19 and/or 20 column 8.

On the latest as-filed Medicare cost report, the allowable freestanding nursing facility routine per diem cost is identified on the CMS-2540-96, worksheet D-1, Part I, line 16 (or the equivalent line on any later version of the 2540). This amount represents the allowable NF cost from

worksheet B, Part I, line 16 and/or 18, column 18; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part 1; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 1 and/or 3, column 7.

The routine per diems above are computed in accordance with Medicare cost principles and trended forward by the CMS Nursing Home without Capital Market Basket inflation factor as necessary.

The above computation is performed separately for the NF component and, if applicable, the SNF component to arrive at separate NF and SNF per diems.

(c) The routine per diem from step b) above is multiplied by the number of Medicaid NF routine days during the current quarter for which the interim payment is being computed. The source of the number of Medicaid NF routine days must be supported by auditable documentation, such as provider patient accounting records and/or managed care encounter data reports.

If applicable, this step is also performed for the SNF component, by multiplying the SNF per diem from step (b) by the number of Medicaid SNF days for the period.

Note that Medicaid routine days should only include Medicaid managed care (Medicaid QEx) routine days and should not include any Medicaid FFS routine days, as Medicaid FFS routine services are fully cost-reimbursed under the Hawaii State plan; there is no Medicaid FFS uncompensated nursing facility cost, for governmental nursing facilities, that needs to be accounted for as part of this protocol.

(d) The allowable Medicaid NF routine costs, including any applicable Medicaid SNF component costs, computed from step c above is offset by all revenues received by the facility for the same Medicaid services, including but not limited to Medicaid managed care payments, payments from third party payers, and payments from or on behalf of the patients. The result is the net Medicaid NF routine loss reimbursable as interim uncompensated care cost payment.

2) *Interim Reconciliation to As-Filed Cost Report*

Each governmental nursing facility's interim uncompensated care cost payments will be reconciled to actual cost based on its as-filed CMS-2552 or 2540 for the expenditure year. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The interim reconciliation is based on each governmental nursing facility's allowable routine cost from its as-filed cost report (filed to the Medicare contractor) for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552. For freestanding nursing facilities, such costs are reported on the CMS-2540.

The same methodology detailed in the interim payment section above will be used for the interim reconciliation. The per diems computed using the as-filed cost report covering the expenditure period will be applied to Medicaid NF days (or SNF days if applicable) furnished during the expenditure period, and all applicable revenues for the period will be applied as offsets. The State will perform this interim reconciliation within twelve months from the filing of the cost report for the expenditure period.

3) *Final Reconciliation to Finalized Cost Report*

Each governmental nursing facility's interim uncompensated care cost payments will also be reconciled to actual cost based on its finalized CMS-2552 or 2540 for the expenditure year. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The final reconciliation is based on each governmental nursing facility's allowable routine cost from its finalized cost report (finalized/settled by the Medicare contractor with the issuance of a Notice of Provider Reimbursement or a revised Notice of Provider Reimbursement) for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552. For freestanding nursing facilities, such costs are reported on the CMS-2540.

The same methodology detailed in the interim payment section above will be used for the final reconciliation. The per diems computed using the finalized cost report covering the expenditure period will be applied to Medicaid NF days (or SNF days if applicable) furnished during the expenditure period. All applicable revenues for the period will be applied as offsets. The State will perform this final reconciliation within six months from the finalization of the cost report for the expenditure period.

Attachment E
Behavioral Health Services Protocol

The "Med-QUEST Division Behavior Health Protocols October 15, 2010" document and Attachments A through G were approved by CMS on November 29, 2010.