EXECUTIVE CHAMBERS

HONOLULU

NEIL ABERCROMBIE
GOVERNOR

December 21, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

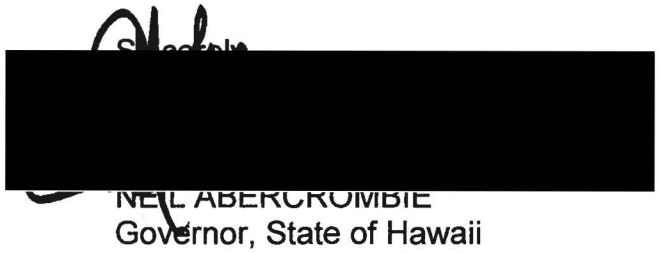
RE: SECTION 1115 DEMONSTRATION (11-W-00001/9) RENEWAL APPLICATION

Enclosed is the State of Hawaii's application for a renewal of its Section 1115 Demonstration. For nearly twenty years, the Demonstration has made it possible for the State to provide comprehensive medical assistance to low-income residents of Hawaii, while controlling costs for both the state and federal governments. Hawaii seeks a five-year renewal under the terms and conditions described in its application, which include coverage for low-income adults consistent with the Medicaid expansion, as well as the other programmatic changes specified in the Affordable Care Act. The State requests this renewal under Section 1115(a) of the Social Security Act.

I am a strong supporter of President Obama and the Affordable Care Act (ACA). Hawaii was the first state to commit to implementing a state-based health insurance exchange and will expand Medicaid eligibility. This renewal application contemplates an effective date of January 1, 2014. However, subject to the approval of the Centers for Medicare & Medicaid Services, Hawaii requests to implement the changes in this renewal effective October 1, 2013, when it will be required to begin evaluating new applications under the modified adjusted gross income (MAGI) methodology, to facilitate its implementation of ACA requirements.

If you have any questions about this application, please feel free to contact me, or Dr. Kenneth S. Fink, Administrator of the Med-QUEST Division, at 808-692-8050 or KFink@medicaid.dhs.state.hi.us.

Thank you for your consideration of this application.



NEIL ABERCROMBIE
Governor, State of Hawaii

Enclosures

c: Marilyn Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services
Cindy Mann, Director, Center for Medicaid and CHIP Services
Victoria Wachino, Children and Adults Health Programs Group

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State of Hawaii
"QUEST Integration" Section 1115 Demonstration

Section 1115(a) Renewal Application
December 28, 2012

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

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I. Introduction

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

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

II. The Current Demonstration - QUEST Expanded

A. Historical Narrative

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

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

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

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

1. The first amendment, approved July 11, 1995, allowed the State to deem parental income for tax dependents up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing

for expansion populations, impose a premium for self-employed individuals, and change the fee-for-service (FFS) window from the date of coverage to the date of enrollment.

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

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

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

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

6. In January 2006, the federal government approved an extension (with a retroactive start date of July 1, 2005) of the Section 1115 waiver for the demonstration, which incorporated the existing program with some significant changes, including:

    - Extension of coverage to all Medicaid-eligible children in the child welfare system;
    - Extension of coverage to adults up to 100% of the FPL who meet Medicaid asset limits through QUEST-ACE;
    - Elimination of premium contributions for children with income at or below 250% of the FPL;
    - Elimination of the requirement that children have prior QUEST coverage as a condition to qualifying for QUEST-Net; and
    - Increase SCHIP eligibility from 200% of the FPL to 300% of the FPL.

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

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

9. In June 2012, CMS approved an amendment to align QUEST-Net and QUEST-ACE benefits with the QUEST benefits package, and to add certain benefits to the QExA benefit package.

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

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

B. Overview of QUEST Expanded Today

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

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

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

QUEST Expanded currently offers two packages of benefits:

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

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

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

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

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

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

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

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

III. Program Description - QUEST Integration

A. QUEST Integration Summary and Objectives

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

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

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

The goals of QUEST Integration will be to:

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

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

1. Integrate QUEST Programs and Streamline Eligibility

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

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

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

Since 1994, the foundation of the QUEST programs has been a capitated managed care system. Over the history of the QUEST and QUEST Expanded demonstrations, the State has found that capitated managed care leads to a more predictable and slower rate of expenditure growth,

thereby allowing the State to make the most efficient use of taxpayer dollars and provide high-quality care to the maximum number of individuals.

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

3. Health Plan Enrollment and Selection

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

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

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

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

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

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

4. Encourage Timely Enrollment By Limiting Retroactive Eligibility

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

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

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

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

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

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

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

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

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

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

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

7. Continue Coverage of Certain Non-Medicaid Beneficiaries

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

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

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

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

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

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

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

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

Hypotheses

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

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

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

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

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

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

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

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

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

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

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

- Comprehensive Diabetes Care (CDC):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Data Collection and Analysis

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

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

IV. Demonstration Eligibility

A. Affected Populations

Hawaii plans to cover the following groups in QUEST Integration:

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

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

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

Expansion Population	
Eligibility Group Name	**Federal Poverty Level and/or Other Qualifying**
Parents or caretaker relatives with an 18-year-old dependent child	Parents or caretaker relatives who (i) are living with an 18-year-old who would be a dependent child but for the fact that s/he has reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age

Individuals in the 42 C.F.R. § 435.217 group receiving HCBS	Income up to and including 100% FPL using the institutional income rules
Medically needy individuals receiving HCBS	Receiving HCBS and meet medically needy income standard using institutional rules for income, assets, and post-eligibility treatment of income
Medically needy ABD individuals whose spend-down exceeds the plans' capitation payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance	Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in the state plan or waiver while receiving assistance payments

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

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

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

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

C. Eligibility and Enrollment Limits

There will be no eligibility limits for QUEST Integration. However, there may be health plan enrollment limits. The State seeks to retain its authority to impose enrollment limits on health plans and to allow health plans to have enrollment limits subject to State approval, provided that at least two health plans operating on an island do not have an enrollment limit.

D. Projected Eligibility

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

E. Post-Eligibility Treatment of Income

There will be no changes in the demonstration's treatment of post-eligibility income. All individuals receiving nursing facility services will be subject to the post-eligibility treatment of income rules set forth in Section 1924 and 42 C.F.R. § 435.733. The application of beneficiary income to the cost of care will be made to the nursing facility. Individuals receiving HCBS will be subject to the post-eligibility treatment of income rules set forth in Section 1924 of the Social Security Act and 42 C.F.R. § 435.735, if they are medically needy or individuals who would be eligible for Medicaid if institutionalized as set forth in 42 C.F.R § 435.217.

V. Demonstration Benefits and Cost Sharing Requirements

A. QUEST Integration Benefits

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

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

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

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

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

QUEST Integration Benefit Package Chart

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

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

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

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

1. Choice of Institutional Services or HCBS

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

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

2. Election of HCBS

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

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

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

3. 1915(c) DD/ID Waiver Enrollees

Individuals enrolled in Hawaii's Section 1915(c) DD/ID waiver will receive HCBS through the 1915(c) waiver, and will receive primary and acute care services through a QI health plan. These individuals will not receive any services under the QI demonstration that are covered under the 1915(c) waiver. (The only exception to this is children who have access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.) QI health plans may offer HCBS that are not covered under the 1915(c) waiver to these individuals, and may have a waiting list for the provision of those HCBS services. Waiting list policies will be based on objective criteria and applied consistently in all geographic areas served.

4. Waiting List for HCBS

The State requests authority to allow the QI health plans to establish waiting lists, upon approval by the State, for the provision of HCBS. Waiting list policies will be based on objective criteria and applied consistently in all geographic areas served. The State will monitor the waiting lists on a monthly basis, and will meet with the health plans on a quarterly basis to discuss any issues associated with management of the waiting lists. Members who are on a waiting list may opt to change to another health plan if it appears that HCBS are available in the other health plan.

C. Access to Behavioral Health Benefits

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

D. Premium Assistance, Premiums, and Cost Sharing

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

VI. Delivery System and Payment Rates for Services

A. Delivery System for Demonstration Benefits

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

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

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

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

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

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

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

B. QUEST Integration Health Plan Enrollment and Selection

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

C. Limitation on Retroactive Eligibility

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

D. Contracting Policies with the QUEST Integration Health Plans

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

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

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

E. Medically Needy Non-ABD Individuals

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

F. Medically Needy ABD Individuals

Medically needy ABD individuals will be enrolled in a QI health plan. If their spend-down liability is expected to exceed the health plans' monthly capitation payment, they will be subject to an enrollment fee equal to the medically needy spend-down amount or, where applicable, the amount of patient income applied to the cost of long-term care.

G. Dual Eligible Beneficiaries

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

H. Self-Direction Opportunities

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

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

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

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

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

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

I. Additional Hospice Payment for Nursing Facility Residents

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

J. Payment Rates

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

1. Quality-Based Supplemental Payments

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

Primary Care Provider

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

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

Hospitals

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

Integrated Service Models

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

VII. Implementation of Demonstration

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

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

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

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

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

VIII. Demonstration Financing and Budget Neutrality

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

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

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

IX. List of Proposed Waivers and Expenditure Authorities

A. Waiver Authority

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

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

   To enable the State to limit medically needy spend-down eligibility to those non-ABD individuals whose gross incomes, before any spend-down calculation, are at or below 300% of the Federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which has no gross income limit.

2. Amount, Duration, and Scope - Section 1902(a)(10)(B)

   To enable the State to offer demonstration benefits that may not be available to all categorically eligible or other individuals.

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

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

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

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

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

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

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

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

B. Expenditure Authorities

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

1. Managed Care Payments. Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of Section 1903(m):

   a) Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to disenroll without cause to within 60 days of initial enrollment in an MCO, as opposed to the 90 days designated under Section 1903(m)(2)(A)(vi) and Section 1932(a)(4)(A)(ii)(I) of the Social Security Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at Section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single health plan in the absence of a choice of health plan on that particular island.

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

2. Quality Review of Eligibility. Expenditures for Medicaid services that would have been disallowed under Section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

3. Demonstration Eligibility. Expenditures to provide coverage to the following populations:

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

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

   c) Individuals who would otherwise be eligible under the State plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of the health plan capitation payment, subject to an enrollment fee equal to the spend-down liability.

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

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

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

5. Home and Community-Based Services (HCBS). Expenditures to provide HCBS not included in the Medicaid State plan and furnished to QUEST Integration enrollees, as follows:

a) Expenditures for the provision of services, through health plans, that could be provided under the authority of Section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

b) Expenditures for the provision of services, through health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, *i.e.*, the "at risk" population.

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

C. Title XIX Requirements Not Applicable to Demonstration Populations

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

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

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

X. Public Notice

A. The State's Public Notice and Input Efforts

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

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

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

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

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

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

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

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

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

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

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

Hilo, Hawaii

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

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

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

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

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

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

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

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

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

Commenters raised the following issues regarding the draft application:

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

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

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

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

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

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

C. Tribal Consultation

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

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

D. The Post-Award Public Input Process

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

XI. Demonstration Administration

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Med-QUEST Division, PPDO
Telephone: (808) 692-8134
Email: nmoon-ng@medicaid.dhs.state.hi.us.

Attachment A

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

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

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

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

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

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

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

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

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

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

Attachment B

Hawaii QUEST Expanded
Section 1115 Demonstration Waiver

Interim Demonstration Evaluation Report

September 5, 2012

Demonstration Year Ending: June 30, 2012

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Executive Summary

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

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

  Effective February 1, 2009, the majority of the fee-for-service (FFS) population was transitioned into managed care in the QUEST Expanded Access (QExA) program. The Medicaid population in QExA consists of beneficiaries 65 years or older or with a disability of any age. The QExA program has two health plans: 'Ohana Health Plan and UnitedHealthcare Community Plan. As of June 30, 2012, the QExA program has approximately 45,000 beneficiaries. The QExA health plans provide a continuum of services to include primary, acute care, standard behavioral health, and long-term care services. The goals of the QExA program are:
  - Improve the health status of the member population;
  - Establish a "provider home" for members through the use of assigned primary care providers (PCPs);
  - Establish contractual accountability among the State, the health plan and healthcare providers;
  - Expand and strengthen a sense of member responsibility and promote independence and choice among members;
  - Assure access to high quality, cost-effective care that is provided, whenever possible, in a member's home and/or community;
  - Coordinate care for the members across the benefit continuum, including primary, acute and long-term care benefits;
  - Provide home and community based services (HCBS) to persons with neurotrauma;
  - Develop a program that is fiscally predictable, stable and sustainable over time; and
  - Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals.

- **Reprocurement of the QUEST program.**

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

  In the new procurement, MQD added or expanded on several new initiatives. These include:
  - Value-based purchasing (e.g., patient centered medical homes and accountable care organizations);
  - Financial incentives for improving quality to their members;

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

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

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

- **Implementation of revised Quality Strategy.**
  MQD implemented a new Quality Strategy in 2010 after receiving approval from CMS. As part of the implementation of the Quality Strategy, MQD has:
  - Increased health plan monitoring;
  - Standardized health plan reporting; and
  - Implemented public reporting of health plan quality results.

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

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

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

Information about the Demonstration

Overview and Brief History of the Demonstration

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

QUEST is a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Assistance Program and its innovative State Health Insurance Program and offered benefits to citizens up to 300 percent FPL. Low-income women and children and adults who had been covered by the two State-only programs were enrolled into fully capitated managed care plans throughout the State. This program virtually closed the coverage gap in the State.

The QUEST program covered adults with incomes at or below 100 percent of the federal poverty level (FPL) and uninsured children with family incomes at or below 200 percent FPL. In addition, the QUEST-Net program provided a full Medicaid benefit for children with family incomes above 200, but not exceeding 300 percent FPL and a limited benefit package for adults with incomes at or below 300 percent FPL. In order to be eligible for QUEST-Net, individuals must first have been enrolled in QUEST or Medicaid fee-for-service and may enroll in QUEST-Net when their income or assets rise above the QUEST or Medicaid fee-for-service eligibility limits. QUEST eligibles who are self-employed were previously assessed a premium. These individuals were allowed to opt for QUEST-Net as a source of insurance coverage.

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

As a condition of the 2007 renewal the State was required to achieve compliance with the August 17, 2007, CMS State Health Official (SHO) letter that mandated by August 16, 2008, the State must meet the specific crowd-out prevention strategies for new title XXI eligibles above 250 percent of the Federal poverty level (FPL) for which the State seeks Federal Financial Participation (FFP). On March 30, 2009 the State requested that this provision be removed from the STCs. The State's request was a result of Public Law 111-3 The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), and the issuance of a Presidential memorandum t to the Secretary of Health and Human services to withdraw the August 17, 2007 SHO letter. On February 6, 2009 the letter was withdrawn through SHO #09-001.

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

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

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

On July 7, 2011, Hawaii submitted an amendment proposal to reduce QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL, including the elimination of the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. On July 8, 2011, Hawaii filed a coordinating budget deficit certification, in accordance with CMS' February 25, 2011, State Medicaid Director's Letter. This certification was approved by CMS on September 22, 2011. This certification grants the State a time-limited non-application of the maintenance of effort provisions in section 1902(gg) of the Act and provides the foundation for CMS to approve the State's amendment to reduce eligibility for non-pregnant, non-disabled adults with income above 133 percent of the FPL in both QUEST-Net and QUEST-ACE. On April 5, 2012, CMS approved an amendment which reduced the QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL and eliminated the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL.

In the July 7, 2011 amendment, Hawaii also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the Demonstration; eliminate the QUEST enrollment limit for childless adults; provide QUEST Expanded Access (QExA) individuals with expanded primary and acute care benefits; remove the Hawaii Premium Plus program, a premium assistance program, due to a lack of Legislative appropriation to continue the program, and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

Population Groups Impacted

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

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

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

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

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

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

Purpose, aims, objectives, and goals of the demonstration

Goals and Objectives of the Demonstration

The goals and objectives of the demonstration include:

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

Hypotheses on the Outcomes of the Demonstration

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

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

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

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

- Comprehensive Diabetes Care (CDC):

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

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

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

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

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

  - Increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<130/80) to meet/exceed the 2010 HEDIS 75th percentile.

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

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

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

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

- Emergency Department Visits (AMB): Improve performance on the state aggregate HEDIS 2010 Emergency Department Visits/1000 rate to meet/fall below the HEDIS 10th percentile.

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

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

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

- Home and Community Based Service (HCBS) clients: Increase by 5% the proportion of clients receiving HCBS instead of institutional-based long-term care services over the next year.

Key Interventions Planned

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

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

Evaluation Design

Management and Coordination of Evaluation

Organization Conducting the Evaluation

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

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

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

Timeline for Implementation of the Evaluation and for Deliverables

Summary of Timeline for Annual Quality Activities

Time Frame	Activity
March	Mail CAHPS surveys to Medicaid beneficiaries
April/May	Health plan site visit by MQD and EQRO to gather HEDIS data from previous year
May	Close CAHPS surveys to Medicaid beneficiaries
June	Preliminary HEDIS results due to EQRO
July	Final HEDIS results released by EQRO to MQD
July	EQRO releases preliminary CAHPS star report to MQD
September	EQRO releases final CAHPS star report to MQD
October	Analysis of health plan HEDIS results to NCQA quality compass (i.e., compare to 75th and 90th results for Medicaid populations)
November	Develop consumer guides for QUEST and QExA health plans Note: the consumer guide is a summary of several HEDIS measures and CAHPS survey results for health plans in both the QUEST and QExA programs that is provided to the public
December	Release of the following items for public reporting: • EQRO annual report • QUEST Consumer Guide • QExA Consumer Guide

Summary of Timeline for Biennial Quality Activities

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

Summary of Timeline for Annual Deliverables

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

Summary of Timeline for Compilation of Demonstration Evaluation Report

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

Performance Metrics

Summary of Performance Metrics

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

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

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

(@) Unlike the other measures, for this measure higher numeric scores are considered negative and lower numeric scores are considered positive. Accordingly, the targets for the HEDIS measures represent the score for the national Medicaid 10th %ile, NOT the score for the 75th %ile.
(*) This numerator changed from BP <130/80 to BP < 140/80 in HEDIS 2011.

Population Groups of Enrollees for which Data will be Analyzed

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

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

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

A determination will be made if unexpected or expected factors are influencing the calculated values. These factors could be internal to DHS, specific to a plan's operations, or external at a state or national level. Either way, there will be a discussion on how we believe these factors are exerting influence on the values.

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

Integration of the State Quality Improvement Strategy

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

MQD's continuing goal is to ensure that our clients receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. MQD has adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. An initial set of ambulatory care measures based on this framework was identified. HEDIS measures that the health plans report

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

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

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

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

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

Measures

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

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

HEDIS Measures

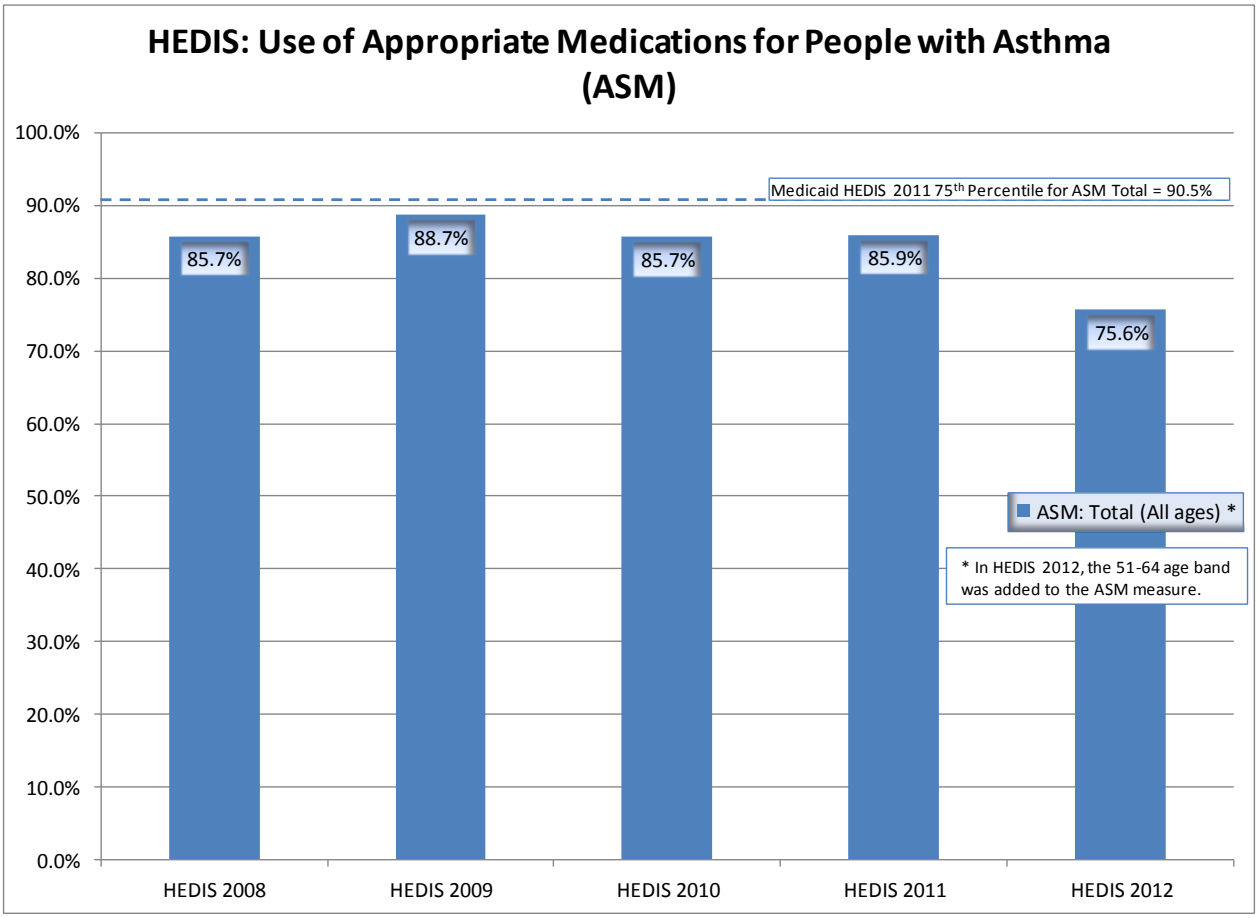
The Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure both the quality of healthcare delivered to, as well as the overall healthcare utilization levels of, the Hawaii QUEST and QExA recipients.

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

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

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

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



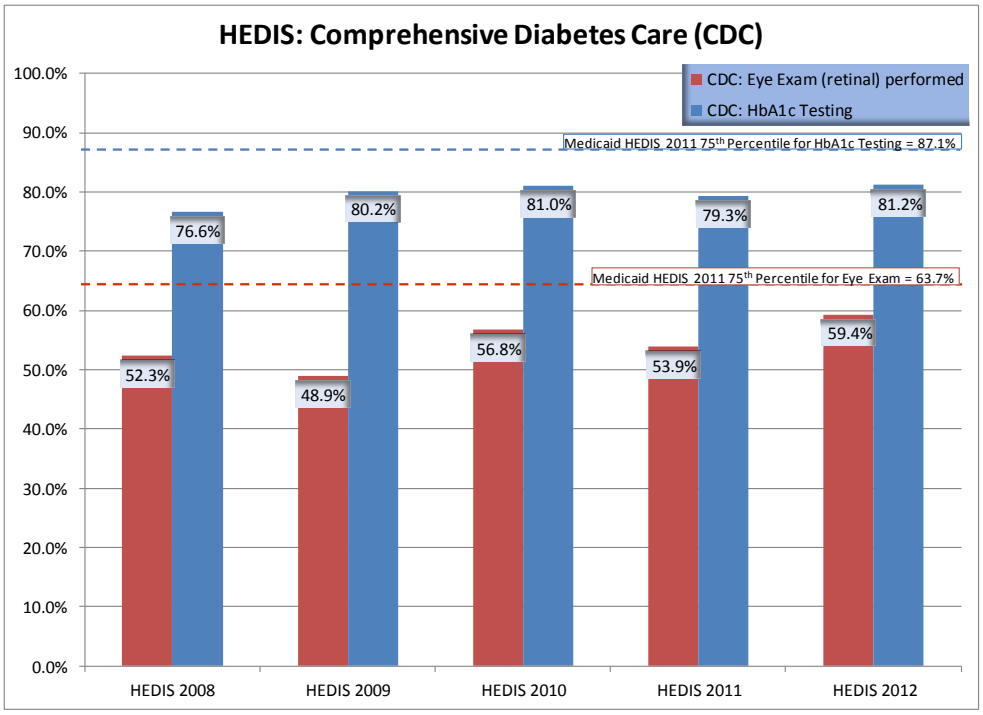
ASM:

- The statewide Medicaid percentage of members 5-64 years of age identified as having persistent asthma and who appropriately prescribed medication has varied between 75% and 89% from 2008 to 2012, with the highest rate of 88.7% occurring in 2009 and the lowest rate of 75.6% occurring in 2012. Note that although the 51-64 year of age group was added in 2012, removing this age group would not have increased the 2012 score past 76.0%.

- The 2012 year's score fell significantly from the previous four-year range between 85% and 88%, clearly falling out of the historical trend for this measure on the negative side.

- The HI Quality Strategy target percentage for the ASM measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 90.5%, which was better than all of the years reported.

CDC – Eye Exam:



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

- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.

- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 63.7%, which was better than all of the years reported.

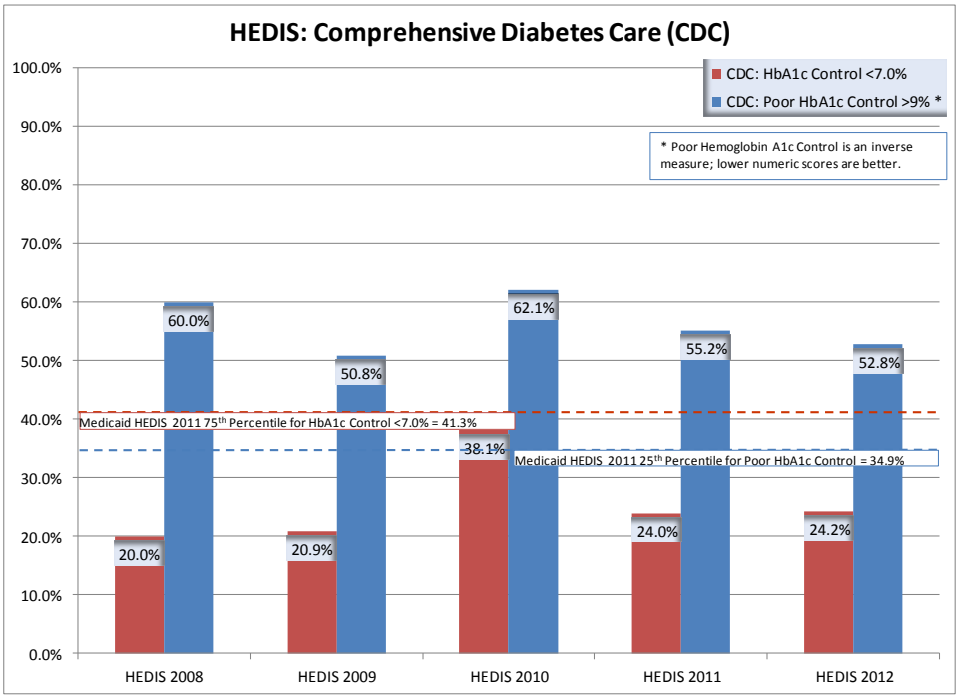
CDC – HbA1c Testing:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an HbA1c test performed varied between 76% and 82% from 2008 to 2012, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.

- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.

- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 87.1%, which is above all of the years reported.

CDC – HbA1c Control <7.0%:



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

- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the earliest year (2008) reported the lowest rate. There is what seems like an outlier score in 2010 of 38.1%, especially when considering the four other years' scores were bunched between 20.0% and 24.2%

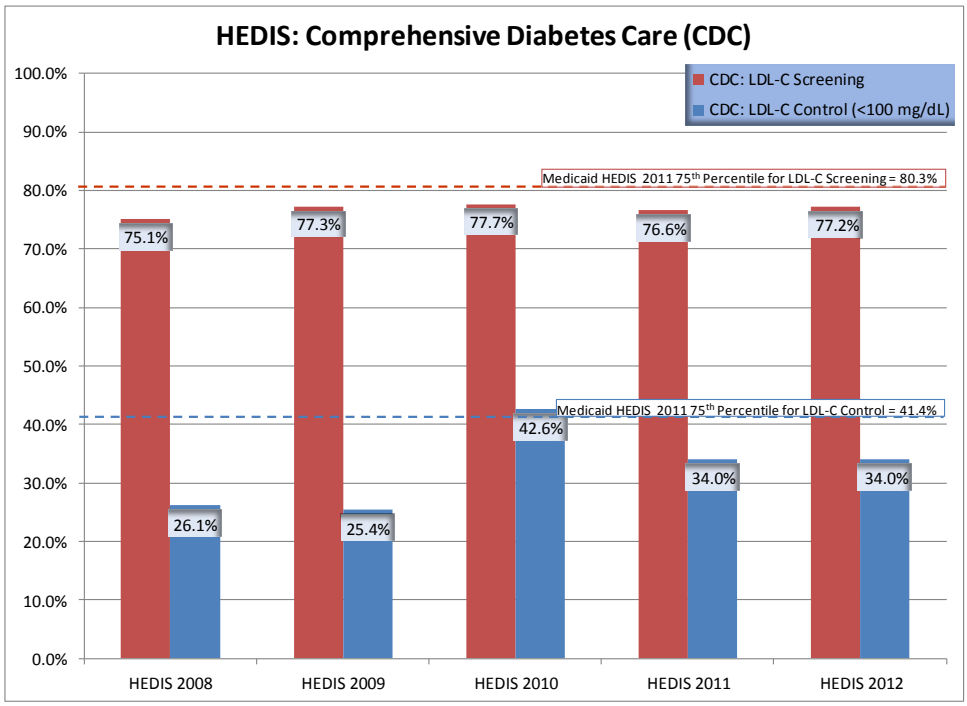
- The HI Quality Strategy target percentage for the CDC – HbA1c Control <7.0% measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 41.3%, which is above all of the years reported.

CDC – HbA1c Poor Control >9.0%:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control varied between 63% and 50% from 2008 to 2012, with the highest rate of 62.1% occurring in 2010 and the lowest rate of 50.8% occurring in 2009. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.

- There is a slight downtrend (good) to flat trend in the rates of the five years reported. The last three years' score went from 62.1% to 55.2% to 52.8%, yet the lowest score occurred in 2009 (50.8%).

- The HI Quality Strategy target percentage for the CDC – HbA1c Poor Control >9.0% measure is the 25th percentile of the national Medicaid population. For the 2011 this target was 34.9%, which is below (not good) all of the years reported.



CDC – LDL-C Screening:

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

- There is a flat trend (no trend) in the rates of the five years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).

- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 80.3%, which is higher than all of the years reported.

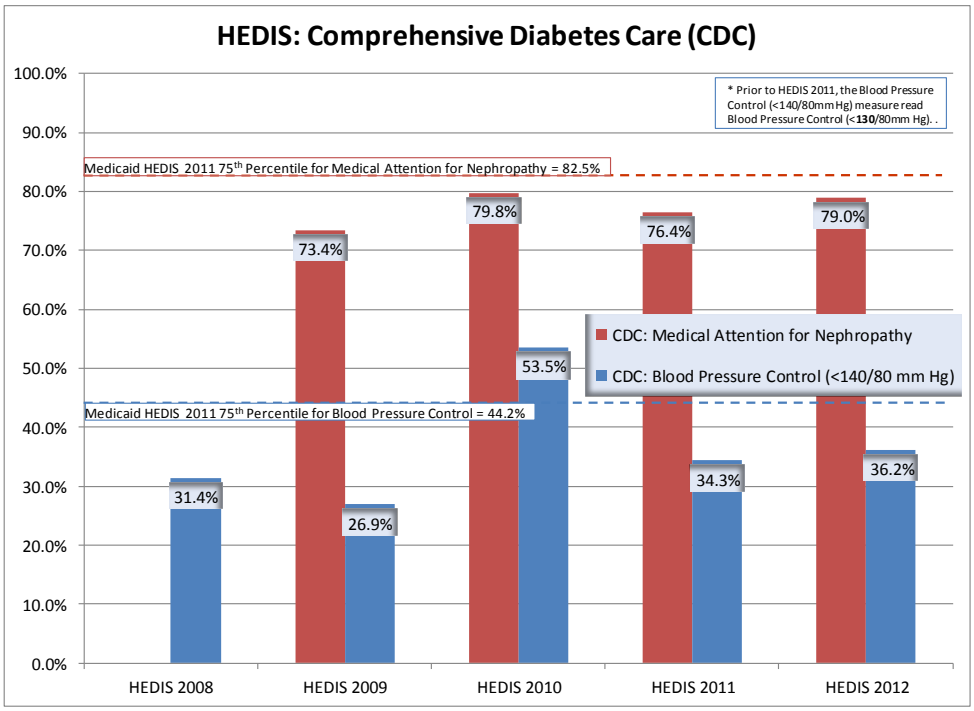
CDC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had LDL-C under control varied between 25% and 43% from 2008 to 2012, with the highest rate of 42.6% occurring in 2010 and the lowest rate of 25.4% occurring in 2009.

- There is a flat trend (no trend) in the rates of the five years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).

- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 80.3%, which is higher than all of the years reported.

CDC – Medical Attention for Nephropathy:



- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had medical attention for nephropathy varied between 73% and 80% from 2009 to 2012, with the highest rate of 79.8% occurring in 2010 and the lowest rate of 73.4% occurring in 2009. Note that this was a new measure in 2009.

- There is a slight up trend in the rates of the four years reported. The lowest rate was reported in the first year (2009), and the latest year reported (2012) had a rate (79.0%) not much lower than the 79.8% in 2010.

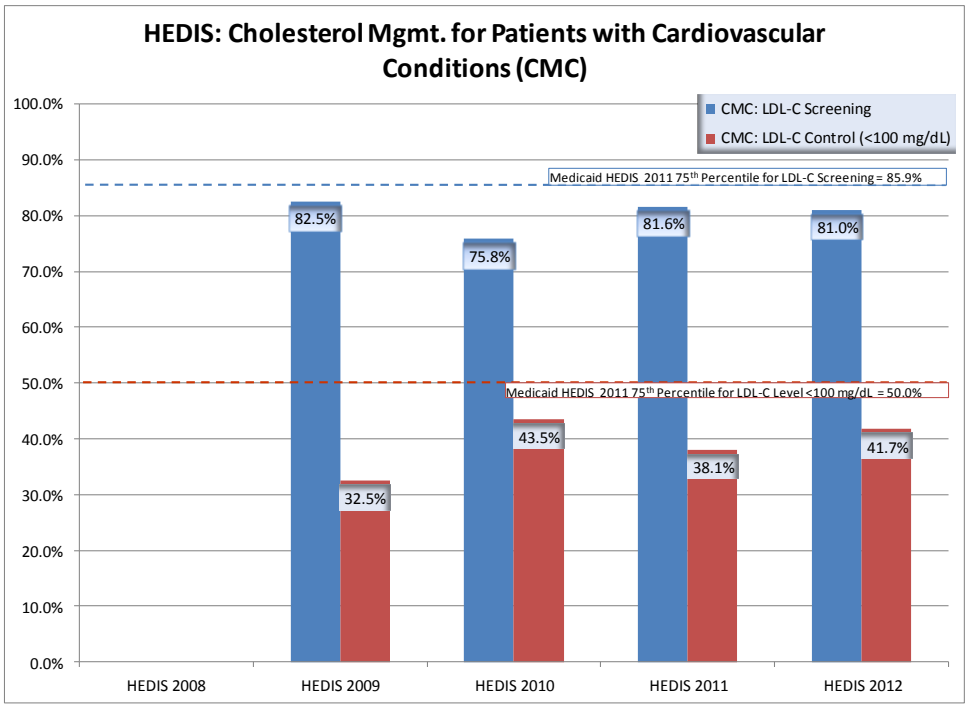
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 this target was 82.5%, which is higher than all of the years reported.

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

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had blood pressure under control below <140/80 mm Hg varied between 26% and 54% from 2008 to 2012, with the highest rate of 53.5% occurring in 2010 and the lowest rate of 26.9% occurring in 2009.

- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010 (which looks like an outlier), the highest two scores were in 2011 (34.3%) and 2012 (36.2%).

- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 44.2%, which is higher than all of the years reported except for in 2010.



CMC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had an LDL-C screening performed varied between 75% and 82% from 2009 to 2012, with the highest rate of 82.5% occurring in 2009 and the lowest rate of 75.8% occurring in 2010. Note that the first year for this measure is 2009.

- There is a flat trend (no trend) in the rates of the four years reported. The highest rate was reported in the first year (2009), the lowest rate occurred in the second year (2010), and the remaining two years' scores fell between these.

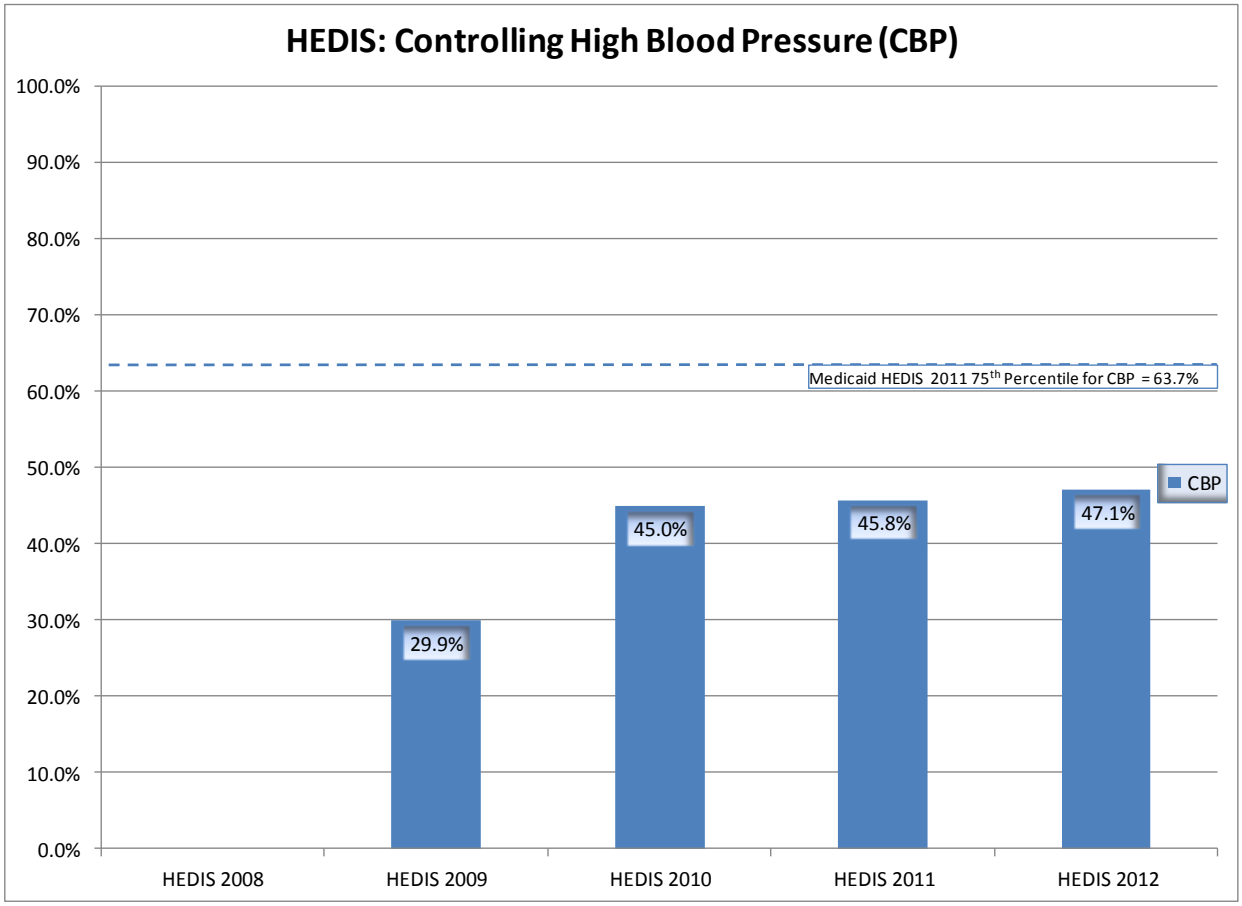
- The HI Quality Strategy target percentage for the CMC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 85.9%, which is higher than all of the years reported.

CMC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had LDL-C under control varied between 32% and 43% from 2009 to 2012, with the highest rate of 43.5% occurring in 2010 and the lowest rate of 32.5% occurring in 2009. Note that the first year for this measure is 2009.

- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010, the highest two scores were in 2011 (38.1%) and 2012 (41.7%).

- The HI Quality Strategy target percentage for the CMC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 50.0%, which is higher than all of the years reported.

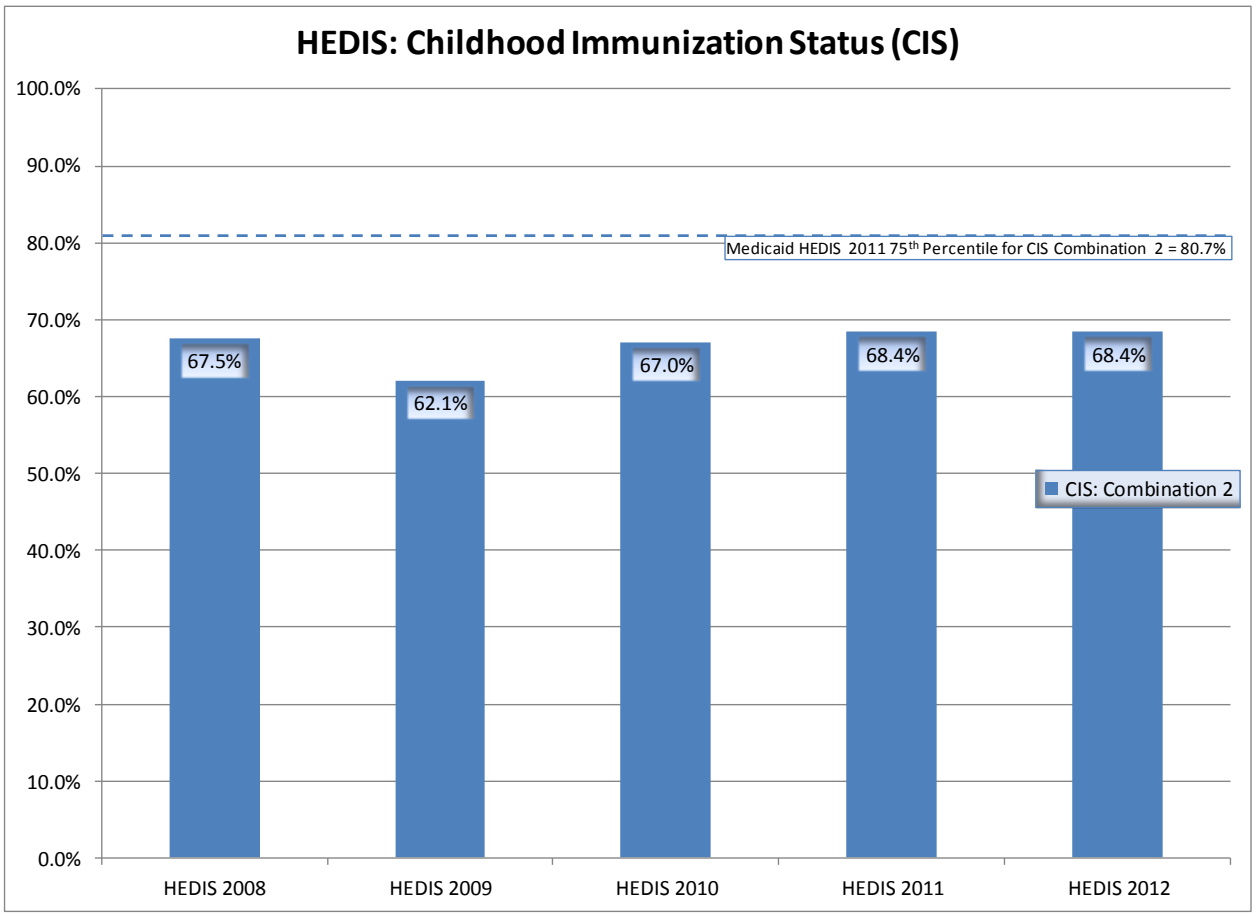


CBP:

- The statewide Medicaid percentage of members 18-85 years of age who had a diagnoses of hypertension and whose blood pressure was under control varied between 29% and 48% from 2009 to 2012, with the highest rate of 47.1% occurring in 2012 and the lowest rate of 29.9% occurring in 2009. Note that the first year for this measure is 2009.

- There is a clear up trend in the rates of the five years reported. From 2009 thru 2012, each subsequent year's score is higher than the last.

- The HI Quality Strategy target percentage for the CBP Control measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 63.7%, which is higher than all of the years reported.

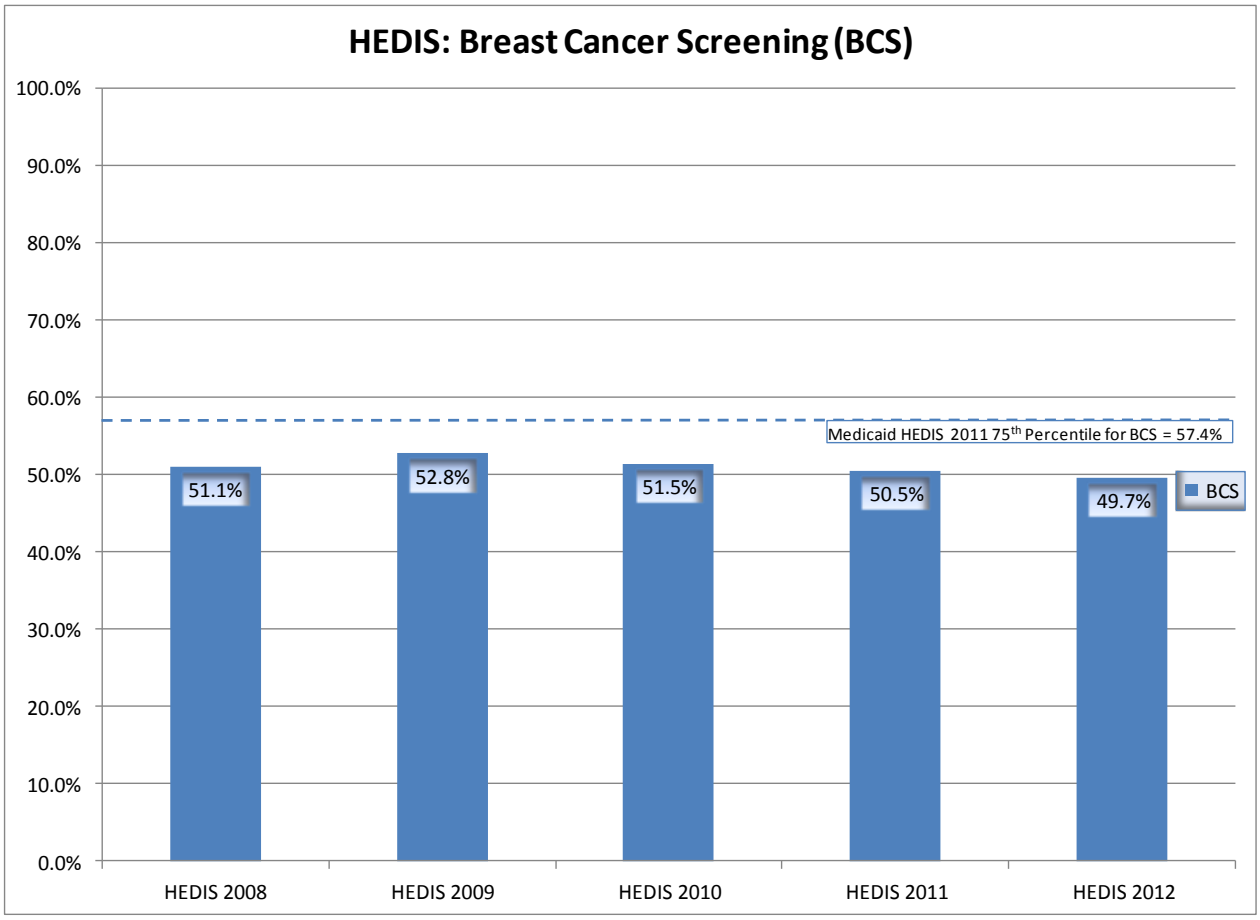


CIS:

- The statewide Medicaid percentage of children 2 years of age who, by their second birthday, had received the entire suite of Combination 2 vaccines (4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB & 1 VZV) varied between 62% and 69% from 2008 to 2012, with the highest rate of 68.4% occurring in 2011 & 2012 and the lowest rate of 62.1% occurring in 2009.

- There is a slight up trend in the rates of the five years reported. Excluding the 2008 rate, the rates increased from 2009 to 2012 by 4.1 percentage points with not yearly decreases.

- The HI Quality Strategy target percentage for the CIS measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 80.7%, which is higher than all of the years reported.

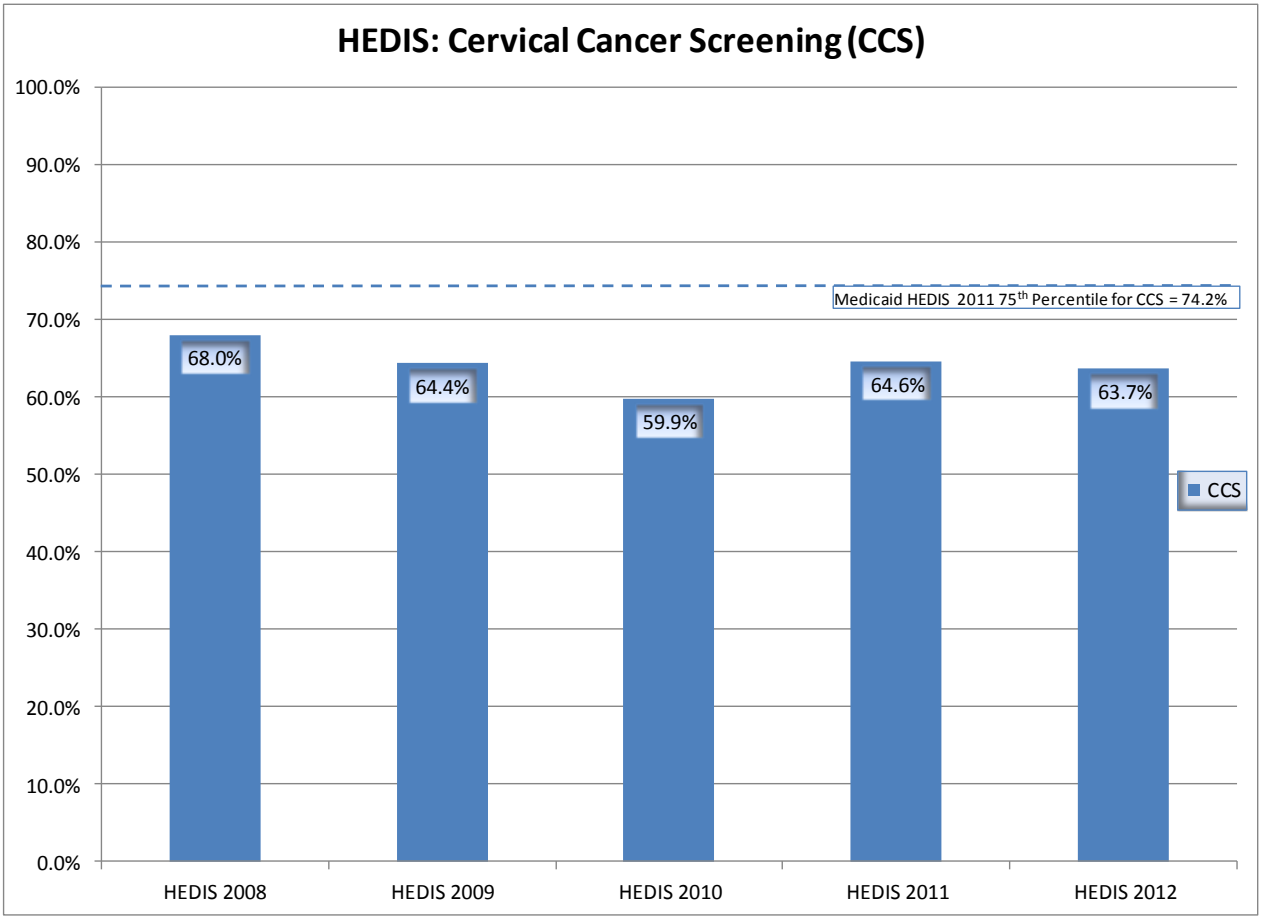


BCS:

- The statewide Medicaid percentage of women 40 - 69 years of age who had a mammogram to screen for breast cancer varied between 49% and 53% from 2008 to 2012, with the highest rate of 52.8% occurring in 2009 and the lowest rate of 49.7% occurring in 2012.

- There is a clear down trend in the rates of the five years reported. Removing the 2008 score, the rates go consistently down approximately 1% per year from 52.8% (2009) to 49.7% (2012).

- The HI Quality Strategy target percentage for the BCS measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 57.4%, which is higher than all of the years reported.

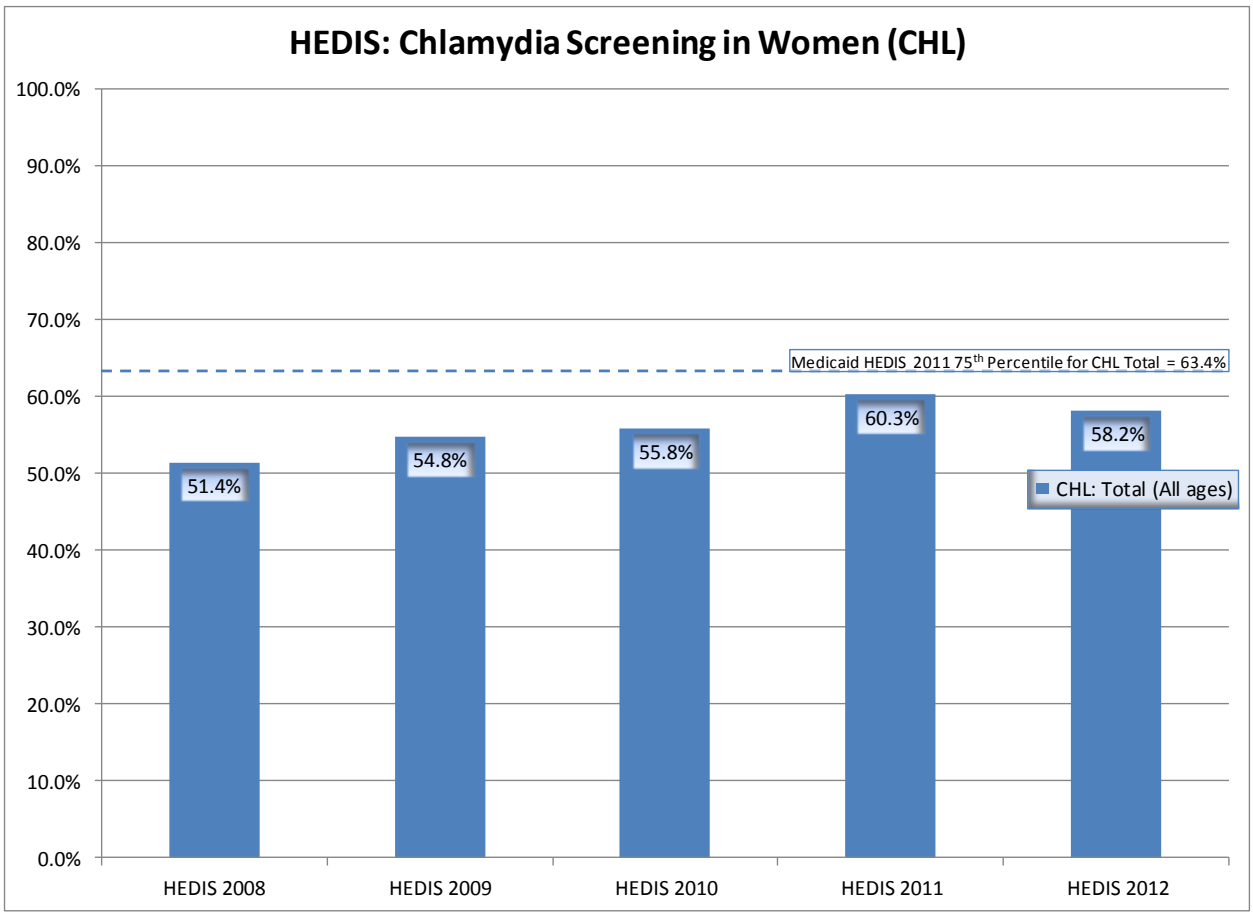


CCS:

- The statewide Medicaid percentage of women 21 - 64 years of age who received one or more Pap tests to screen for cervical cancer varied between 59% and 68% from 2008 to 2012, with the highest rate of 68.0% occurring in 2008 and the lowest rate of 59.9% occurring in 2010.

- There is a slight down trend in the rates of the five years reported. Removing the middle 2010 score, the highest rate (68.0%) is in 2008 and the lowest rate (63.7%) is in 2012.

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 74.2%, which is higher than all of the years reported.

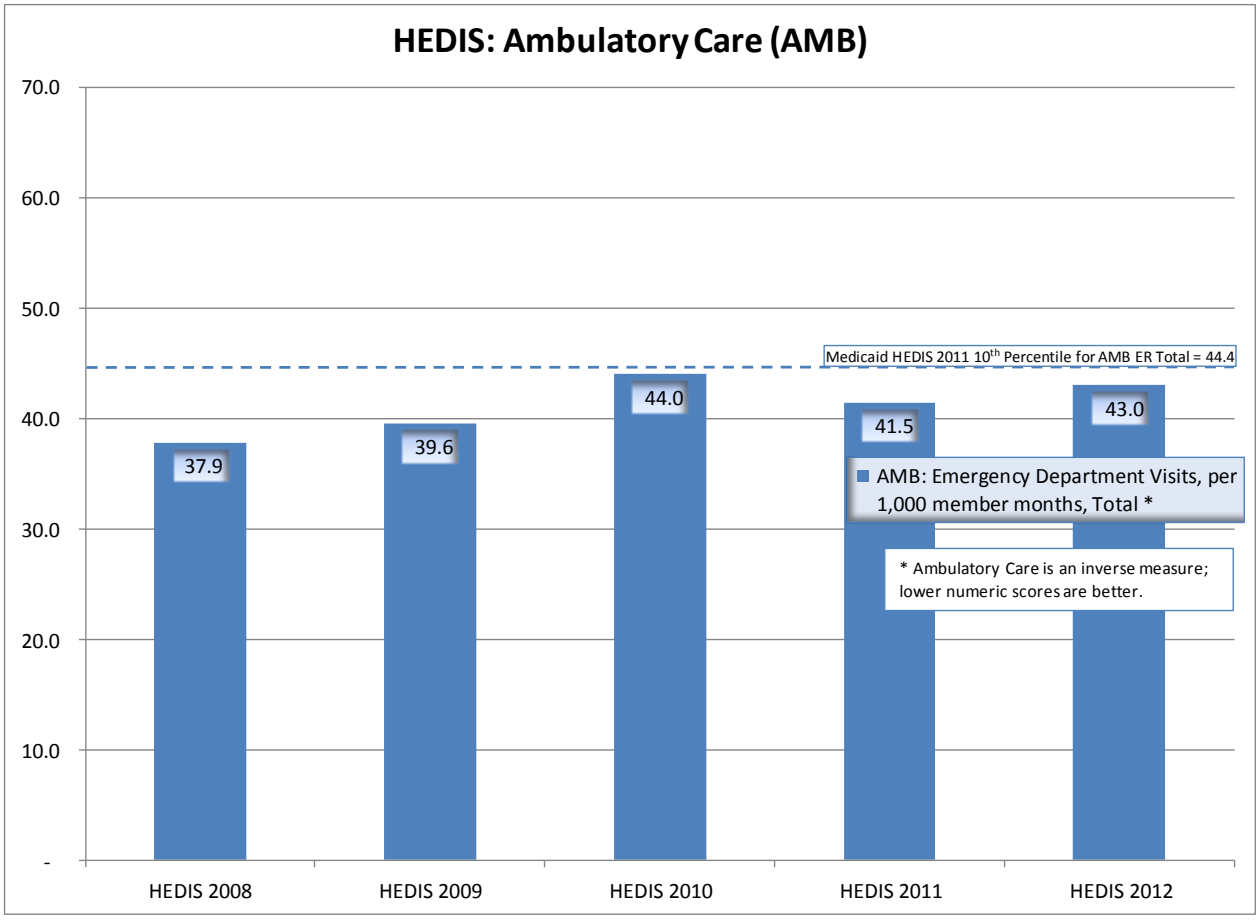


CHL:

- The statewide Medicaid percentage of women 16 - 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year varied between 51% and 61% from 2008 to 2012, with the highest rate of 60.3% occurring in 2011 and the lowest rate of 51.4% occurring in 2008.

- There is a clear up trend in the rates of the five years reported. Removing the most recent score, the lowest rate (51.4%) is in 2008 and the highest rate (60.3%) is in 2011.

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 63.4%, which is higher than all of the years reported.



AMB:

- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 37.0 and 44.0 from 2008 to 2012, with the highest rate of 44.0 occurring in 2010 and the lowest rate of 37.9 occurring in 2008. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.

- There is a clear up trend (bad) in the rates of the five years reported. Putting aside the high rate in 2010, the lowest rate (37.9) occurred in 2008, and the highest rate (43.0) occurred in 2012.

- The HI Quality Strategy target percentage for the CCS measure is the 10th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 44.4, which is higher (good) than all of the years reported.

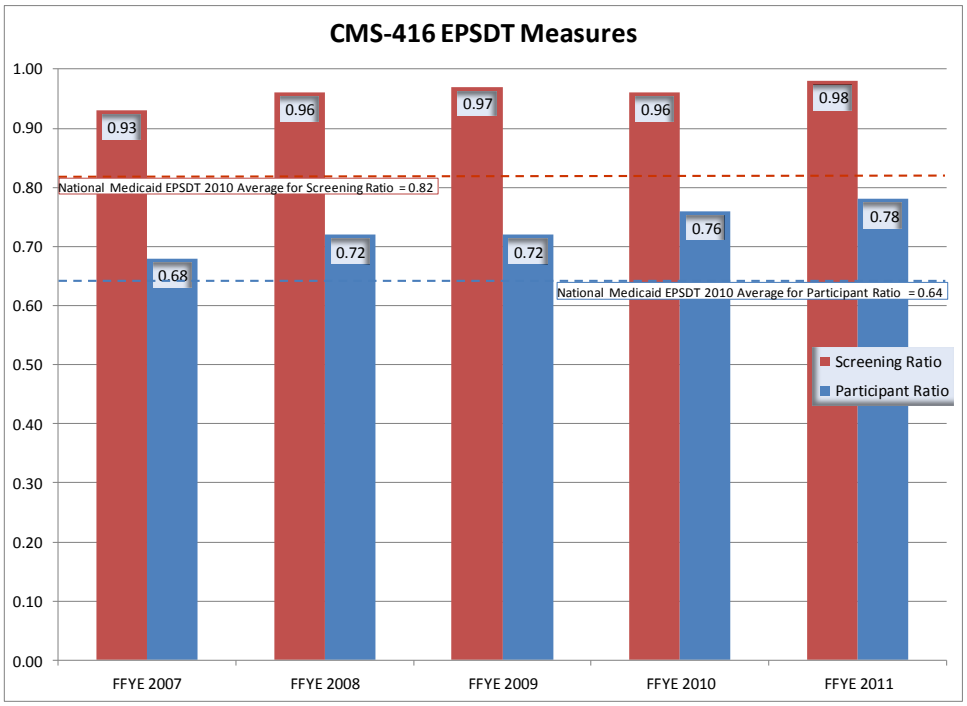
EPSDT Measures

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

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

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

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



EPSDT – Screening Ratio:

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

- There is a clear up trend in the rates of the five years reported. The lowest rate of 0.93 was reported in the first year (2007), and the highest rate of 0.98 was reported in the last year (2011), with a mostly steady uptrend in between.

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

EPSDT – Participant Ratio:

- The statewide Medicaid participant ratio from the EPSDT report varied between a high of 0.78 occurring in 2011 and the lowest rate of 0.68 occurring in 2007.

- There is a clear up trend in the rates of the five years reported. Each year's score was at least equal to, and more often greater than, the previous year's score, ending in a high of 0.78 in 2011.

- The MQD quality strategy has no benchmark for the EPSDT Participant Ratio. For comparison purposes in 2010 – the latest reported year – then national average is 0.64, which is lower than all of the years reported.

CAHPS Measures

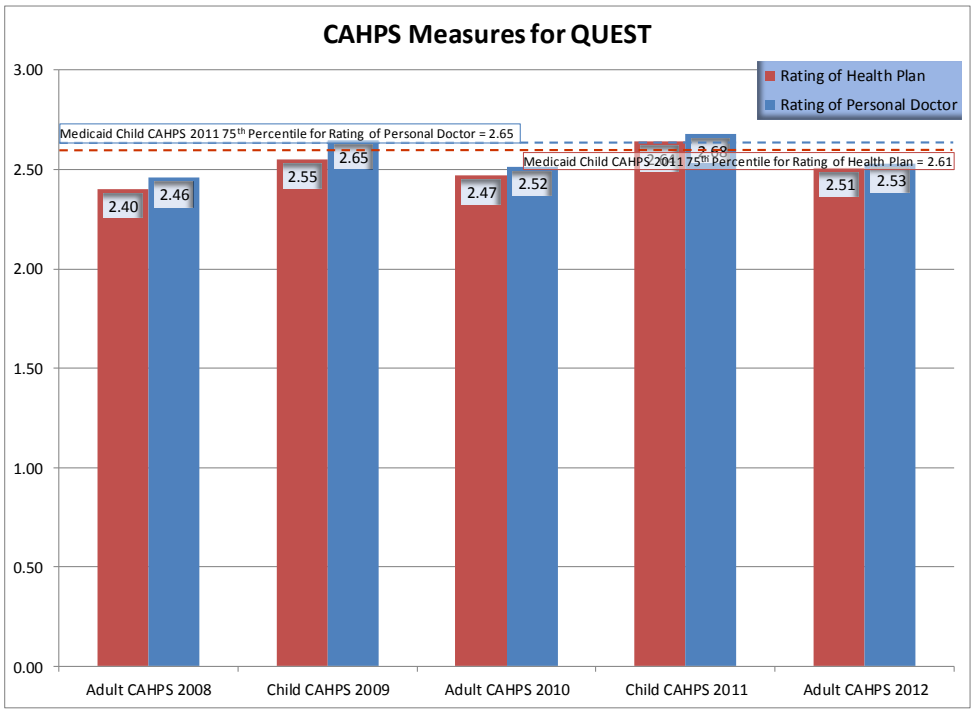
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are included in this report to measure the degree of recipient satisfaction with Hawaii Med-QUEST.

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

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

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

CAHPS for QUEST – Rating of Health Plan:



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

- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.40 to 2.47 to 2.51. The Child years show a similar pattern, moving from 2.55 to 2.64.

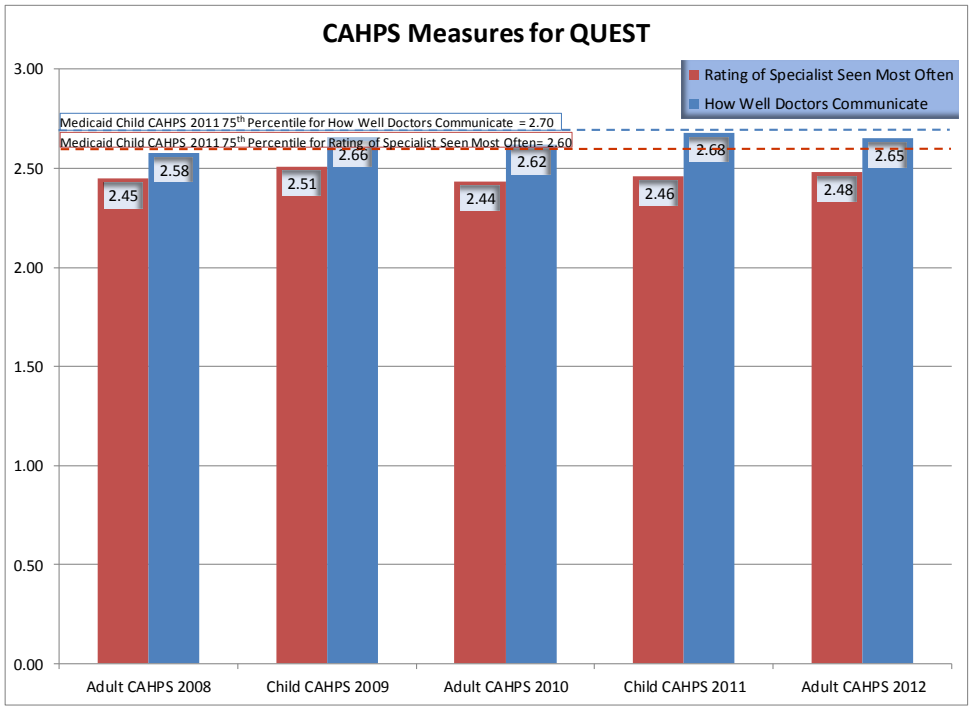
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.61, which was exceeded by the 2.64 rate reported in 2011.

CAHPS for QUEST – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.46 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.46 to 2.52 to 2.53. The Child years show a similar pattern, moving from 2.65 to 2.68.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was exceeded by the 2.68 rate reported in 2011.



CAHPS for QUEST – Rating of Specialist Seen Most Often:

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

- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move slightly up from 2.45 to 2.44 to 2.48. The Child years show a down pattern, moving from 2.51 to 2.46.

- The HI Quality Strategy target percentage for the CAHPS Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.60, which was higher than all of the reported year.

- Improving the QUEST scores for CAHPS – Rating of Specialist Seen Most Often have involved: 1) Emphasizing telemedicine as an option for neighbor island clients seeking specialist services, 2) Increasing the frequency of specialists visits to neighbor islands, and 3) Implementing communication programs for physicians focused on skill building in the area of dealing with challenging situations.

CAHPS for QUEST – How Well Doctors Communicate:

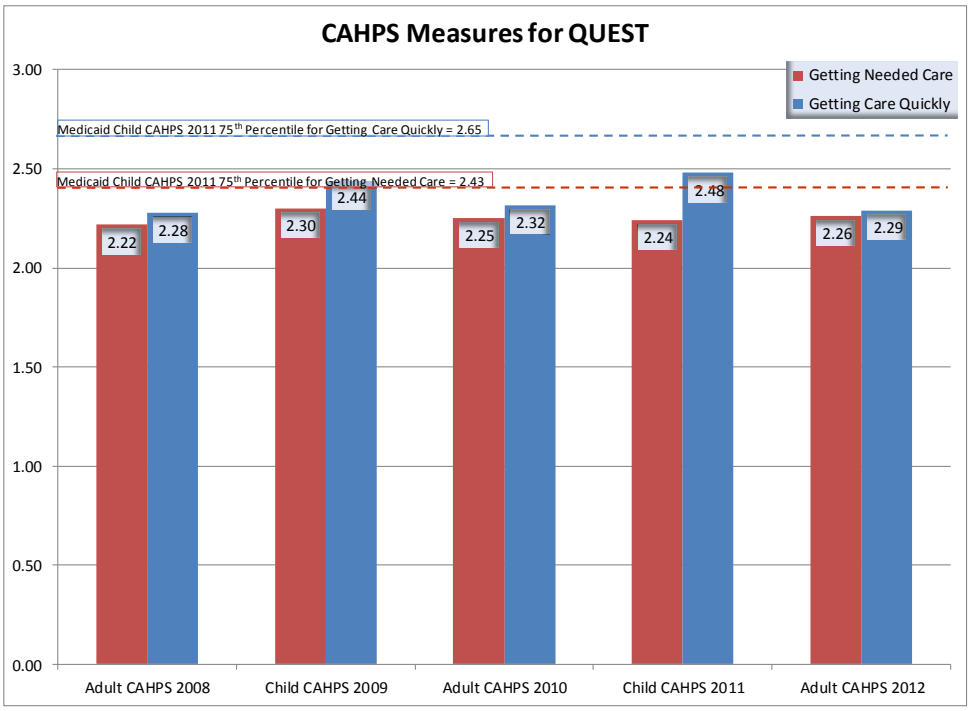
- The statewide CAHPS – How Well Doctors Communicate for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.58 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.58 to 2.62 to 2.65. The Child years show a similar pattern, moving from 2.66 to 2.68.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.70, which was higher than all of the reported year.

- The QUEST plans have taken the following step to improve the CAHPS – How Well Doctors Communicate rates: 1) Improving the care coordination and communication between member and the primary care team.

CAHPS for QUEST – Getting Needed Care:



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

- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move slightly up from 2.22 to 2.25 to 2.26. The Child years show a down pattern, moving from 2.30 to 2.24.

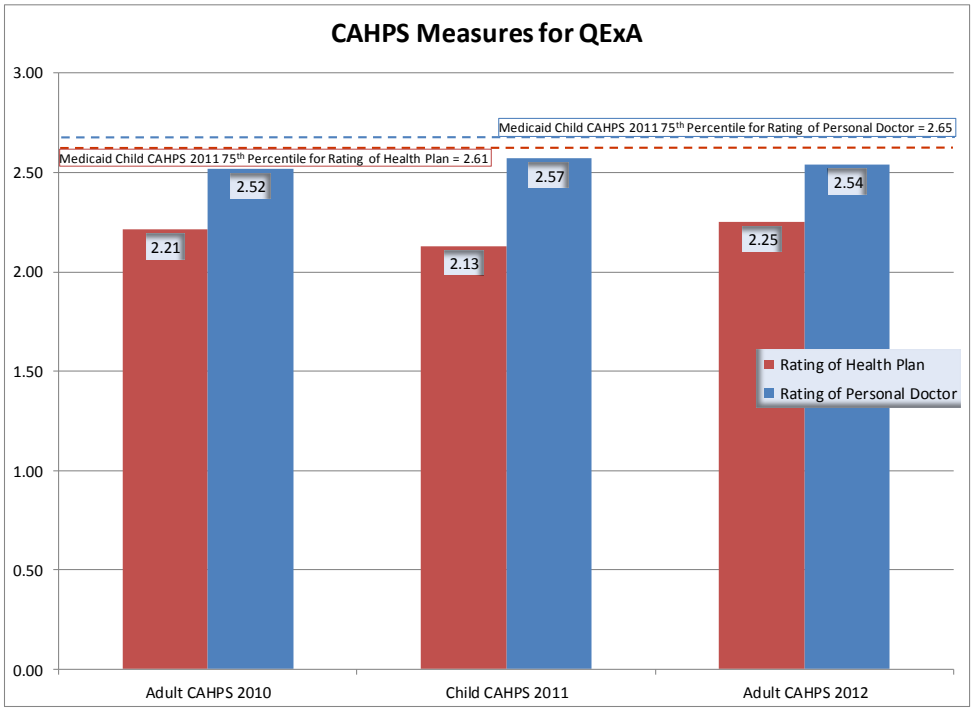
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.43, which was higher than all of the reported year.

CAHPS for QUEST – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QUEST population varied between a high rate of 2.48 occurring in 2011 and the lowest rate of 2.28 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move sideways from 2.28 to 2.32 to 2.29. The Child years show an up trend, moving from 2.44 to 2.48.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported year



CAHPS for QExA – Rating of Health Plan:

- The statewide CAHPS – Rating of Health Plan for the QExA population varied between a high rate of 2.25 occurring in 2012 and the lowest rate of 2.13 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child. Also note that the QExA program began in February 2009, which limits the number of data points.

- There is a flat trend in the rates of the three years reported. The low point in 2011 was the only data point for the Child population.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2011 year this target was 2.61, which was better than all reported rates.

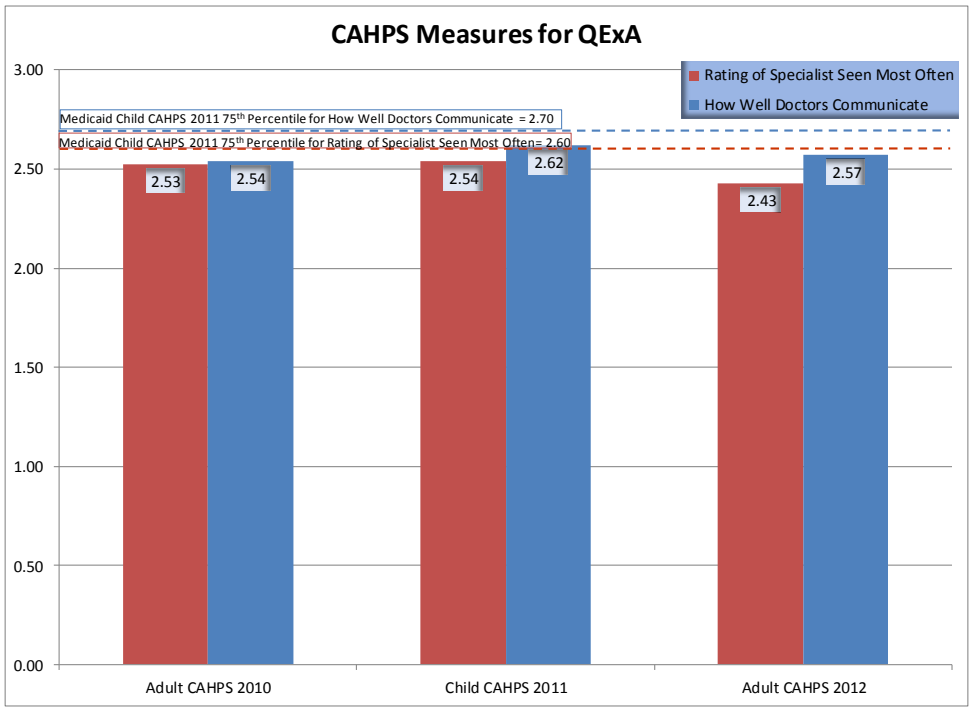
CAHPS for QExA – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QExA population varied between a high rate of 2.57 occurring in 2011 and a low rate of 2.52 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the three years reported. All years lie within a 0.05 point window.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported years' rates.

CAHPS for QExA – Rating of Specialist Seen Most Often:



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

- There is no clear trend in the rates of the three years reported.

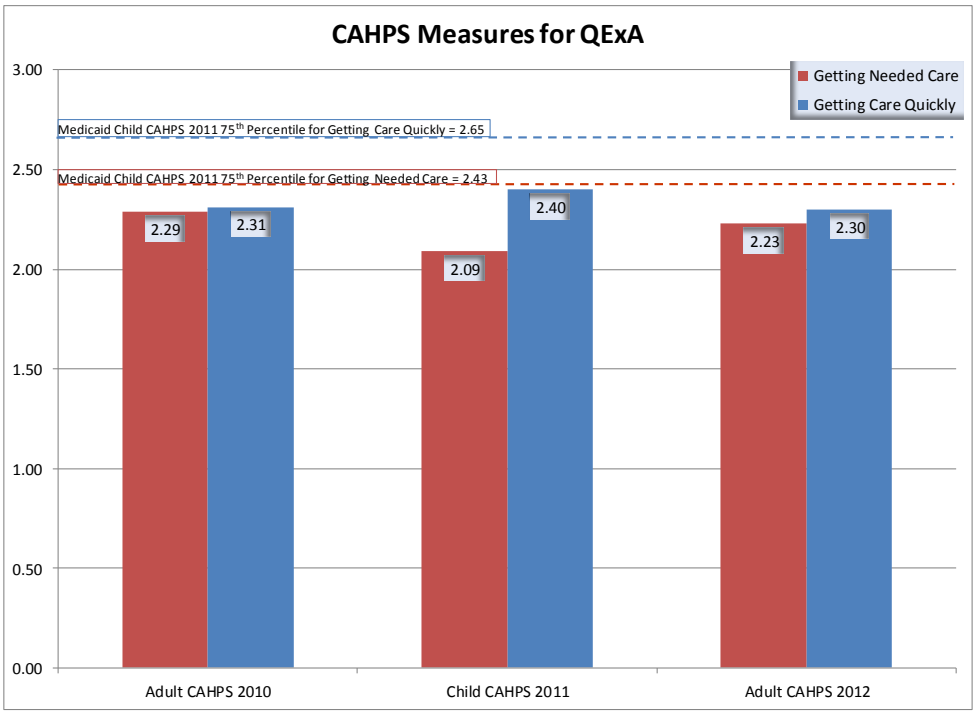
- The HI Quality Strategy target percentage for the CAHPS – Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.60, which was higher than all of the reported year.

CAHPS for QExA – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QExA population varied between a high rate of 2.62 occurring in 2011 and the lowest rate of 2.54 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no trend in the rates of the three years reported. Removing the Child year in 2011, the Adult score moves from 2.54 to 2.57 from 2010 to 2012.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.70, which was higher than all of the reported year.



CAHPS for QExA – Getting Needed Care:

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

- There is no clear trend in the rates of the three years reported.

- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.43, which was above each of the reported years.

CAHPS for QExA – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QExA population varied between a high rate of 2.40 occurring in 2011 and the lowest rate of 2.30 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the three years reported.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported year.

Physicians' Assessment Measures

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

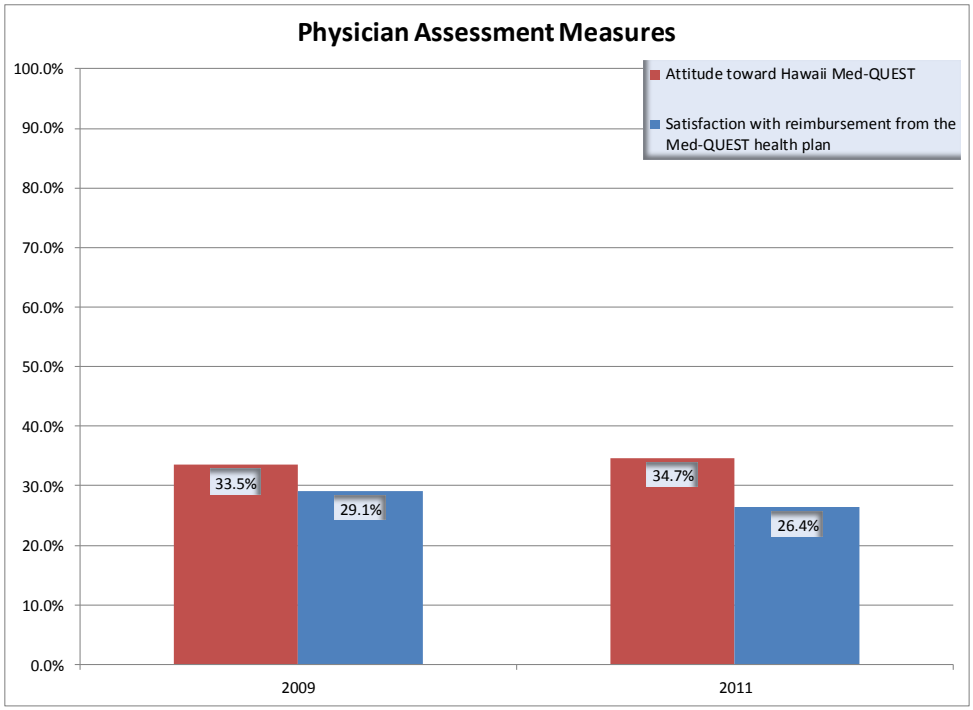
The Physician Assessment measures are based on surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The scores are based on clean responses from a survey of randomly selected PCPs and high-volume specialties, and are expressed as percentage scores. The overall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

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

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

Physician Assessment – Attitude Toward Hawaii Med-QUEST:

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



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

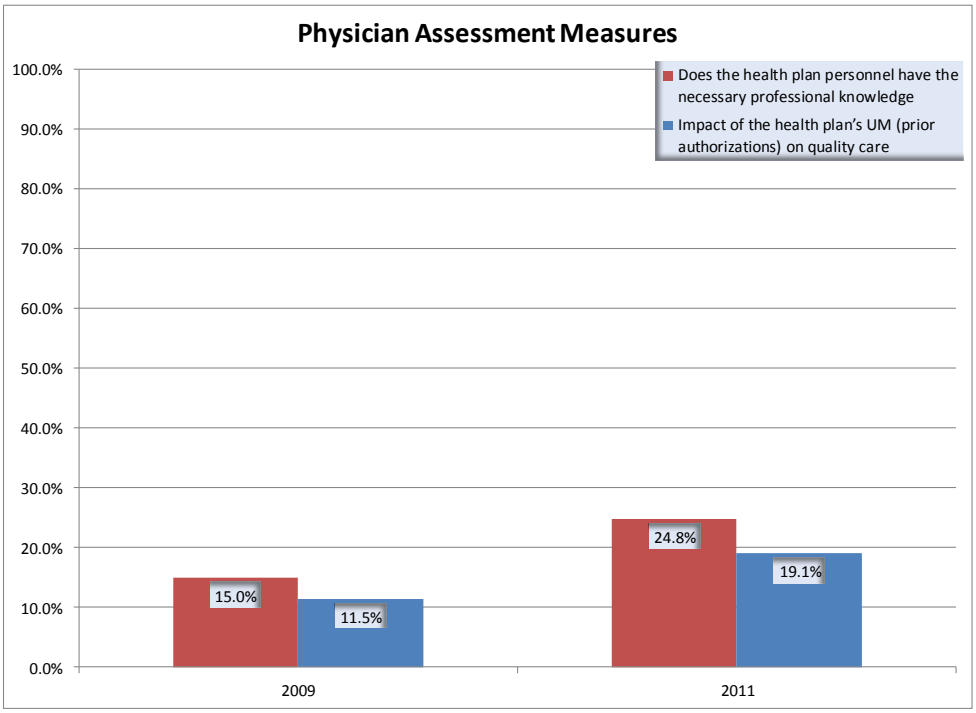
- There are no National average percentages available for the Physician Assessment Measures.

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

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

Physician Assessment – Necessary Professional Knowledge:

- The statewide Physician Assessment – Necessary Professional Knowledge went from 15.0% in 2009 to 24.8% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.



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

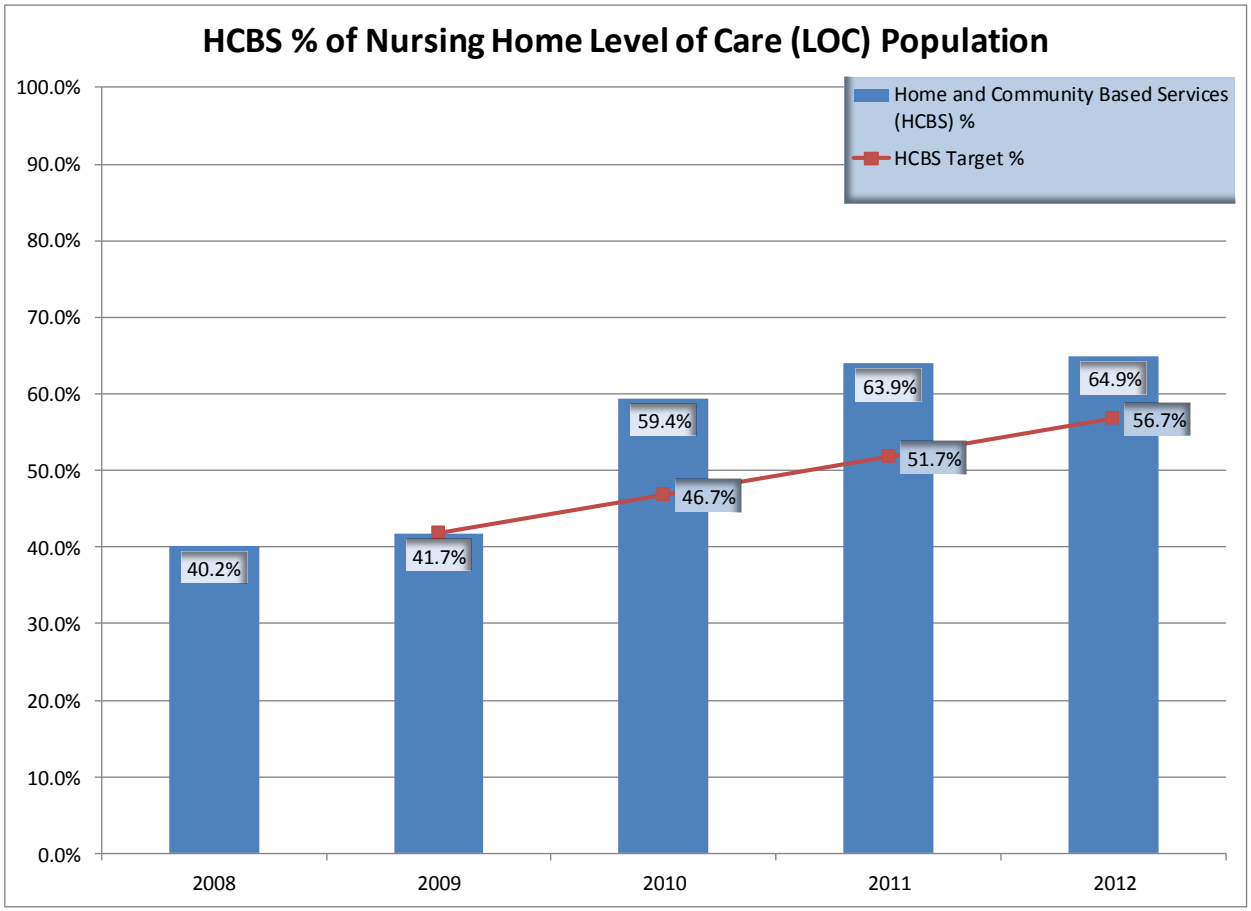
- The statewide Physician Assessment – Impact of the health plan's UM went from 11.5% in 2009 down to 19.1% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

Med-QUEST Internal Measures

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

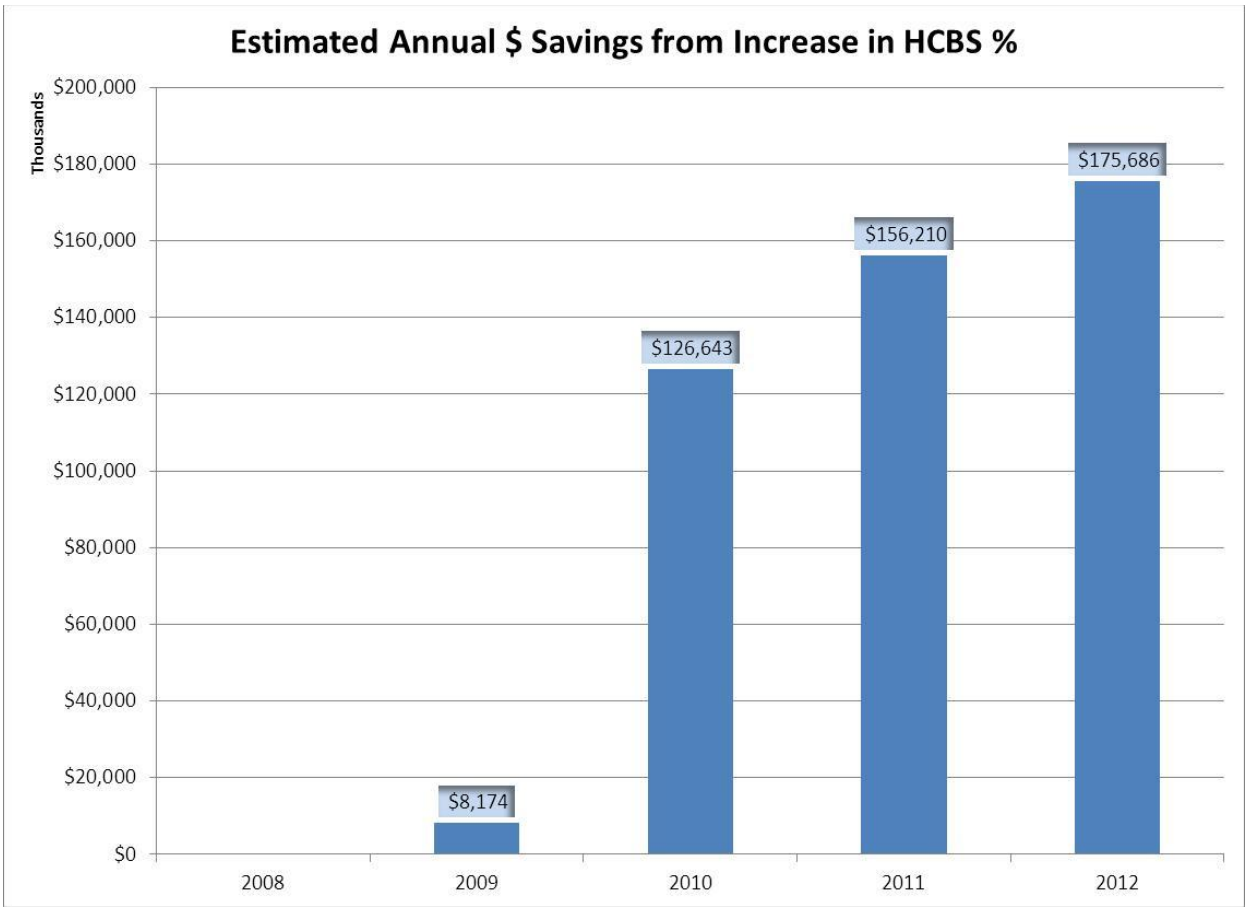
The QUEST Expanded Access (QExA) program began February 1, 2009 and moved aged, blind, and disabled. One of the goals of QExA was to increase the percentage of nursing home level of care (LOC) clients in Home and Community Based Services (HCBS) provided to nursing home level of care (LOC) clients is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

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



HCBS % of Nursing Home LOC Population:

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

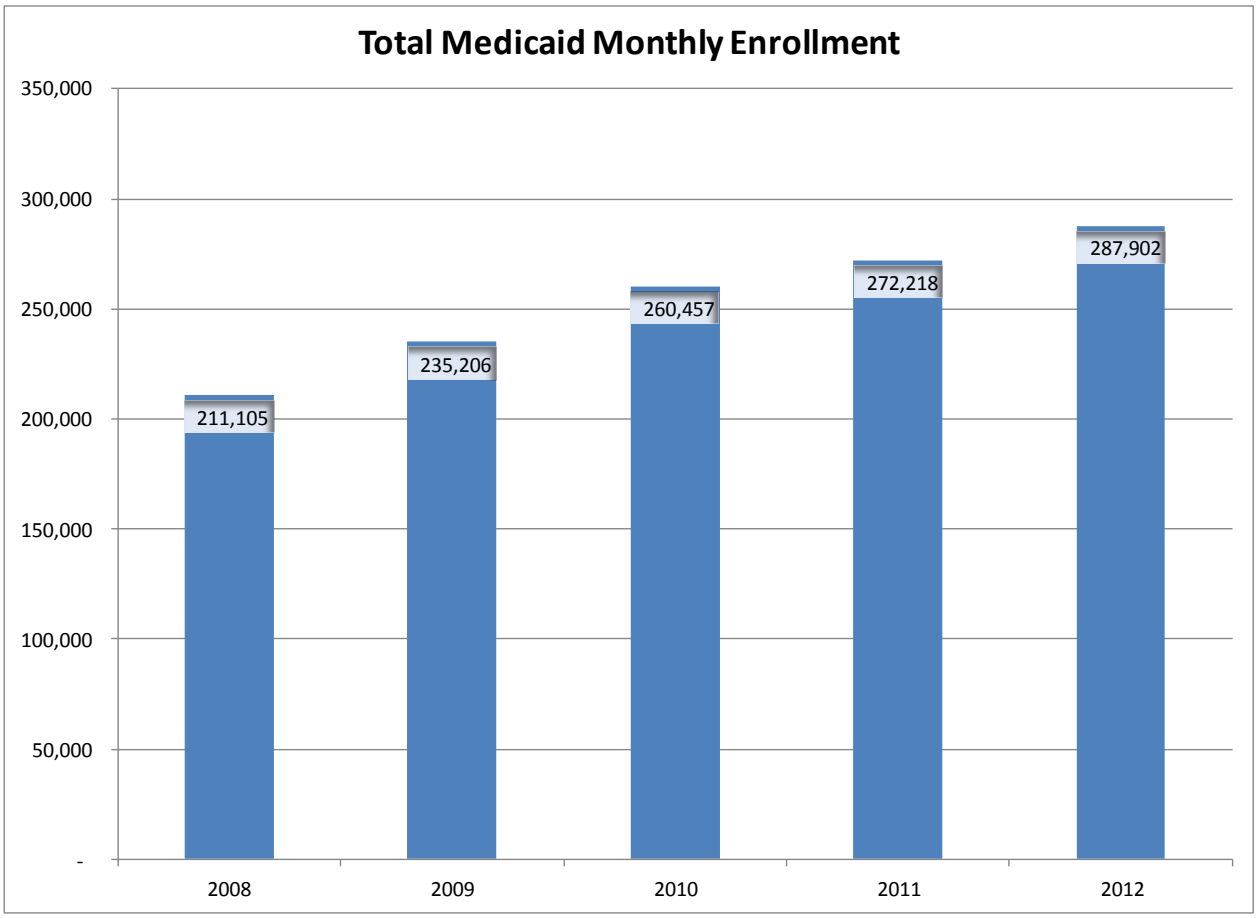


Estimated Annual $ Savings from Increase in HCBS %:

- The statewide Estimated Annual $ Savings from Increase in HCBS % went from $8,174,000 in 2009 to $175,686,000 in 2012. The 2011 actual differential in $ pmpm cost between institutional care and HCBS care is $6,194.86, and this was used in the calculation of cost savings.

- Following the clear upward trend in the HCBS %, there is a corresponding cumulative increase in the dollars saved from this transition to HCBS.

- There is no National average available for dollars saved based on the move to HCBS.



Total Medicaid Monthly Enrollment:

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

Budget Neutrality Savings

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

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

QUEST Expanded Member Months

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

Expenditures for QUEST-ACE Program

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

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

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

Recent Initiatives on Measures

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

HEDIS Initiatives

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

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

Comprehensive Diabetes Care (CDC) Initiatives:

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

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

- Distributing periodic newsletters with diabetes articles and updates.

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

- Provided education to member and provider to increase awareness of cholesterol management and the importance of medication compliance.

- Implemented reminder systems for members who have had cardiovascular condition. These reminder systems may be in various forms, including postcards phone calls, or e-mails.

    - One health plan initiated process management improvements by identifying patients discharged for MI or CVA/TIA for referral for lipid management and partner with the cardiology department to help identify and refer CVD patients for HTN/lipid management.

    - One health plan implemented a "Hospital to Home" care management program for those high-risk members who have been hospitalized in which a service coordinator conducts an assessment within 3 days of hospital discharge on the member's understanding of his/her disease and care management and the ability of the member to manage their care post-hospitalization. Interventions are applied as appropriate to the individual member's case.

Childhood Immunization Status (CIS) Initiatives:

- Provided physicians with a list of patients who are due or past due for routine immunizations so the physician can follow up with the patient.

- Established patient reminder and recall systems that include: 1) Postcard reminders, and 2) Telephone to non-responders for missed appointments and/or immunizations.

    - One plan has a unique alert system for the customer service representatives. When a member calls customer service for assistance, upon completion of assisting the member with their request, the alert system informs the customer service representative of an outstanding care gaps (non-compliant HEDIS measures) in which the member is overdue. The customer service representative briefly explains the care gap and offers to assist the member in making an appointment with his or her provider.

- Conducted regular assessments of immunization rates.

- One plan reports on the trends and performance: clinic level via the Keiki Score Card-Provider specific Level via the How Are we Doing Reports and conducts systems and process improvement recommendations for underperforming clinics.

- Implemented provider incentives and/or a comparison of performance to a goal or standard.
    - Several plans meet with providers regularly to provide them with their HEDIS reports and discuss their progress.

- Implemented mechanisms to collect and report the data in a supplemental database so that immunizations that are provided without a claim being submitted to the plan can still be tracked and reported.

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

- Implemented reminder systems that inform patients of upcoming mammogram, cervical cancer screening appoints and eligible females who have not received a screening for Chlamydia in the recommended time frame.

- Reduced barriers that may be preventing the patient from receiving a mammogram.
    - One health plan reports success with their Mobile Health Vehicle and plans to expand this service in 2012 to include diagnostic breast imaging in addition to screening mammography
    - One health plan is trialing evening outreach for pap appointments and focusing pap clinics in areas with highest screening needs.

- Improved the capture of screenings for members who have been screened.
    - One plan executed contract amendments with the two main laboratories in Hawaii to assure lab results' supplemental data are obtained for those performance measures which require a result determination.
    - One plan receives supplemental data from an FQHC that does not submit claims to the health plan for Chlamydia screening. The health plan obtains a list of members who have received a screening as well as a sample of the Electronic Health Records for primary source verification, which is then reviewed by an auditor for compliance. This supplemental data had a positive impact on the 2011 HEDIS rate as there was an increase of 10% in the number of members receiving a Chlamydia test during the measurement year for the QUEST population.

Ambulatory Care (AMB) Initiatives:

- Implemented education of members on appropriate ER use.

- One health plan provided intervention for high utilizers with active case management by clinicians and case managers. Case managers assigned to these members directed them to appropriate care, ensuring that the patient has an assigned PCP, identified any barriers in care, reason for frequent visits to the ER and provided education on appropriate use of the ER.

- One health plan has Disease Management staff address care gaps during the assessment process and follow-up calls, in addition to supporting and reminding members of the importance of complying with disease management recommendations.

CMS-416 EPSDT Measures Initiatives

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

CAHPS (QUEST & QExA) Initiatives

Rating of Health Plan & Rating of Personal Doctor Initiatives:

- Utilized online and technology assets to outreach to members.

    - One plan launched a new Health & Wellness section on its website, along with notifying member of this new section.

    - One plan updated their secure member portal, to add functionality to include ordering and printing ID cards, change PCPs, and update demographic information.

- Used face-to-face meetings to assess and evaluate the membership experience with the health plan.

    - One plan conducted member educations sessions on various health topics as well as emphasizing the need to communicate with their doctors.

    - One plan conducted quarterly focus groups to gain a better understanding of the member needs, expectations and dissatisfactions.

- Utilized “hard copy” media to outreach to the member and increase member satisfaction with the health plans.

    - One plan sent out members-specific letters detailing preventive visits and screenings or tests that are coming due, as well as an explanation as to the necessity of these visits.

- One plan created and deployed a new set of documents for the Service Coordinators to share with the member that will improve their understanding of their benefits, and how the plan supports these benefits.

- Conducted an internal review of information flow to improve health plan responsiveness to member problems.
    - One plan recently improved its process to reimburse dual-eligible members for erroneously paid co-pays. Service coordinator and call center staff were re-trained to follow new protocols to speed the identification and reimbursement to the member. Provider education was provided on appropriate billing for dual-eligible members to prevent this from occurring in the first place.

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

- Utilized online and technology assets to outreach to provider to improve care delivery.
    - One plan made available members' HEDIS care gaps to providers via secure online content. Providers could then close these recommended care gaps with their members.

- Incentivized providers to improve care.
    - One plan offered $100 per member incentives to providers to complete care gaps for dual eligible members.

Getting Needed Care & Getting Care Quickly Initiatives:

- Utilized online and technology assets to improve the ability of members to connect to providers.
    - One plan streamlined the provider search functionality on their website.
    - One plan increased the update frequency of the online provider directories to daily.
    - One plan improved the online provider directory by adding hospital privileges, and increasing the update frequency to monthly.
    - One plan added online 'enter' and 'view' functionality for prior authorizations, admissions and referrals

- Reached out to members to gauge provider access and care delivery.
    - One plan conducted telephonic member surveys on access to provider care, and relaying these findings to providers during regular, periodic training visits.
    - One plan conducted ongoing member surveys to further gauge timely access to care.

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

Physicians' Assessment Initiatives

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

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

- One plan created a centralized email inbox to streamline provider inquiries to the health plan's provider relations department, including reimbursement and claim issues.

- Created internal advocacy for provider needs and interests.
    - One plan started a Provider Advisory Group within the Health Plan to take the provider's point of view, and to review new provider forms and programs.

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

- Improved the knowledge base of their employees through various training modalities.
    - One plan implemented an on-line learning system containing all staff training material, and pre- and post-testing, made available to all front-line staff.
    - One plan added training on appeals and grievance, benefits, authorization and utilization management to basic New Employee Orientation agendas.
    - One plan increased staff coaching and mentoring activities.
    - One plan conducted monthly knowledge quizzes to gauge whether additional training is needed.

- Initiated improvements to the prior authorization process.
    - One plan reviewed notification and prior authorization (PA) requirements, and eliminated PA requirements for many behavioral health services and cardiology services.
    - One plan added an online PA application to streamline the PA process.
    - One plan increased provider training and education related to the online PA process.
    - One plan distributed handouts on the PA process during periodic provider relations visits.
    - One plan conducted statewide provider workshops to educate providers on referrals and pre-certifications, and had follow-up Q&A opportunities post-workshop as well as through evaluation forms.
    - One plan analyzed the rate of PA approvals by specialty category, and for those categories with high approval rates removed the PA requirement for those services.
    - One plan reviewed the compliance to the health plan's clinical review criteria for selected providers, and eliminated the PA requirement where compliance was consistent.

Home and Community Based Services (HCBS) Initiatives

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

Hawaii Medicaid Enrollment Initiatives

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

Recommendations

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

1. Improve process for gathering information from providers

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

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

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

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

3. Increase the Pay for Performance withhold from health plans

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

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

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

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

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

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

5. Implement Health Plan Collaborative with EQRO

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

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

6. Revise and update Quality Strategy

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

Conclusion

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

Appendix A

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

Appendix B

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

Attachment C

HAWAII MED-QUEST QUALITY STRATEGY 2010

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- Guiding Principles
- History of Managed Care
- Quality Strategy Development
- Quality Strategy Implementation
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    - External Quality Review (EQR) activities and technical report
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- State Standards and Contract Compliance
    - Access to Care
    - Structure and Operations
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- Monitoring and Evaluation
    - Monitoring and Quality Improvement Flow Process
    - Sources for Monitoring and Quality Improvement
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    - HCBS Monitoring and Quality Improvement
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7. Deeming Strategy and Crosswalk

I. QUALITY STRATEGY INTRODUCTION AND OVERVIEW

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

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

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

MISSION

The Quality Strategy supports the Mission of the MQD, which is:
To be a leader for improving the health status of Hawaii residents and to ensure that those eligible for Med-QUEST programs have access to and receive coordinated and comprehensive high quality care.

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

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

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

GUIDING PRINCIPLES

The MQD's quality approach aspires to the following:

Collaborative Partnerships

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

Patient-Centered Medical Home

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

Transparency

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

Data Driven

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

Quality Based Purchasing

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

HISTORY OF MANAGED CARE

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

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

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

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

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

QUALITY STRATEGY DEVELOPMENT

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

EQRO Input

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

Client and Provider Input

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

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

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

QUALITY STRATEGY IMPLEMENTATION

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

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

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

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

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

Figure 1: Quality Flow Process Diagram:

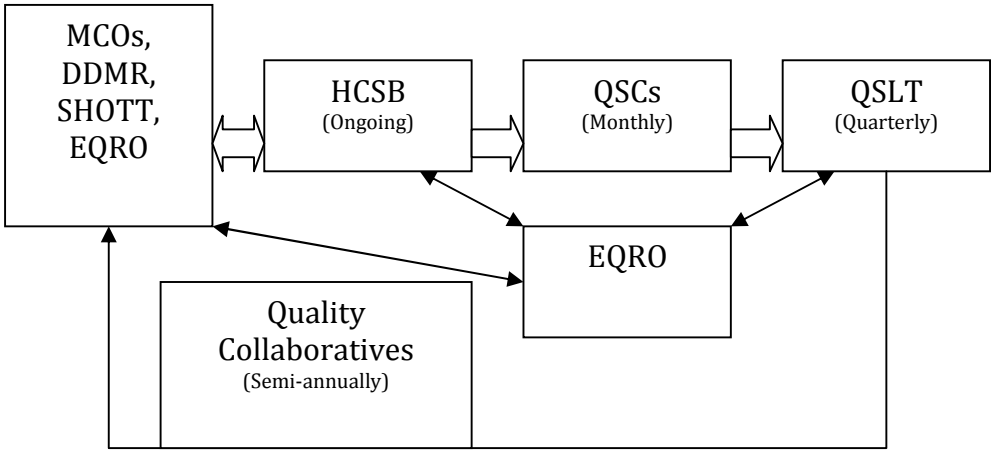


Table 1: Summary of the Quality Strategy Oversight:

Entities	Membership	Responsibilities
Quality Strategy Leadership Team (QSLT)	• MQD leadership from several MQD branches and offices • MQD Medical Director • EQRO consultant as needed	• Lead the development, review, and revision of Quality Strategy. • Oversight for review of quality data and monitoring reports • Oversight for quality improvement recommendations and implementation of these recommendations by MCOs and programs. • Meets quarterly and more often as needed. • Meets semi-annually in Collaboratives with MCOs and programs.
Quality Strategy Committees (QSC)	• QSLT representative • MQD technical expert(s) • MQD HCBS reviewer(s)	• Committees may include: QUEST/QExA compliance, QUEST/QExA ambulatory care quality, HCBS, Long-term Care, Inpatient Care, Mental Health • Review of quality data and monitoring reports from MCOs, programs, and EQRO. • Recommendations for corrective actions, quality improvement, and system changes. • Follow-up of corrective actions and quality improvement recommendations. • Meets in a monthly rotation.
Quality Collaboratives	• QSLT representative(s) • MQD technical expert(s) • MCO or program representative(s) • EQRO consultant	• Serves as forum between MQD and MCOs/programs for dialogue, feedback, follow-up of corrective action, PIPs, best practices.

Table 2: MQD Quality Flow Process Calendar of Events

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

Legend:

QSC	Quality Strategy Committee	QLST	Quality Strategy Leadership Team

GOALS AND OBJECTIVES

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

Goal 1: Improve preventive care for women and children

Objectives:

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

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

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

Goal 2: Improve care for chronic illness

Objectives:

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

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

Goal 3: Improve client satisfaction with health plan services

Objectives:

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

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

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

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

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

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

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

II. ASSESSMENT

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

QUALITY AND APPROPRIATENESS OF CARE

Race, Ethnicity, and Primary Language

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

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

Table 3: Race Codes and Categories

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

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

Table 4: Primary Language Codes

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

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

External Quality Review (EQR) Activities and Report

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

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

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

The EQRO is responsible to perform mandatory and optional activities as described in 42 CFR 438.358. Mandatory activities for each MCO include: a) validation of performance improvement projects; b) validation of performance measures reported as required by the State of Hawaii; and c) a review, conducted within the previous 3-year period, to determine compliance with standards established by the State with regards to access to care, structure and operations, and quality measurement and improvement. Optional activities as required by the State of Hawaii have included: a) administration of the CAHPS Consumer Survey; b) administration of a provider satisfaction survey; c) encounter data validation; and c) provision of technical assistance to the MCOs to assist in conducting activities related to the EQR activities.

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

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

Clinical Standards and Guidelines

The MQD uses clinical guidelines to guide its policy development. Guidelines are adapted or adopted from national professional organizations, such as the United States Preventive Services Task Force (USPSTF) for screening recommendations, the Centers for Disease Control/American Committee on Immunization Practices for immunization recommendations, the Public Health Service Clinical Practice Guidelines for tobacco cessation guidelines, and the American Academy of

Pediatrics/Bright Futures for Early Periodic Screening Diagnostic and Treatment (EPSDT) periodicity of screening and diagnostic testing.

At the same time, MQD requires contracted MCOs to adopt practice guidelines consistent with 42 CFR 438.6(h) and 422.208, which are relevant to MCO membership, based on valid and reliable clinical evidence, adopted in consultation with network providers, reviewed and updated regularly, and disseminated to all affected providers and upon request to members or potential members. MQD requires the MCOs to develop at least three clinical guidelines for medical conditions and at least 2 for behavioral health conditions. These may include asthma, diabetes, high risk pregnancy, depression, and attention deficit hyperactivity disorder, among others.

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

Performance Measures

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

Table 5: Selected HEDIS Performance Measures for 2009

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

STATE STANDARDS AND CONTRACT COMPLIANCE

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

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

MONITORING AND EVALUATION

Monitoring and Quality Flow Process

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

Sources for Monitoring and Quality Improvement

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

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

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

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

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

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

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

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

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

The grid below summarizes monitoring for the required standards.

Table 6: Monitoring Mechanisms and Frequency

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

Non-Duplication Strategy

The non-duplication regulation provides states the option to use information from a private accreditation review to avoid duplication with the review of select standards required under 42 CFR 438.204(g). The standards that may be considered for this deemed compliance as referenced in 438.204(g) are those listed in Subpart D of the regulations for access to care, structure and operations, and measurement and improvement. MQD acknowledges that the activities required under 438.240(b)1&2 (for conducting PIPs and calculating performance measures) are an option for deeming only for plans that serve only dual eligible clients and therefore does not apply to our contracted MCOs.

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

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

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

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

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

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

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

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

HEALTH INFORMATION TECHNOLOGY

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

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

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

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

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

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

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

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

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

III. IMPROVEMENT AND INTERVENTIONS

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

INTERVENTIONS

State Agency Collaboration

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

MCO Collaboration

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

Performance Measure Validation

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

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

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

Performance Improvement Projects

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

The general expectations for PIPs include:
Year 1: PIP development process, appropriate study topic, clearly defined study question and indicators, correctly identified study population, baseline results, valid

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

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

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

Public Reporting

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

Financial Incentives and Disincentives

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

MCO Sanctions

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

HCBS Quality Improvement Interventions

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

EPSDT transformation grant and MCO collaboration

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

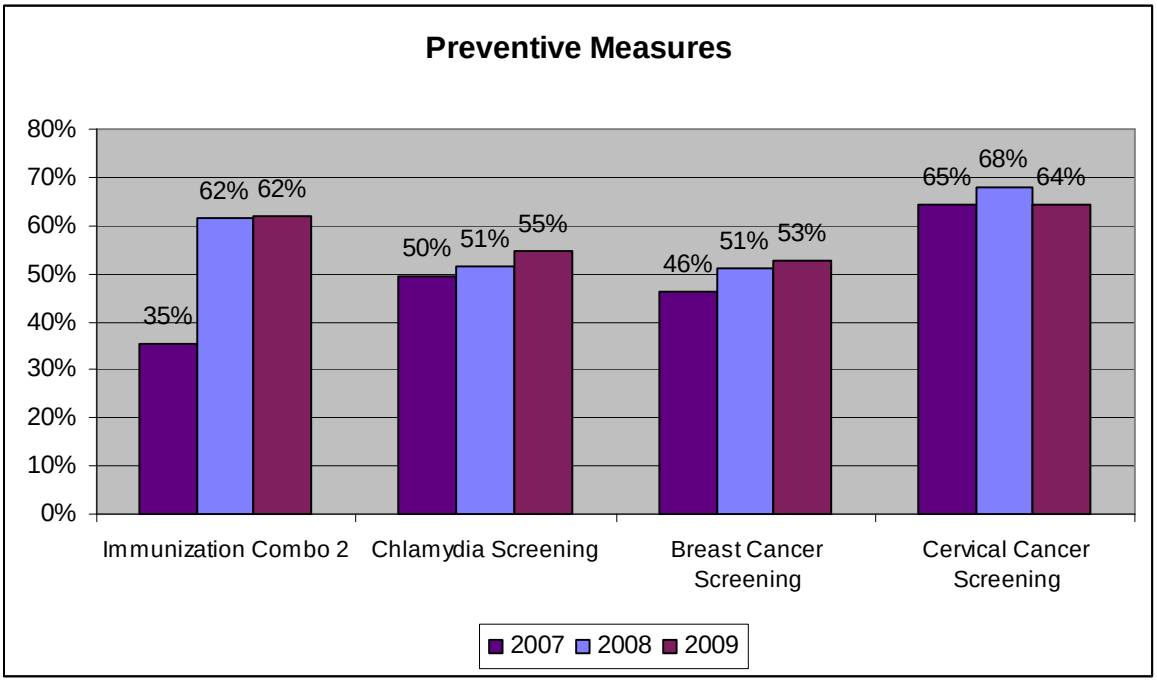
PROGRESS TOWARDS OBJECTIVES

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

Goal 1: Improve preventive care for women and children

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

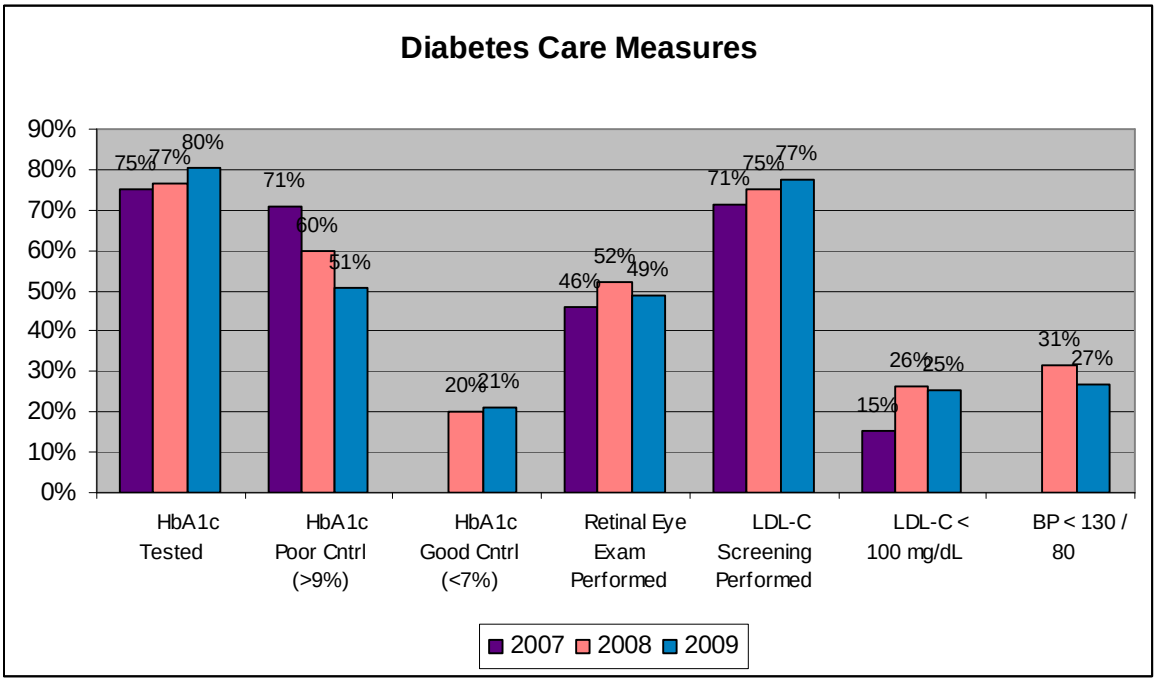
Figure 2: QUEST MCO Baseline for Goal 1 Objectives



<u>Goal 2: Improve care for chronic illness</u>

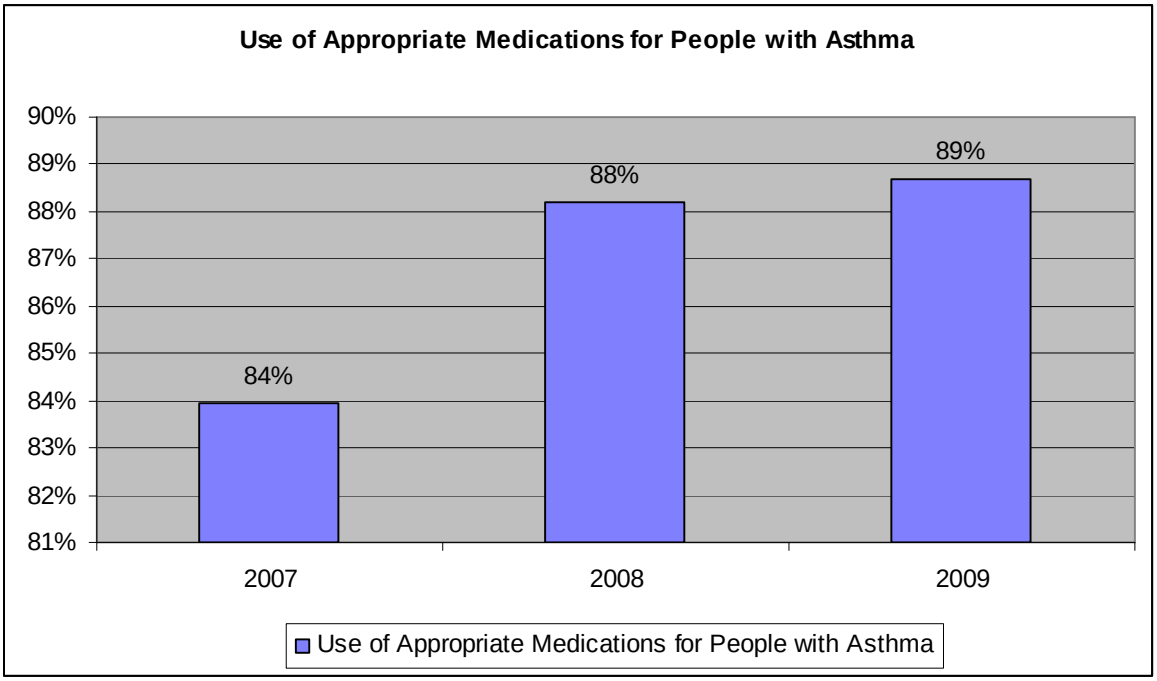
For the measures under Goal 2, the most robust baseline data is for the Diabetes Care Measures for the QUEST MCOs who have been submitting HEDIS data to MQD. Figure 3 below shows data from the last three years. There are multiple areas for improvement, including HbA1c, LDL, and blood pressure control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

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



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

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



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

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

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

Goal 3: Improve client satisfaction with health plan services

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

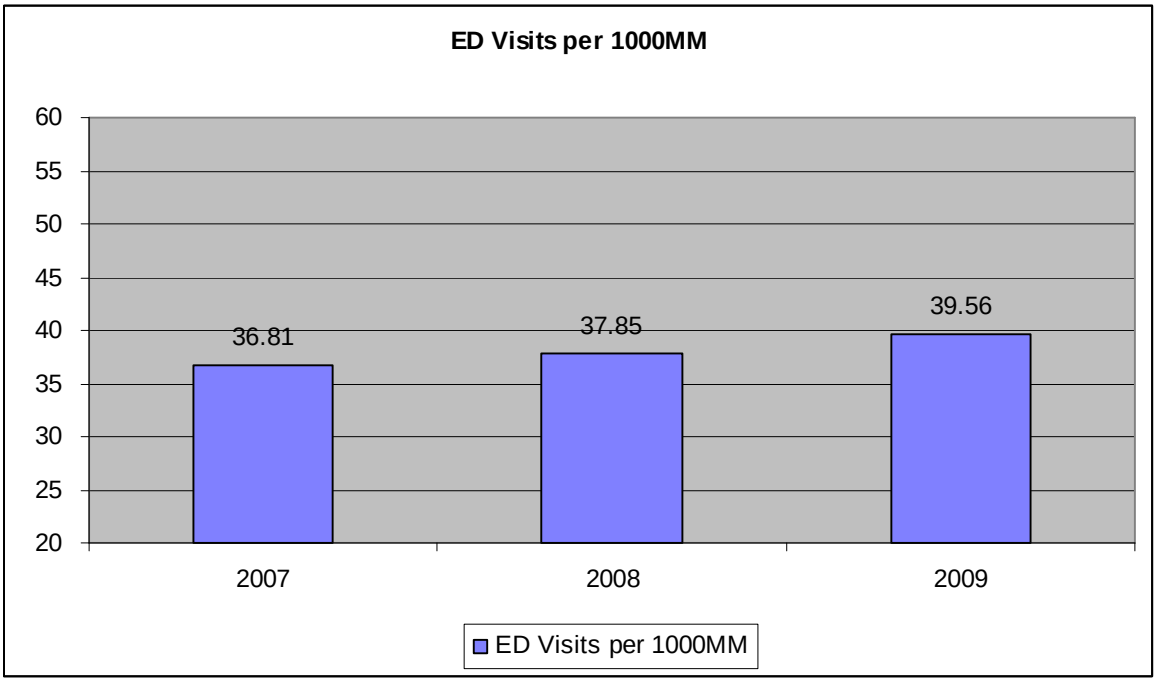
Table 7: QUEST MCO 2008 Baseline for Goal 3 Satisfaction Measures

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

Goal 4: Improve cost-efficiency of health plan services

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

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



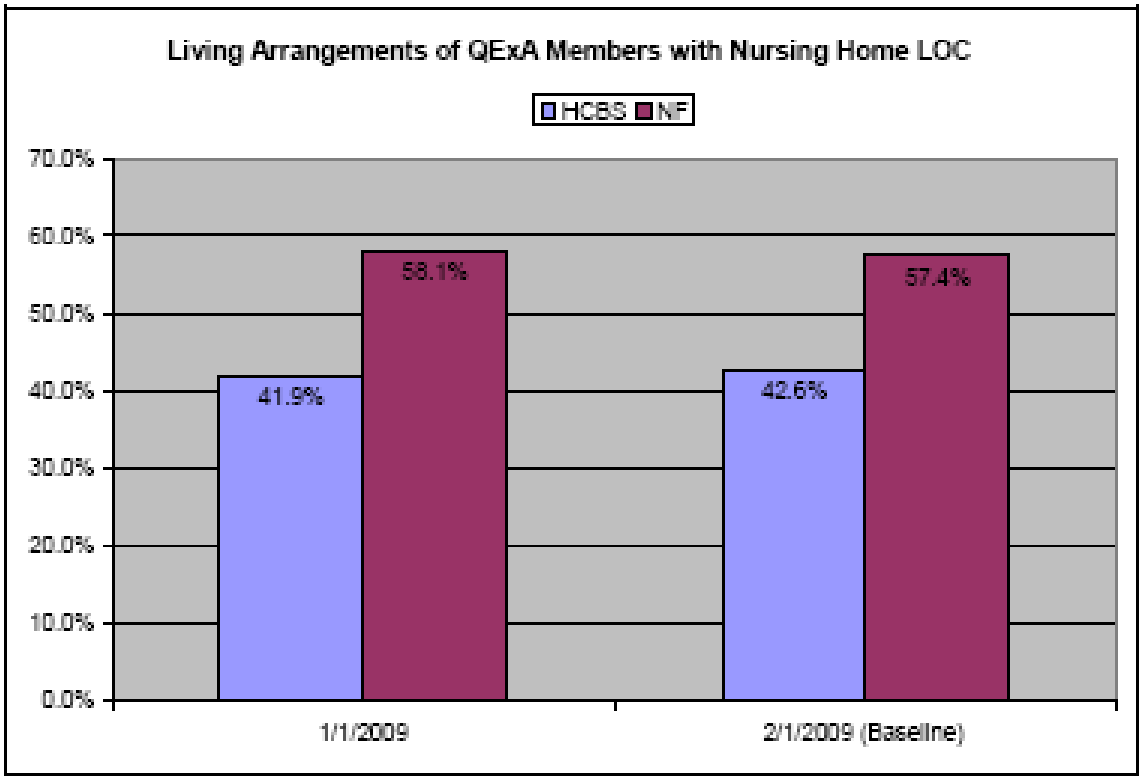
Goal 5: Monitor HCBS clients who have transitioned from waiver programs into QExA health plans.

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

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

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

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



IV. QUALITY STRATEGY REVIEW AND EFFECTIVENESS

PROCESS AND TIMELINE OF QUALITY STRATEGY REVIEW

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

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

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

REPORTING REQUIREMENTS

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

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

V. ACHIEVEMENTS AND OPPORTUNITIES

ACHIEVEMENTS

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

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

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

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

CHALLENGES AND FUTURE PLANS

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

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

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

Attachment D

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

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

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code	Fiscal Year								
HI	2011	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1a. Total individuals eligible for EPSDT	CN:	158,910	9,032	19,489	27,616	31,697	34,075	25,494	11,507
	MN:	0	0	0	0	0	0	0	0
	Total:	158,910	9,032	19,489	27,616	31,697	34,075	25,494	11,507
1b. Total Individuals eligible for EPSDT for 90 Continous Days	CN:	144,843	5,894	18,091	25,780	29,855	32,084	23,875	9,264
	MN:	0	0	0	0	0	0	0	0
	Total:	144,843	5,894	18,091	25,780	29,855	32,084	23,875	9,264
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	26,234	175	1,546	3,304	6,119	7,714	6,174	1,202
	MN:	0	0	0	0	0	0	0	0
	Total:	26,234	175	1,546	3,304	6,119	7,714	6,174	1,202
2a. State Periodicity Schedule			5	4	3	2	3	2	1
2b. Number of Years in Age Group			**1**	**2**	**3**	**4**	**5**	**4**	**2**
2c. Annualized State Periodicity Schedule			5.00	2.00	1.00	0.50	0.60	0.50	0.50
3a. Total Months of Eligibility	CN:	1,594,086	46,768	202,980	289,167	335,878	360,982	268,298	90,013
	MN:	0	0	0	0	0	0	0	0
	Total:	1,594,086	46,768	202,980	289,167	335,878	360,982	268,298	90,013
3b. Average Period of Eligibility	CN:	0.92	0.66	0.93	0.93	0.94	0.94	0.94	0.81
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.92	0.66	0.93	0.93	0.94	0.94	0.94	0.81
4. Expected Number of Screenings per Eligible	CN:		3.30	1.86	0.93	0.47	0.56	0.47	0.41
	MN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:		3.30	1.86	0.93	0.47	0.56	0.47	0.41
5. Expected Number of Screenings	CN:	124,092	19,450	33,649	23,975	14,032	17,967	11,221	3,798
	MN:	0	0	0	0	0	0	0	0
	Total:	124,092	19,450	33,649	23,975	14,032	17,967	11,221	3,798
6. Total Screens Received	CN:	121,192	28,205	37,766	18,865	12,147	13,488	9,431	1,290
	MN:	0	0	0	0	0	0	0	0
	Total:	121,192	28,205	37,766	18,865	12,147	13,488	9,431	1,290
7. SCREENING RATIO	CN:	0.98	1.00	1.00	0.79	0.87	0.75	0.84	0.34
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.98	1.00	1.00	0.79	0.87	0.75	0.84	0.34
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	94,978	5,894	18,091	23,975	14,032	17,967	11,221	3,798
	MN:	0	0	0	0	0	0	0	0
	Total:	94,978	5,894	18,091	23,975	14,032	17,967	11,221	3,798

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

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

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

Attachment E

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

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

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

BENEFIT CHART

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

BENEFITS NOT PROVIDED

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

Benefit Specifications and Provider Qualifications

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

Name of Benefit or Service: Clubhouse

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

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

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:
There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

☐ Day(s) _____
☐ Week(s) _____
☐ Month(s) _____
☐ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications
Provider Category(s): *Agencies*
☐ Individual (list types) ☑ Agency (list types of agencies)

Agencies accredited by ICCD

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

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

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

Provider Type:	*Accredited Clubhouse*	
License Required:	□ Yes	☑ No
Certificate Required:	☑ Yes	□ No

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

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

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

Benefit Specifications and Provider Qualifications

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

Name of Benefit or Service: Peer Specialist

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

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

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:
There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

☐ Day(s) _____
☐ Week(s) _____
☐ Month(s) _____
☐ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessment to ensure medically necessary.

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) ☑ Agency (list types of agencies)

Certified Peer Specialist *Certified Mental Health providers*

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

□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:

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

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

Provider Type:	*Certified Peer Specialist*	
License Required:	□ Yes	☑ No
Certificate Required:	☑ Yes	□ No

Describe:

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

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

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

Benefit Specifications and Provider Qualifications

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

Name of Benefit or Service: Representative Payee

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

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

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:
There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year

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

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

☐ Day(s) _____
☐ Week(s) _____
☐ Month(s) _____
☐ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications

Provider Category(s):

☐ Individual (list types) ☑ Agency (list types of agencies)
Certified Mental Health provider

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

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

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

Provider Type:	*Certified Mental Health provider*	
License Required:	☐ Yes	☑ No
Certificate Required:	☑ Yes	☐ No

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

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

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

Benefit Specifications and Provider Qualifications

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

Name of Benefit or Service: *Substance Abuse Treatment*

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

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

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s) _____

☐ Week(s) _____

☐ Month(s) _____

☐ (Other) _____

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

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

Provider Specifications and Qualifications

Provider Category(s):

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

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

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

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

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

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

Provider Type:

License Required:	☐ Yes	☑ No
Certificate Required:	☑ Yes	☐ No

Describe:

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

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

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*

- *List of Excluded Individuals and Entities (LEIE)- annually*
- *Office of Inspector General exclusion list- annually*

Benefit Specifications and Provider Qualifications

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

Name of Benefit or Service: Supportive Employment

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

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

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s) _____
☐ Week(s) _____
☐ Month(s) _____
☐ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications

Provider Category(s):
☐ Individual (list types)
☑ Agency (list types of agencies)
Certified Mental Health provider

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

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

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

Provider Type: *Certified Mental Health provider*

License Required:	☐ Yes	☑ No
Certificate Required:	☑ Yes	☐ No

Describe:
All agencies that provide supportive employment benefits shall be certified by DOH, AMHD to provide the services described above.

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

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

Benefit Specifications and Provider Qualifications

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

Name of Benefit or Service: Supportive Housing

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

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

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:
There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per ☐ Day ☐ Week ☐ Month ☐ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

☐ Day(s) _____
☐ Week(s) _____
☐ Month(s) _____
☐ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications
Provider Category(s):

☐ Individual (list types) ☑ Agency (list types of agencies)
Certified Mental Health provider

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

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

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

Provider Type: *Certified Mental Health provider*
License Required: ☐ Yes ☑ No
Certificate Required: ☑ Yes ☐ No

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Adult Day Care*

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

Adult day care provides regular supportive care to four (4) or more disabled adult participants in accordance with HAR§17-1417. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s) _____

☐ Week(s) _____

☐ Month(s) _____

☐ (Other) _____

Authorization Requirements:

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

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

Provider Specifications and Qualifications

Provider Category(s): *Agencies*

☐ Individual (list types)

☑ Agency (list types of agencies)
Licensed Adult Day Care centers

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

☐ Legally Responsible Person

☐ Relative/Legal Guardian

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

Provider Type: *Adult Day Care*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

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

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

Adult day health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96 and HAR §11-94.1-47. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community.

Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse.

In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s) _____

☐ (Other) _____

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

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

Provider Specifications and Qualifications

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

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

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

☐Legally Responsible Person ☐Relative/Legal Guardian

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

Provider Type: *Adult Day Health Centers*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

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

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

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Assisted Living Services*

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

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

An assisted living facility, as defined in HRS 321-15.1, is licensed by the Department of Health. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:

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

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

Provider Specifications and Qualifications

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

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

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

☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:

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

Provider Type: *Assisted Living Facilities*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Describe:

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

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

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Community Care Foster Family Home (CCFFH)*
Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

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

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)
_____
☐ Week(s)
_____
☐ Month(s)
_____
☐ (Other)
_____

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

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

Provider Specifications and Qualifications

Provider Category(s):

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

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

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

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

1. **Provider Type:** *Community Care Foster Family Home*
License Required: ☐Yes ☑No
Certificate Required: ☑Yes ☐No

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Counseling and Training*

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

Counseling and training will be provided to family members/caregivers, professional and paraprofessional caregivers to support them in caring for members regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling. In contrast, the Medicaid State Plan only provides counseling and training services for only eligible recipients with certain limitations and conditions as specified in the State Plan.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

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

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

Provider Specifications and Qualifications

Provider Category(s):
☑Individual (list types) ☐Agency (list types of agencies)

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

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

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

Provider Type: *Individual*

License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Environmental Accessibility Adaptations*

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

Environmental accessibility adaptations are those physical adaptations to the home, required by the individual's care plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s) _____

☐ Week(s) _____

☐ Month(s) _____

☐ (Other) _____

Authorization Requirements:

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

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

Provider Specifications and Qualifications

Provider Category(s): *Independent licensed contractors*

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

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

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

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

Provider Type: *Independent licensed contractors*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Describe:

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Home Delivered Meals*

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

Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:

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

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

Provider Specifications and Qualifications

Provider Category(s): *Agencies*

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

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

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

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

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

Provider Type: *Home Delivered Meals*

License Required: ☐Yes ☑No

Certificate Required: ☐Yes ☑No

Describe:

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Home Maintenance*

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

Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

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

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

Provider Specifications and Qualifications

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

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

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

☐Legally Responsible Person ☐Relative/Legal Guardian

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

Provider Type: *Agencies*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

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

Describe:

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Moving Assistance*

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

Moving assistance is provided in rare instances when it is determined through an assessment by the care coordinator that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; member is evicted from their current living environment; the member is no longer able to afford the home due to a rent increase; or relocation to receive ongoing medically necessary services. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s) _____

☐ Week(s) _____

☐ Month(s) _____

☐ (Other) _____

Authorization Requirements:

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

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

Provider Specifications and Qualifications

Provider Category(s): *Moving companies in the State of Hawaii.*

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

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

☐ Legally Responsible Person ☐ Relative/Legal Guardian

Description of allowable providers:

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

Provider Type: *Agency*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Describe:

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Non-Medical Transportation*

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

Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Members shall receive the most appropriate modality of transportation based on their individual needs. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:

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

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

Provider Specifications and Qualifications

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

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

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

☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:

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

Provider Type: *Agency*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Describe:

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Personal Assistance Services*

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

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

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

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

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

☐ Day(s) _____

☐ Week(s) _____

☐ Month(s) _____

☐ (Other) _____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications
Provider Category(s): *Individuals or Personal care agencies or home health agencies.*
☑ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a:
☑ Legally Responsible Person ☑ Relative/Legal Guardian
Family or friends (through self-direction)
Providers include the following:
- *Family or friends (through self-direction)*
- *Personal care agencies*
- *Home health agencies*

Family or friends shall be trained to perform the necessary personal assistance services, if applicable. If an agency, they must be a registered business in Hawaii.
Oversight occurs through service planning, review of incident reports, and visiting the beneficiary without a prearranged visit.

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

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

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

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

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

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

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

License Required: ☐Yes ☑No
Certificate Required: ☐Yes ☑No

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

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

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

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

License Required: ☑Yes ☐No
Certificate Required: ☐Yes ☑No

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

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

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

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

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

PERS is a twenty-four (24) hour emergency assistance service which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, or who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

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

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

Provider Specifications and Qualifications

Provider Category(s): *Agencies*

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

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

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

☐ Legally Responsible Person ☐ Relative/Legal Guardian

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

Provider Type: *Agency*

License Required: ☐Yes ☑No

Certificate Required: ☐Yes ☑No

Describe:

Providers shall be a registered business in the State of Hawaii. Providers shall have the qualifications to provide the benefit described above to the beneficiary.
Oversight occurs through service planning, review of incident reports by service coordinator, and beneficiary satisfaction.

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Residential Care Services*

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

Residential care services are personal care services, homemaker, chore, companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principle care provider who lives in the home.

Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH), allowing five (5) or fewer residents with up to six (6) residents allowed at the discretion of the DHS, of which no more than two (2) may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, of which no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC and receive services in conjunction with residing in the home.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

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

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

Provider Specifications and Qualifications

Provider Category(s):
☑Individual (list types) ☑Agency (list types of agencies)

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

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

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

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

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

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

License Required: ☑Yes ☐No
Certificate Required: ☐Yes ☑No

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

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

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

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

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

2. Provider Type: *E-ARCH – Type II*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Describe:

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

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

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

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Respite Care*

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

Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; foster home/expanded-care adult residential care home; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the State. Respite care services are authorized by the member's PCP as part of the member's care plan. Respite services may be self-directed.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:

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

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

Provider Specifications and Qualifications

Provider Category(s):
☑Individual (list types) ☑Agency (list types of agencies)

The service may be provided by a:
☑Legally Responsible Person ☑Relative/Legal Guardian

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

1. Provider Type: *Individual*

License Required: ☐Yes ☑No
Certificate Required: ☐Yes ☑No

Describe:
These services may be self-directed. If the beneficiary is unable to make his or her own decisions, a surrogate may be utilized. The self-directed service provider may be a family member or friend, the legally responsible person or legal guardian, but cannot be the surrogate as well.

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

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

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

2. Provider Type: *Agency/Facility*

License Required: ☐Yes ☐No
Certificate Required: ☐Yes ☐No

Describe:
The following providers can provide respite services. The HCBS provider requirements are described in other sections of this document. Nursing facilities are licensed by the Department of Health.

Licensed providers that can provide respite services:

- *Adult day care facility*
- *Adult day health facility*
- *E-ARCH*

- *Home health agency*
- *Nursing facility*

Certified providers that can provide respite services:
- *CCFFH*

Providers that are not licensed or certified that can provide respite service:
- *Personal care agency*

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

The following requirements are currently met for adult day care, CCFFH, and personal care agencies. Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met for all other licensed agencies.
- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Skilled Nursing (or Private Duty Nursing)*
Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Skilled or private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses (as defined in HAR § 16-89) within the scope of State law.

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)
_____
☐ Week(s)
_____
☐ Month(s)
_____
☐ (Other)
_____

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

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

Provider Specifications and Qualifications

Provider Category(s):

☑Individual (list types) ☑Agency (list types of agencies)

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

☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:

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

Types of individuals: Registered Nurses

Types of agencies: Personal care agencies, Home health agencies.

1. Provider Type: *Individual*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Describe:

Individual: Licensing occurs by the Department of Commerce and Consumer Affairs (DCCA) to meet the requirements provided in Hawaii Administrative Rule 16-89.

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

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

2. Provider Type: *Personal Care Agency*

License Required: ☐Yes ☑No

Certificate Required: ☐Yes ☑No

Describe:

Agency: Personal care agencies shall be a registered business in the State of Hawaii. Agencies may only utilize Licensed Registered Nurses to perform this service.

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

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*

- *List of Excluded Individuals and Entities (LEIE)- annually*
- *Office of Inspector General exclusion list- annually*
- *Tuberculosis (TB)- annually*
- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

3. Provider Type: *Home Health Agencies*

License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:
Agency: Home Health agency are licensed by Department of Health, Office of Health Care Assurance, Medicare Certification Section under Hawaii Administrative Rule 11-97. Agencies may only utilize Licensed Registered Nurses to perform this service.

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

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

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

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

`Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Specialized Community Case Management (CCMA) Services*
Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of members; ongoing face-to-face monitoring and implementation of the member's care plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. 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,

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)
_____
☐ Week(s)
_____
☐ Month(s)
_____
☐ (Other)
_____

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

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

Provider Specifications and Qualifications

Provider Category(s): *Licensed Case Management Agencies*

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

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

☐ Legally Responsible Person ☐ Relative/Legal Guardian

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

Provider Type: *Agency*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Describe:

These agencies are specialized in the provision of case management services. Their employees who work with Medicaid beneficiaries are either licensed Registered Nurses or Licensed Social Workers. Agencies are licensed by the Department of Human Services in accordance with Hawaii Administrative Rule 17-1754, Subchapter 1 and 2. They see their beneficiaries monthly to perform an assessment to assure that their needs are being addressed in either a CCFFH or E-ARCH.

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

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

Long Term Services Benefit Specifications and Provider Qualifications

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

Name of Service: *Specialized Medical Equipment and Supplies*

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

Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. The providers of these services are the same providers that offer Medicaid State Plan services for durable medical equipment and medical supplies. All items shall meet applicable standards of manufacture, design and installation.

Amount of Benefit/Service

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

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

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

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

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

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

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

Provider Specifications and Qualifications

Provider Category(s): *Durable Medical Equipment Suppliers*

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

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

☐Legally Responsible Person ☐Relative/Legal Guardian

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

Provider Type: *Agency*

License Required: ☐Yes ☐No

Certificate Required: ☐Yes ☐No

Describe:

All suppliers of specialized medical equipment and supplies shall be Durable Medical Equipment and Medical Supplies agencies. These agencies shall be accredited by a CMS-approved independent National Accreditation organization. All suppliers shall meet the CMS quality standards for DMEPOS as part of their accreditation as a Medicare provider.

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

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

Attachment F

Med-QUEST Division
Behavioral Health Protocol

I. OVERVIEW

The Med-QUEST Division (MQD) is responsible for providing behavioral health services to all its beneficiaries. MQD provides standard behavioral health services to all beneficiaries and specialized behavioral health services to beneficiaries with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).

Regardless of the type of behavioral health service a beneficiary receives or where the beneficiary receives his/her behavioral health services, the beneficiary continues to have access to all of the other services for which he/she is eligible, including:

- Primary and acute care services from his/her health plan;
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services if he/she is under the age of 21;
- Home and community based services/long-term supports and services (HCBS/LTSS) services under the section 1115 demonstration waiver; and
- Services or under the Developmental Disabilities or Intellectual Disabilities (DD/ID) 1915(c) waiver.

All beneficiaries have access to standard behavioral health services through the contracted managed care health plans. The standard behavioral health services include inpatient psychiatric hospitalization, medications, medication management, psychiatric and psychological evaluation and management, and alcohol and drug dependency treatment services.

Beneficiaries with SMI, SPMI, or SEBD may be in need of specialized behavioral health services. For children (individuals <21), the SEBD services are provided through the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD); for adults (individuals ≥21) the SMI/SPMI services are provided through the DOH Adult Mental Health Division (AMHD), the MQD's behavioral health program Community Care Services (CCS), or the managed care health plans. Regardless of how adults with SMI/SPMI access specialized behavioral health services, all have access to the same services, and MQD ensures no duplication. The available specialized services include:

- For children: multidimensional treatment foster care, family therapy, functional family therapy, parent skills training, intensive home and community based intervention, community-based residential programs, and hospital-based residential programs, and
- For adults: crisis management, crisis and specialized residential treatment, intensive care coordination/case management, psychosocial rehabilitation, clubhouse, peer

specialist, representative payee, supportive employment, supportive housing partial or intensive outpatient hospitalization, and therapeutic living supports.

See Addendum A for an overview of the behavioral health services delivery systems for individuals with SMI, SPMI, or SEBD; and see Addendum B for a detailed description of the services provided by CAMHD, AMHD, CCS, and the managed care health plans.

II. RECEIPT OF BEHAVIORAL HEALTH SERVICES BY CHILDREN (INDIVIDUALS <21 YEARS)

A. Clinical Criteria

Beneficiaries <21 years old with a diagnosis of SEBD are eligible for additional behavioral health services within CAMHD if meeting the following criteria:

- The beneficiary is age three through twenty (3-20) years;
- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least six (6) months or is expected to demonstrate the qualifying diagnosis for the next six (6) months; and
- The beneficiary's Child and Adolescent Functional Assessment Scale (CAFAS) score is > 80.
- Beneficiaries who do not meet the eligibility criteria, but based upon assessment by the CAMHD medical director that additional behavioral health services are medically necessary for the member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

B. Service Delivery

MQD has a Memorandum of Understanding (MOU) with CAMHD to provide services to Medicaid beneficiaries. The CAMHD is responsible for providing SEBD services to all individuals age three through twenty (3-20) years who meet eligibility criteria. CAMHD provides services to approximately 900 children. CAMHD had previously functioned as a Pre-paid Inpatient Health Plan (PIHP) but changed to billing these services to MQD through a fee-for-service (FFS) process effective October 1, 2008.

The health plan can make a referral to CAMHD through use the SEBD Referral Form developed by CAMHD. The health plan will continue to provide behavioral health services even after CAMHD admits the individual into their program. In these cases, the health plan will not provide services offered by CAMHD, and CAMHD will not provide services offered by the health plan. The MQD informs the health plans, via the 834-transaction file, when an individual is receiving services through the CAMHD program. When a child is no longer eligible for services through CAMHD, CAMHD will coordinate transition of care with the child's health plan. The health plan will be notified that the individual is no longer receiving services via CAMHD via the 834-transaction file.

Referrals to CAMHD can also occur through the school, parent, child, or the health plan. CAMHD considers all referrals through an assessment process. Even if a child qualifies for SEBD services, parents can choose to have their children's behavioral health services provided through the child's health plan. However, the health plans are only able to provide the behavioral health services identified in their contract. CAMHD would need to be involved for any specialized behavioral health services. These additional behavioral health services include both intensive case management and targeted case management and are distinct from the services provided through the health plans.

III. RECEIPT OF SPECIALIZED BEHAVIORAL HEALTH SERVICES BY ADULTS (INDIVIDUALS ≥21 YEARS)

A. Clinical Criteria

Beneficiaries >/=21 years old with a SMI or SPMI are eligible for specialized behavioral health services if they meet the following criteria:

- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The beneficiary meets at least one of the criteria below demonstrating instability and/or functional impairment:
  - Global Assessment of Functioning (GAF) < 50;
  - Clinical records demonstrate that the beneficiary is currently unstable under current treatment or plan of care (ex. multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable to include but not limited to consistently noncompliant with medications and follow-up, unengaged with providers, significant and consistent isolation, resource deficit causing instability, significant co-occurring medical illness causing instability, poor coping/independent living/problem solving skills causing instability, at risk for hospitalization); or
  - Beneficiary is under Protective Services or requires intervention by housing or law enforcement officials.
- Beneficiaries who do not meet the requirements listed above, but based upon an assessment by a programmatic medical director, that additional behavioral health services are medically necessary for the member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

B. Service Delivery

The current organization for the delivery of specialized behavioral health services is largely historical. Around the time that the QUEST program was implemented in the mid-1990's, for which specialized behavioral health services were carved out, the CCS program was created due to the lack of

behavioral health services for Medicaid beneficiaries with a SMI/SPMI. (AMHD had a limited service package at that time.) In the early 2000 timeframe, AMHD expanded its services significantly, largely modeling the CCS services, due to a mandated court decree that was withdrawn in 2006. However, MQD continued to offer its CCS program despite the expansion of services within AMHD.

CCS predominately served non-Aged, Blind and Disabled (ABD) individuals, and AMHD largely served ABDs. When QExA was implemented as managed care for the ABD population, specialized behavioral health services remained carved out. Over the years as individuals were offered choice, an increasing number of non-ABDs began to receive their services through AMHD, and an increasing number of ABDs began to receive their services through CCS.

In an effort to improve integration between medical and behavioral health care, effective July 1, 2010, the MQD transitioned all behavioral health services provided to QUEST adult beneficiaries by AMHD and the CCS program into the QUEST health plans. MQD observed that neither behavioral health outcomes nor medical outcomes were improved for this population, and the fragmentation among multiple health plans created confusion for patients and providers alike.

Effective March 1, 2013, CCS will be converted from primarily a third party administrator contract to a Pre-paid Inpatient Health Plan (PIHP), and MQD intends to transition all adults to receive their specialized behavioral health services through CCS. The following describes the current alternative service delivery options for adults until all adults can be transitioned to the CCS program to receive their specialized behavioral health services as described in this protocol.

1. <u>AMHD</u>

   MQD had a MOU with AMHD to provide services to Medicaid beneficiaries. Currently, AMHD provides specialized behavioral health services to approximately 1,200 Medicaid ABD adults, until this population can be transitioned to the CCS program. AMHD bills specialized behavioral health services to the MQD through a FFS process.

   Referrals to AMHD occur through either the beneficiary (self-referral) by calling the AMHD access line, or by beneficiary choice after a health plan referral and determination of eligibility. AMHD considers all referrals through an assessment process and uses the same criteria as listed in section A above. If the individual meets criteria, AMHD will notify MQD, develop an individual service plan, and begin providing services.

   Currently, the QExA health plans make referrals for adult members identified with a SMI/SPMI. All referrals are reviewed by a MQD

physician for eligibility. Eligible beneficiaries can choose to receive their specialized behavioral health services through AMHD or CCS, until the transition at which time they will only be able to receive the specialized behavioral health services through CCS.

The specialized behavioral health services provided by AMHD include both intensive case management and targeted case management. These services are distinct from the services provided through the managed care health plans.

2. CCS
   The CCS program provides specialized behavioral health services to approximately 900 Medicaid ABD adults. MQD awards the CCS program to a contractor through a Request for Proposals (RFP) to provide specialized behavioral health services to eligible adults as a PIHP. Certain new services may be reimbursed on a fee-for-service basis until able to be incorporated into the capitation rates.

   Currently, the QExA health plans make referrals for adult members identified with a SMI/SPMI. All referrals are reviewed by a MQD physician for eligibility. Eligible beneficiaries can choose to receive their specialized behavioral health services through AMHD or CCS, until the transition at which time they will only be able to receive the specialized behavioral health services through CCS. Once enrolled in CCS, CCS performs an assessment and develops an individual service plan.

3. Managed Care Health Plans
   All managed care health plans provide all their beneficiaries with first line behavioral health services. Currently, the QUEST health plans also provide approximately 2,000 adults with specialized behavioral health services, until this population is transitioned to receive specialized behavioral health services through CCS. Payment to the health plans is incorporated into their capitation rates. The health plans identify adult members with a SMI/SPMI and perform an assessment to develop an individual service plan. Certain specialized services are provided by CCS instead of the health plan.

Regardless of the specialized behavioral health service delivery option an adult utilizes, the individual will have access to the same specialized behavioral health services. This will be clear, and the delivery system will be more integrated, once MQD successfully transitions all adults with SMI/SPMI to receive their specialized behavioral health services through the CCS program.

IV. COVERED SPECIALIZED BEHAVIORAL HEALTH SERVICES

The standard behavioral health services are State plan services. The covered specialized behavioral health services include those covered under the State plan and those covered under the section 1115 demonstration. These services may be provided through CAMHD or through AMHD, CCS, or health plans. The State plan services are listed below with details available in the State plan. The 1115 demonstration services are described in detail below, and these services are not available through the health plans. Individuals receiving specialized behavioral health services through the health plans in need of these additional services can receive them either through AMHD or CCS.

A. State Plan Standard Behavioral Health Services

1. Acute Psychiatric Hospitalization
2. Diagnostic/Laboratory Services
3. Electroconvulsive Therapy
4. Evaluation and Management
5. Methadone Treatment
6. Prescription Medications
7. Substance Abuse Treatment
8. Transportation

B. State Plan Specialized Behavioral Health Services

1. Assertive Community Treatment (intensive case management and community-based residential programs)
2. Biopsychosocial Rehabilitation
3. Crisis Management
4. Crisis Residential Services
5. Hospital-based Residential Programs
6. Intensive Family Intervention
7. Intensive Outpatient Hospital Services
8. Therapeutic Living Supports and Therapeutic Foster Care Supports (Addendum D includes the State plan pages for these Community Mental Health Rehabilitative Services)

C. 1115 Demonstration Specialized Behavioral Health Services

1. <u>Clubhouse</u>
   a. A Clubhouse is a local community center that offers people who have mental illness opportunities to achieve their full potential by forming a community of people who are working together to achieve a common goal. A Clubhouse is organized to support people living with mental illness.
   b. Clubhouse is an organization accredited by International Center for Clubhouse Development (ICCD). ICCD is an organization that provides resources for communities to create solutions for people with mental illness.

c. MQD would reimburse this service utilizing half-day and full-days attending Clubhouse.

2. Peer Specialist
   a. The peer specialist works in collaboration with interdisciplinary team members to assist beneficiaries to:
      i. Understand recovery and the value of every individual's recovery experience;
      ii. Identify strengths and needs for recovery;
      iii. Understand and set goals for recovery;
      iv. Determine the objectives needed to reach beneficiary-centered recovery goals; and
      v. Help beneficiaries create, maintain and utilize their own recovery plan.
   b. Peer specialists shall be certified by AMHD as part of their Hawaii Certified peer specialist (HCPS) program. Peer specialists are persons who have self-identified themselves as receiving (or previously received) mental health services for their own personal recovery.
   c. These individuals help SMI beneficiaries by providing support to others who are facing a similar situation they have faced in the past. Peer specialists promote self-determination, personal responsibility, and community integration for beneficiaries.
3. Representative Payee
   a. A representative payee is an individual or organization that is chosen for a beneficiary that cannot manage or direct someone else to manage his or her money. This benefit is only for those without access to the social security representative payee program.
   b. The main responsibilities of a payee are to use the beneficiary's income to pay for the current and foreseeable needs of the beneficiary and properly save any income not needed to meet current needs. A payee must also keep records of expenses. Reports shall be provided quarterly on each beneficiary's account.
4. Supportive Employment
   a. Supported employment includes activities needed to obtain and sustain paid work within the general workforce by beneficiaries and includes assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the beneficiary, transitioning the beneficiary from volunteer work to paid employment, and assisting the beneficiary in maintaining an individual job in the general workforce at or above the state's minimum wage.
   b. Supported employment support is conducted in a variety of settings to include self-employment. With regard to self-employment, individual employment support services may include:
      i. Aiding the beneficiary to identify potential business opportunities;
      ii. Assisting in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business;

iii. Identifying the supports that are necessary in order for the beneficiary to operate the business; and
iv. Providing ongoing assistance, counseling and guidance once the business has been launched.

5. Supportive Housing
   a. This is housing-based care management focused on ensuring housing stability, recognizing housing's role as an essential platform for recovery and improved health.
   b. The service will include assisting individuals with finding and retaining housing such as Section 8, Section 811, other Housing and Urban Development (HUD) programs, and public housing.
   c. Available to previously homeless individuals or others in public housing.

Addendum A. Overview of Behavioral Health Service Delivery

	Adults without SMI/SPMI	Non-ABD Adults with SMI/SPMI	ABD Adults with SMI/SPMI Enrolled in AMHD	ABD Adults with SMI/SPMI Enrolled in CCS	Children with SEBD Enrolled in CAMHD
Standard Behavioral Health Services					
Acute Psychiatric Hospitalization	HP	HP	HP	CCS	HP
Diagnostic/laboratory Services	HP	HP	HP	CCS	HP
Electroconvulsive Therapy	HP	HP	HP	CCS	HP
Evaluation and Management	HP	HP	HP	CCS	CAMHD/ HP
Methadone Treatment	HP	HP	HP	CCS	HP
Prescription Medications	HP	HP	HP	CCS	HP
Substance Abuse Treatment	HP	HP	HP	CCS	HP
Transportation	HP	HP	HP	CCS	HP
Specialized State Plan Behavioral Health Services					
Biopsychosocial Rehabilitation	n/a	HP	AMHD	CCS	n/a
Community Based Residential Programs	n/a	n/a	n/a	n/a	CAMHD
Crisis Management	n/a	HP	AMHD	CCS	CAMHD
Crisis Residential Services	n/a	CCS	AMHD	CCS	CAMHD
Hospital-based Residential Services	n/a	n/a	n/a	n/a	CAMHD
Intensive Case Management	n/a	HP	AMHD	CCS	CAMHD
Intensive Family Intervention	n/a	n/a	n/a	n/a	CAMHD
Intensive Outpatient Hospital Services	n/a	HP	AMHD	CCS	CAMHD
Therapeutic Living Supports and Therapeutic Foster Care Supports	n/a	HP	AMHD	CCS	CAMHD
Specialized 1115 Behavioral Health Services					
Clubhouse	n/a	HP	AMHD	CCS	n/a

Peer Specialist	n/a	HP	AMHD	CCS	n/a
Representative Payee	n/a	CCS	AMHD	CCS	n/a
Supportive Employment	n/a	CCS	AMHD	CCS	n/a
Supportive Housing	n/a	CCS	AMHD	CCS	n/a

Legend:

ABD	Aged, Blind, or Disabled
AMHD	Adult Mental Health Division in the Department of Health
HP	Health Plan
CAMHD	Child and Adolescent Mental Health Division in the Department of Health
CCS	Community Care Services program
SEBD	Support for Emotional and Behavioral Development
SMI	Severe Mental Illness
SPMI	Serious and Persistent Mental Illness

Addendum B. Details of Covered Behavioral Health Services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Payment methodology	N/A	**Payment to health plans** Capitation	**Payment to DOH-AMHD** Billed FFS to MQD	**Payment to the Behavioral Health Organization** Capitation/FFS	**Payment to DOH-CAMHD** Billed FFS to MQD
Standard Behavioral Health Services					
Acute psychiatric hospitalization	Hospitals licensed to provide psychiatric services	Twenty-four (24) hour care for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services as needed o Other medically necessary services o Pharmaceuticals o Rehabilitation services, as needed	Provided by health plan	Twenty-four (24) hour are for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services, as needed o Other medically necessary services o Pharmaceuticals o Rehabilitation services, as needed	Provided by health plan
Diagnostic/ laboratory services	Laboratories	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol problems o Other medically necessary diagnostic services	Provided by health plan	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol problems o Other medically necessary diagnostic services	Provided by health plan
Electro-	Acute Psychiatric	ECT	Provided by health plan	ECT	Provided by health plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
convulsive Therapy (ECT)	Hospital Outpatient facility	o Medically necessary, may do more than one/day o Inclusive of anesthesia		o Medically necessary, may do more than one/day o Inclusive of anesthesia	
Evaluation and Management	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	Psychiatric or psychological evaluation Individual and group counseling and monitoring	Psychiatric or psychological evaluation for SMI/SPMI Individual and group counseling and monitoring for SMI/SPMI HP provides individual and group counseling and monitoring for non-SMI/SPMI	Psychiatric, psychological or neuropsychological evaluation for SMI/SPMI Individual and group counseling and monitoring for SMI/SPMI HP provides individual and group counseling and monitoring for non-SMI/SPMI	Psychiatric, psychological or neuropsychological evaluation for SEBD Individual and group counseling and monitoring for children requiring SEBD HP provides individual and group counseling and monitoring for all other children
Methadone Treatment	Methadone clinics	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan
Prescription Medications	Providers licensed to prescribe (e.g. Psychiatrist and APRN Rx). Medications are dispensed by licensed pharmacies.	Prescribed drugs including medication management and patient counseling	Provided by health plan	Prescribed drugs including medication management and patient counseling	Provided by health plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Substance Abuse Treatment	Certified substance abuse counselors* Specialized residential treatment facilities Facilities licensed to perform substance abuse treatment	Substance Abuse – Residential: o Medically necessary services based on American Society of Addiction Medicine (ASAM) Substance Abuse – Out-patient: o Screening o Treatment and treatment planning o Therapy/counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary o Screening for drugs and alcohol	Provided by health plan	Substance Abuse – Residential: o Medically necessary services based on American Society of Addiction Medicine (ASAM) Substance Abuse – Out-patient: o Screening o Treatment and treatment planning o Therapy/counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary o Screening for drugs and alcohol	Provided by health plan
Transportation	Approved transportation providers to include medical vans, taxi cabs, bus services, and handicap bus services.	Transportation o Air o Ground for medically necessary services	Provided by health plan	Transportation o Air o Ground for medically necessary services	Provided by health plan
Specialized Behavioral Health Services					
Biopsychosocial Rehabilitative Programs	AMHD Qualified Mental Health Provider**	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Not provided

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Clubhouse*	AMHD	Beneficiaries participate in programs that support them in obtaining employment, education and housing.	Beneficiaries participate in programs that support them in obtaining employment, education and housing.	Beneficiaries participate in programs that support them in obtaining employment, education and housing.	Not provided
Community Based Residential Programs	Small homes certified to perform community based residential programs. Each home is staffed with several qualified mental health professionals.	Not provided	Not provided	Not provided	These programs provide twenty-four (24) hour integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression, or deviance, which prevent the youth from taking part in family and/or community life.
Crisis Management	Qualified Mental Health Provider**	Crisis Management Services o 24-hour crisis hotline o Mobile outreach services o Crisis intervention/ stabilization services	Crisis Management Services o 24-hour crisis hotline o Mobile outreach services o Crisis intervention/ stabilization services	Crisis Management Services o 24-hour crisis hotline o Mobile outreach services o Crisis intervention/ stabilization services	Crisis Management Services o 24-hour crisis hotline o Mobile outreach services o Crisis intervention/ stabilization services
Crisis Residential Services	Qualified Mental Health Provider**	Not provided	Crisis Residential Services	Crisis Residential Services	Crisis Residential Services
Hospital based residential programs	Acute psychiatric hospital	Not provided	Not provided	Not provided	Hospital based residential treatment
Intensive Case Management	Qualified Mental Health Provider**	Care Coordination/Case Management	Intensive case management/ community based case	Care Coordination/Case Management	Intensive case management/ community based case

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	Health plan	o Case assessment o Case planning (service planning, care planning) o Outreach o Ongoing monitoring and service coordination	management Targeted Case Management	o Case assessment o Case planning (service planning, care planning) o Outreach o Ongoing monitoring and service coordination	management Targeted Case Management
Intensive family intervention	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	Not provided	Not provided	Not provided	Intensive family intervention
Intensive Outpatient Hospital Services	Acute psychiatric hospitals Qualified Mental Health Provider**	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy	Intensive Outpatient Hospital Services: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy	Intensive Outpatient Hospital Services: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		and aftercare o Other medically necessary services	and aftercare o Other medically necessary services	and aftercare o Other medically necessary services	and aftercare o Other medically necessary services
Peer Specialist*	Certified peer specialists	Structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promote socialization, recovery, wellness, self-advocacy, development of natural supports, and maintenance of community skills.	Not provided
Representative Payee*	Qualified Mental Health Provider**	Not provided	Assist beneficiary in managing their financial status.	Assist beneficiary in managing their financial status.	Not provided
Supportive Employment*	Qualified Mental Health Provider**	Not provided	Activities to obtain and sustain paid work by beneficiaries.	Activities to obtain and sustain paid work by beneficiaries.	Not provided
Suportive Housing*	Qualified Mental Health Provider**	Not provided	Housing-based care management focused on ensuring housing stability.	Housing-based care management focused on ensuring housing stability.	Not provided
Therapeutic Living Supports and Therapeutic Foster Care Supports	Specialized residential treatment facility	Specialized residential treatment facilities	Specialized residential treatment facilities	Specialized residential treatment facilities	Therapeutic living and therapeutic foster care supports

Legend:

*	Approved waiver services
**	Medicaid provider that offers multiple behavioral health services in one organization in order to provide continuity for the participants in the behavioral health program. Qualified providers are licensed or certified as required by Hawaii Revised Statutes.

Addendum C: Eligibility Diagnoses for Specialized Behavioral Health Services

Support for Emotional and Behavioral Development

Eligible Diagnoses

- Demonstrates the presence of a primary DSM (most current edition) Axis I diagnosis for at least six (6) months or is expected to demonstrate the diagnosis for the next six (6) months. See excluded diagnoses in the next section.

*Excluded Diagnoses**

- Mental Retardation** (317, 318.0, 318.1, 318.2, 319)
- Pervasive Developmental Disorders** (299.0, 299.80, 299.10)
- Learning Disorders (315.0, 315.1, 315.2, 315.9)
- Motor Skills Disorders (315.3)
- Communication Disorders (315.31, 315.32, 315.39, 307.0, 307.9)
- Substance Abuse Disorders
- Mental Disorders Due to a General Medical Condition
- Delirium, Dementia, Amnestic, and other Cognitive Disorders
- Factitious Disorders
- Feeding Disorders of Infancy or Childhood
- Elimination Disorders
- Sexual Dysfunctions
- Sleep Disorders

* If a diagnosis listed above is the **ONLY** DSM (most current edition) diagnosis, the child/youth is ineligible for SEBD services. However, these diagnoses may and often do co-exist with other DSM diagnoses, which would not make the child/youth ineligible for SEBD services.

** Co-occurring diagnoses of Mental Retardation and Pervasive Developmental Disorders require close collaboration and coordination with State of Hawaii Department of Health (DOH) and State of Hawaii Department of Education (DOE) services. The health plan, with CAMHD, is responsible for coordinating these services. These diagnoses may be subject to a forty-five (45) day limit on hospital-based residential services, after which utilization review and coordination of services with DOE need to occur.

Severe Mental Illness/ Serious and Persistent Mental Illness

Eligible Diagnoses

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)

- Delusional Disorders (297.1)
- Mood Disorders- Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders- Depressive Disorders (296.24, 296.33, 296.34)
- Post-traumatic stress disorder
- Substance induced psychosis

12d. Same as 6b

Limitations on prescription eyeglasses are as follows:

Trifocal lenses are covered only for those currently wearing these lenses satisfactorily and for specific job requirements.

Tinted or coated lenses are excluded except for persons with aphakia, albinism, glaucoma, etc. exclusive of photophobia not associated with such conditions.

Oversize lenses are excluded.

Bilateral plano glasses covered as safety glasses for persons with one remaining eye.

Individuals with presbyopia who require no or minimal distance correction shall be fitted with ready made half glasses instead of bifocal. Contact lenses for cosmetic purposes and blended bifocals are excluded.

13a. Certain categories of diagnostic procedures or out-of-state procedures require prior authorization.

13d. Rehabilitative services are subject to the limitations specified on these supplement pages for particular services, i.e., physical therapy, speech therapy, etc.

Community Mental Health Rehabilitative Services: Medicaid Rehab Option

The covered Community Mental Health Rehabilitative Services will be available to all Medicaid eligibles who are medically determined to need mental health and/or drug abuse/alcohol services. These services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.

Individuals who are mentally retarded (MR) or developmentally delayed (DD) are not eligible for these services, including MR/DD individuals who are in Home & Community Based Waiver programs.

These services are to be provided by the following qualified mental health professionals: licensed psychiatrist, licensed psychologist, licensed clinical social worker (CSW) with experience in behavioral health, licensed advance practical nurse (APRN) in behavioral health, or a licensed Marriage and Family Therapist (LMFT) with experience in behavioral health. Additionally, provider qualifications must be in

compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

The services are defined as follows:

1. **Crisis Management.** This service provides mobile assessment for individuals in an active state of crisis (24 hours per day, 7 days per week) and can occur in a variety of community settings including the consumer's home. Immediate response is required. Included in Crisis Management services are an assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation. If necessary, this may include referral to licensed psychiatrist, licensed psychologist, or to an inpatient acute care hospital. The presenting crisis situation may necessitate that the services be provided in the consumer's home or natural environment setting. Thus, crisis management services may be provided in the home, school, work environment or other community setting as well as in a health care setting. These services are provided through JCAHO, CARF, or COA accredited agencies. In addition, agencies must have staff that includes one or more qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.

2. **Crisis Residential Services.** Crisis Residential Services are short-term, interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization or inpatient hospital based psychiatric care at levels of care below acute psychiatric inpatient. Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, and daily living skills training. Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting. All crisis residential programs will have less than 16 beds. The services do not include payment for room and board. The staff providing crisis residential services must be qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.

3. **Biopsychosocial Rehabilitative Programs :** A therapeutic day rehabilitative social skill building service which allows individuals with serious mental illness to gain the necessary social and communication skills necessary to allow them to remain in or return to naturally occurring community programs.

Services include group skill building activities that focus on the development of problem-solving techniques, social skills and medication education and symptom management. All services provided must be part of the individual's plan of care. The therapeutic value of the specific therapeutic recreational activities must be clearly described and justified in the plan of care. At a minimum the plan of care must define the goals/objectives for the individual, educate the individual about his/her mental illness, how to avoid complications and relapse, and provide opportunities for him/her to learn basic living skills and improve interpersonal skills. Services are provided by qualified mental health professionals or staff that are under the supervision of a qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

4. **Intensive Family Intervention.** These are time limited intensive interventions intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for children with serious emotional or behavioral disturbance or adults with serious mental illness. These services: 1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; 2) assess and monitor the service needs of the identified individual so that he/she can be safely maintained in the family; 3) ensure the clinical appropriateness of services provided; and 4) improve the individual's ability to care for self and the family's capacity to care for the individual. This service includes focused evaluations and assessments, crisis case management, behavior management, counseling, and other therapeutic rehabilitative mental health services toward improving the individual's ability to function in the family. Services are directed towards the identified individual within the family. Services can be provided in-home, school or other natural environment. Services are provided by a multidisciplinary team comprised of qualified mental health professionals. If the services are provided by staff other than that listed above, the staff must be supervised by one of the licensed disciplines noted above and at a minimum be a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

5. **Therapeutic Living Supports and Therapeutic Foster Care Supports.** These are services covered in settings such as group living arrangements or therapeutic foster homes. Group living arrangements usually provide services for 3 to 6 individuals per home but not more than 15. Therapeutic foster homes provide services for a maximum of 15 individuals per home. Although these group living arrangements and therapeutic foster homes may provide 24 hour per day of residential care, only the therapeutic services provided are covered. There is no reimbursement of room and board charges. Covered

therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home. The identified individual must be either a child with serious emotional or behavioral disturbance or the adult with a serious mental illness. Services provided in therapeutic group homes and therapeutic foster homes include: supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training (individual, group, family), directed at the amelioration of functional and behavioral deficits and based on the individual's plan of care developed by a team of licensed and qualified mental health professionals. Services are provided in a licensed facility and are provided by a qualified mental health professional or staff under the supervision of a qualified mental health professional with 24-hour on-call coverage by a licensed psychiatrist or psychologist.

6. **Intensive outpatient hospital services.** These are outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. Services are provided to an individual who is either a child with serious emotional or behavioral disturbance or an adult with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) are unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The goals of service are clearly identified in an individualized plan of care. The short term and long term goals and continuing care plan are established prior to admission through a comprehensive assessment of the consumer to include a severity-adjusted rating of each clinical issue and strength. Treatment is time-limited, ambulatory and active offering intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Services are available at least 20 hours per week. All services are provided by qualified mental health professionals, or by individuals under the supervision of a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Registered nurses or licensed practical nurses must be available for nursing interventions and administration of medications. Licensed psychiatrists or psychologist must be actively involved in the development, monitoring, and modification of the plan of care. The services must be provided in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for

coverage of partial hospitalization/day treatment. These services area not provided to individuals in the inpatient hospital setting and do not include acute inpatient hospital stays.

7. **Assertive Community Treatment (ACT).** This is an intensive community rehabilitation service for individuals who are either children with serious emotional or behavioral disturbance or adults with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) is unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The ACT rehabilitative treatment services are to restore and rehabilitate the individual to his/her maximum functional level. Treatment interventions include crisis management (crisis assessment, intervention and stabilization); individual restorative interventions for the development of interpersonal, community coping and independent living skills; services to assist the individual develop symptom monitoring and management skills; medication prescription, administration and monitoring medication and self medication; and treatment for substance abuse or other co-occurring disorders. Services include 24 hours a day, 7 days a week coverage, crisis stabilization, treatment, and counseling. Also, individuals included in ACT receive case management to assist them in obtaining needed medical and rehabilitative treatment services within their ACT treatment plan. Services can be provided to individuals in their home, work or other community settings. ACT services are provided by agencies whose staffs include one or more licensed qualified mental health professionals. If the services are provided by staff other than a licensed qualified mental health professional, the staff must be supervised by a licensed qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Case management is an integral part of this service and reimbursement for case management as a separate service is not allowed. If biopsychosocial rehabilitation is part of the individual's plan of care under intensive case management, reimbursement for biopyschosocial rehabilitation as a separate service is not allowed.

13d. **Limitations continued**

The covered services are available only to Medicaid eligible recipients with a written plan of care developed with the participation of a licensed psychiatrist or psychologist. Services provided must be medically necessary. Prior approval is required.

15a. & 15b. Authorization by the department's medical consultant for the recommended level of care is required.

16. **Psychiatric services for individuals under age 21.**
Provides secure locked residential treatment consisting of highly structured daily programming, close supervision, educational services, and integrated service planning designed for severely emotionally/behaviorally disturbed to function in a less restrictive setting. Services include multi-disciplinary assessment of the child, skilled milieu of services by trained staff who are supervised by a licensed professional on a 24 hour per day basis, individual psychotherapy and/or counseling, individualized adjunctive therapies, and substance abuse education and counseling, as appropriate and as part of an interdisciplinary treatment plan. Services are required to be staff secure at all times. Hospital-based residential services are provided in a licensed inpatient facility serving individuals who are under the age of 21 and are provided by a qualified mental health professional. If the services are provided by staff other than that listed above, the staff must be supervised by a qualified mental health professional.

Services are not limited and must be authorized.

In communities where a psychiatric facility is not readily available, emergency inpatient psychiatric services may be provided for up to forty-eight hours at the closest licensed general hospital.

17. Limited to nurse midwives sponsored by a physician.

Attachment G

State of Hawaii
1115A Waiver Renewal
Total Computable

		Trend Rates	DY20 Trended	1/2014-12/2014 DY21	1/2015-12/2015 DY22	1/2016-12/2016 DY23	1/2017-12/2017 DY24	1/2018-12/2018 DY25	5 Year Total
MEG									
WITHOUT WAIVER (WOW)									
PMPM									
Children 6-18 >100% to 133%	CHIP children up to 133%	4.00%	$162.76	$169.27	$176.04	$183.08	$190.41	$198.02	
Newly Eligible	QUEST NET/ACE and newly eligible	4.00%	$292.52	$304.22	$316.39	$329.05	$342.21	$355.90	
Childless to 100%	QUEST 100% and below	4.00%	$393.75	$409.50	$425.88	$442.92	$460.63	$479.06	
Foster Children to Age 25		4.00%	$170.95	$177.79	$184.90	$192.30	$199.99	$207.99	
State Plan Option up to 100%	GA Adults; Parents up to 100%	4.00%	$463.80	$482.35	$501.65	$521.71	$542.58	$564.28	
State Plan Adults		4.00%	$769.25	$800.02	$832.02	$865.30	$899.91	$935.91	
State Plan Children		4.00%	$444.52	$462.30	$480.79	$500.02	$520.03	$540.83	
Aged	Aged with/without Medicare	4.50%	$1,643.48	$1,717.44	$1,794.72	$1,875.48	$1,959.88	$2,048.08	
Blind/Disabled	Blind/Disabled with/without Medicare	4.50%	$2,111.54	$2,206.56	$2,305.85	$2,409.62	$2,518.05	$2,631.36	
Breast & Cervical Cancer		4.50%	$2,390.74	$2,498.32	$2,610.75	$2,728.23	$2,851.00	$2,979.30	
Member Months									
Children 6-18 >100% to 133%		3.0%		112,116	115,479	118,944	122,512	126,188	
Newly Eligible		3.0%		374,253	385,481	397,045	408,956	421,225	
Childless to 100%		3.0%	437,592	450,720	464,241	478,169	492,514	507,289	
Foster Children to Age 25		3.0%	2,376	2,447	2,521	2,596	2,674	2,754	
State Plan Option up to 100%		3.0%	125,596	129,364	133,245	137,242	141,359	145,600	
State Plan Adults		3.0%		492,138	506,902	522,109	537,772	553,906	
State Plan Children		3.0%		1,401,486	1,443,531	1,486,836	1,531,442	1,577,385	
Aged		1.2%		250,185	253,187	256,225	259,300	262,412	
Blind/Disabled		1.2%		298,231	301,810	305,431	309,097	312,806	
Breast & Cervical Cancer		1.2%		368	372	377	381	386	
Projected Without Waiver Expenditures									
Children 6-18 >100% to 133%				$18,977,920	$20,329,148	$21,776,583	$23,327,076	$24,987,964	**$109,398,692**
Newly Eligible				$113,856,715	$121,963,313	$130,647,101	$139,949,174	$149,913,555	**$656,329,858**
Childless to 100%				$184,569,742	$197,711,107	$211,788,138	$226,867,454	$243,020,416	**$1,063,956,857**
Foster Children to Age 25				$435,097	$466,076	$499,261	$534,808	$572,886	**$2,508,128**
State Plan Option up to 100%				$62,398,926	$66,841,730	$71,600,861	$76,698,842	$82,159,800	**$359,700,159**
State Plan Adults				$393,720,243	$421,753,124	$451,781,946	$483,948,821	$518,405,977	**$2,269,610,111**
State Plan Children				$647,908,099	$694,039,156	$743,454,744	$796,388,721	$853,091,598	**$3,734,882,318**
Aged				$429,676,876	$454,400,483	$480,546,687	$508,197,343	$537,439,019	**$2,410,260,408**
Blind/Disabled				$658,064,387	$695,929,411	$735,973,190	$778,321,087	$823,105,682	**$3,691,393,757**
Breast & Cervical Cancer				$919,383	$972,284	$1,028,230	$1,087,394	$1,149,962	**$5,157,253**
PCP Increase				$44,500,000	$47,000,000	$49,600,000	$52,300,000	$55,300,000	**$248,700,000**
Without Waiver Expenditures				***$2,555,027,387***	***$2,721,405,833***	***$2,898,696,740***	***$3,087,620,721***	***$3,289,146,861***	***$14,551,897,541***
DSH/UCC Ceiling				***$94,547,507***	***$94,547,507***	***$94,547,507***	***$94,547,507***	***$94,547,507***	***$472,737,535***
TOTAL WITHOUT WAIVER EXPENDITURES				***$2,649,574,894***	***$2,815,953,340***	***$2,993,244,247***	***$3,182,168,228***	***$3,383,694,368***	***$15,024,635,076***
WITH WAIVER (WW)									
PMPM									
Children 6-18 >100% to 133%		4.00%		$169.27	$176.04	$183.08	$190.41	$198.02	
Newly Eligible		4.00%		$304.22	$316.39	$329.05	$342.21	$355.90	
Childless to 100%		4.00%		$409.50	$425.88	$442.92	$460.63	$479.06	
Foster Children to Age 25		4.00%		$177.79	$184.90	$192.30	$199.99	$207.99	
State Plan Option up to 100%		4.00%		$482.35	$501.65	$521.71	$542.58	$564.28	
State Plan Adults		4.00%	$327.98	$341.10	$354.74	$368.93	$383.69	$399.04	
State Plan Children		4.00%	$188.57	$196.11	$203.96	$212.12	$220.60	$229.42	
Aged		4.50%	$1,568.19	$1,638.76	$1,712.50	$1,789.57	$1,870.10	$1,954.25	
Blind/Disabled		4.50%	$1,242.77	$1,298.69	$1,357.14	$1,418.21	$1,482.03	$1,548.72	
Breast & Cervical Cancer		4.50%	$2,390.74	$2,498.32	$2,610.75	$2,728.23	$2,851.00	$2,979.30	
Caretaker to age 19		4.00%	$277.40	$288.50	$300.04	$312.04	$324.52	$337.50	
Member Months									
Children 6-18 >100% to 133%		3%	108850	112116	115479	118944	122512	126188	
Newly Eligible				374253	385481	397045	408956	421225	
Childless to 100%				450720	464241	478169	492514	507289	
Foster Children to Age 25				2447	2521	2596	2674	2754	
State Plan Option up to 100%				129364	133245	137242	141359	145600	
State Plan Adults				492138	506902	522109	537772	553906	
State Plan Children				1401486	1443531	1486836	1531442	1577385	
Aged				250185	253187	256225	259300	262412	
Blind/Disabled				298231	301810	305431	309097	312806	
Breast & Cervical Cancer				368	372	377	381	386	
Caretaker to age 19				4296	4348	4400	4453	4506	
Projected With Waiver Expenditures									
Children 6-18 >100% to 133%				$18,977,920	$20,329,148	$21,776,583	$23,327,076	$24,987,964	**$109,398,692**
Newly Eligible				$113,856,715	$121,963,313	$130,647,101	$139,949,174	$149,913,555	**$656,329,858**
Childless to 100%				$184,569,742	$197,711,107	$211,788,138	$226,867,454	$243,020,416	**$1,063,956,857**
Foster Children to Age 25				$435,097	$466,076	$499,261	$534,808	$572,886	**$2,508,128**
State Plan Option up to 100%				$62,398,926	$66,841,730	$71,600,861	$76,698,842	$82,159,800	**$359,700,159**
State Plan Adults				$167,867,878	$179,820,071	$192,623,260	$206,338,036	$221,029,304	**$967,678,550**
State Plan Children				$274,849,344	$294,418,617	$315,381,222	$337,836,365	$361,890,315	**$1,584,375,863**
Aged				$409,992,808	$433,583,794	$458,532,206	$484,916,149	$512,818,224	**$2,299,843,180**
Blind/Disabled				$387,311,004	$409,596,879	$433,165,084	$458,089,403	$484,447,867	**$2,172,610,237**
Breast & Cervical Cancer				$919,383	$972,284	$1,028,230	$1,087,394	$1,149,962	**$5,157,253**
Caretaker to age 19				$1,239,379	$1,304,421	$1,372,877	$1,444,926	$1,520,756	**$6,882,360**
PCP Increase				$44,500,000	$47,000,000	$49,600,000	$52,300,000	$55,300,000	**$248,700,000**
UCC				$94,547,507	$94,547,507	$94,547,507	$94,547,507	$94,547,507	**$472,737,535**
Total With Waiver Expenditures				***$1,761,465,702***	***$1,868,554,948***	***$1,982,562,329***	***$2,103,937,134***	***$2,233,358,557***	***$9,949,878,671***
Cost Share				-$9,000,000	-$9,000,000	-$9,000,000	-$9,000,000	-$9,000,000	
Net Expenditures				***$1,752,465,702***	***$1,859,554,948***	***$1,973,562,329***	***$2,094,937,134***	***$2,224,358,557***	
DY BN Savings				**$897,109,192**	**$956,398,392**	**$1,019,681,918**	**$1,087,231,094**	**$1,159,335,811**	
Cummulative Savings		***Carryover***	***$2,098,447,093***	***$2,995,556,285***	***$3,951,954,676***	***$4,971,636,594***	***$6,058,867,688***	***$7,218,203,498***	

State of Hawaii			FMAP	0.5185	0.5185	0.5185	0.5185	0.5185	
1115A Waiver Renewal			CHIP	0.663	0.663	0.663	0.663	0.663	
Federal Share			Newly Enrolled	1	1	1	0.95	0.94	
			Transitional	0.7593	0.8074	0.8556	0.8637	0.8979	
				1/2014-12/2014	1/2015-12/2015	1/2016-12/2016	1/2017-12/2017	1/2018-12/2018	
		Trend Rates	DY20 Trended	DY21	DY22	DY23	DY24	DY25	5 Year Total
MEG									
WITHOUT WAIVER (WOW)									
PMPM									
Children 6-18 >100% to 133%	CHIP children up to 133%	4.00%	$162.76	$169.27	$176.04	$183.08	$190.41	$198.02	
Newly Eligible	QUEST NET/ACE and newly eligible	4.00%	$292.52	$304.22	$316.39	$329.05	$342.21	$355.90	
Childless to 100%	QUEST 100% and below	4.00%	$393.75	$409.50	$425.88	$442.92	$460.63	$479.06	
Foster Children to Age 25		4.00%	$170.95	$177.79	$184.90	$192.30	$199.99	$207.99	
State Plan Option up to 100%	GA Adults; Parents up to 100%	4.00%	$463.80	$482.35	$501.65	$521.71	$542.58	$564.28	
State Plan Adults		4.00%	$769.25	$800.02	$832.02	$865.30	$899.91	$935.91	
State Plan Children		4.00%	$444.52	$462.30	$480.79	$500.02	$520.03	$540.83	
Aged	Aged with/without Medicare	4.50%	$1,643.48	$1,717.44	$1,794.72	$1,875.48	$1,959.88	$2,048.08	
Blind/Disabled	Blind/Disabled with/without Medicare	4.50%	$2,111.54	$2,206.56	$2,305.85	$2,409.62	$2,518.05	$2,631.36	
Breast & Cervical Cancer		4.50%	$2,390.74	$2,498.32	$2,610.75	$2,728.23	$2,851.00	$2,979.30	
Member Months									
Children 6-18 >100% to 133%		3.0%		112,116	115,479	118,944	122,512	126,188	
Newly Eligible		3.0%		374,253	385,481	397,045	408,956	421,225	
Childless to 100%		3.0%	437,592	450,720	464,241	478,169	492,514	507,289	
Foster Children to Age 25		3.0%	2,376	2,447	2,521	2,596	2,674	2,754	
State Plan Option up to 100%		3.0%	125,596	129,364	133,245	137,242	141,359	145,600	
State Plan Adults		3.0%		492,138	506,902	522,109	537,772	553,906	
State Plan Children		3.0%		1,401,486	1,443,531	1,486,836	1,531,442	1,577,385	
Aged		1.2%		250,185	253,187	256,225	259,300	262,412	
Blind/Disabled		1.2%		298,231	301,810	305,431	309,097	312,806	
Breast & Cervical Cancer		1.2%		368	372	377	381	386	
Projected Without Waiver Expenditures									
Children 6-18 >100% to 133%			$0	$12,582,361	$13,478,225	$14,437,875	$15,465,851	$16,567,020	**$72,531,333**
Newly Eligible				$113,856,715	$121,963,313	$130,647,101	$132,951,716	$140,918,742	**$640,337,586**
Childless to 100%				$140,143,805	$159,631,948	$181,205,931	$195,945,420	$218,208,032	**$895,135,135**
Foster Children to Age 25				$225,598	$241,660	$258,867	$277,298	$297,041	**$1,300,464**
State Plan Option up to 100%				$32,353,843	$34,657,437	$37,125,046	$39,768,350	$42,599,856	**$186,504,532**
State Plan Adults				$204,143,946	$218,678,995	$234,248,939	$250,927,464	$268,793,499	**$1,176,792,843**
State Plan Children				$335,940,349	$359,859,302	$385,481,285	$412,927,552	$442,327,994	**$1,936,536,482**
Aged				$222,787,460	$235,606,651	$249,163,457	$263,500,323	$278,662,131	**$1,249,720,021**
Blind/Disabled				$341,206,384	$360,839,400	$381,602,099	$403,559,484	$426,780,296	**$1,913,987,663**
Breast & Cervical Cancer				$609,551	$644,624	$681,716	$720,942	$762,425	**$3,419,259**
PCP Increase				$44,500,000	$24,369,500	$25,717,600	$27,117,550	$28,673,050	**$150,377,700**
Without Waiver Expenditures				***$1,448,350,012***	***$1,529,971,055***	***$1,640,569,916***	***$1,743,161,948***	***$1,864,590,087***	***$8,226,643,019***
DSH/UCC Ceiling				***$94,547,507***	***$94,547,507***	***$94,547,507***	***$94,547,507***	***$94,547,507***	***$472,737,535***
TOTAL WITHOUT WAIVER EXPENDITURES				***$1,542,897,519***	***$1,624,518,562***	***$1,735,117,423***	***$1,837,709,455***	***$1,959,137,594***	***$8,699,380,554***
WITH WAIVER (WW)									
PMPM									
Children 6-18 >100% to 133%		4.00%		$169.27	$176.04	$183.08	$190.41	$198.02	
Newly Eligible		4.00%		$304.22	$316.39	$329.05	$342.21	$355.90	
Childless to 100%		4.00%		$409.50	$425.88	$442.92	$460.63	$479.06	
Foster Children to Age 25		4.00%		$177.79	$184.90	$192.30	$199.99	$207.99	
State Plan Option up to 100%		4.00%		$482.35	$501.65	$521.71	$542.58	$564.28	
State Plan Adults		4.00%	$327.98	$341.10	$354.74	$368.93	$383.69	$399.04	
State Plan Children		4.00%	$188.57	$196.11	$203.96	$212.12	$220.60	$229.42	
Aged		4.50%	$1,568.19	$1,638.76	$1,712.50	$1,789.57	$1,870.10	$1,954.25	
Blind/Disabled		4.50%	$1,242.77	$1,298.69	$1,357.14	$1,418.21	$1,482.03	$1,548.72	
Breast & Cervical Cancer		4.50%	$2,390.74	$2,498.32	$2,610.75	$2,728.23	$2,851.00	$2,979.30	
Caretaker to age 19		4.00%	$277.40	$288.50	$300.04	$312.04	$324.52	$337.50	
Member Months									
Children 6-18 >100% to 133%		3%	108850	112116	115479	118944	122512	126188	
Newly Eligible				374253	385481	397045	408956	421225	
Childless to 100%				450720	464241	478169	492514	507289	
Foster Children to Age 25				2447	2521	2596	2674	2754	
State Plan Option up to 100%				129364	133245	137242	141359	145600	
State Plan Adults				492138	506902	522109	537772	553906	
State Plan Children				1401486	1443531	1486836	1531442	1577385	
Aged				250185	253187	256225	259300	262412	
Blind/Disabled				298231	301810	305431	309097	312806	
Breast & Cervical Cancer				368	372	377	381	386	
Caretaker to age 19				4296	4348	4400	4453	4506	
Projected With Waiver Expenditures									
Children 6-18 >100% to 133%			$0	$12,582,361	$13,478,225	$14,437,875	$15,465,851	$16,567,020	**$72,531,333**
Newly Eligible				$113,856,715	$121,963,313	$130,647,101	$132,951,716	$140,918,742	**$640,337,586**
Childless to 100%				$140,143,805	$159,631,948	$181,205,931	$195,945,420	$218,208,032	**$895,135,135**
Foster Children to Age 25				$225,598	$241,660	$258,867	$277,298	$297,041	**$1,300,464**
State Plan Option up to 100%				$32,353,843	$34,657,437	$37,125,046	$39,768,350	$42,599,856	**$186,504,532**
State Plan Adults				$87,039,495	$93,236,707	$99,875,160	$106,986,272	$114,603,694	**$501,741,328**
State Plan Children				$142,509,385	$152,656,053	$163,525,164	$175,168,155	$187,640,128	**$821,498,885**
Aged				$212,581,271	$224,813,197	$237,748,949	$251,429,023	$265,896,249	**$1,192,468,689**
Blind/Disabled				$200,820,756	$212,375,982	$224,596,096	$237,519,355	$251,186,219	**$1,126,498,408**
Breast & Cervical Cancer				$609,551	$644,624	$681,716	$720,942	$762,425	**$3,419,259**
Caretaker to age 19				$642,618	$676,343	$711,837	$749,194	$788,512	**$3,568,503**
PCP Increase				$44,500,000	$24,369,500	$25,717,600	$27,117,550	$28,673,050	**$150,377,700**
UCC				$49,022,882	$49,022,882	$49,022,882	$49,022,882	$49,022,882	**$245,114,412**
Total With Waiver Expenditures				***$1,036,888,279***	***$1,087,767,871***	***$1,165,554,224***	***$1,233,122,009***	***$1,317,163,852***	***$5,840,496,234***
Cost Share				-$4,666,500	-$4,666,500	-$4,666,500	-$4,666,500	-$4,666,500	
Net Expenditures				***$1,032,221,779***	***$1,083,101,371***	***$1,160,887,724***	***$1,228,455,509***	***$1,312,497,352***	
DY BN Savings				**$510,675,740**	**$541,417,191**	**$574,229,699**	**$609,253,947**	**$646,640,242**	
Cummulative Savings		***Carryover***	***$1,558,726,915***	***$2,069,402,656***	***$2,610,819,846***	***$3,185,049,545***	***$3,794,303,492***	***$4,440,943,734***	

Attachment H

The Department of Human Services sent the following email and attachment on November 20, 2012, to the individuals listed below:

E-Mail Content:

The Med-QUEST Division (MQD) is seeking public comment on its section 1115 demonstration project application. You are receiving this email as a key stakeholder regarding the provision of care to Medicaid beneficiaries and have either participated in previous MQD community forums and/or indicated a desire to receive such notifications. Please see the attached full public notice that provides detailed information on how to access the application documents and how to provide comment. Thank you for your continuing support of MQD programs and our beneficiaries.

Attachment

Notice of Request for a Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration (11-W-00001/9)

The State of Hawaii, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 demonstration from the Centers for Medicare & Medicaid Services (CMS). This renewal, which will be effective January 1, 2014, will be entitled "QUEST Integration."

By November 20, 2012, a copy of the proposed renewal application will be available at the Department of Human Services, Med-QUEST Division, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707, or at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/. We are providing this notice pursuant to CMS requirements in 42 C.F.R. § 431.408.

QUEST Integration Renewal Application

The State's current demonstration, QUEST Expanded, is set to expire June 30, 2013, but the State expects it will be extended to December 31, 2013 pursuant to the extension request submitted in June 2012. QUEST Integration seeks to build on the successes of Hawaii's existing demonstration, while integrating the current programs to align with requirements in the Affordable Care Act (ACA) and deliver better health outcomes more efficiently.

Program Description, Goals, and Historical Context

Originally implemented as the QUEST program in 1994, QUEST Expanded is the current version of Hawaii's demonstration project to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. The provision of benefits through managed care has saved hundreds of millions of dollars in State and federal funds and has

enabled the State to use some of the savings to provide coverage to individuals not otherwise eligible for Medicaid.

The Hawaii Medicaid program covers adults in certain categories and up to certain income levels, as well as all children up to 300% of the federal poverty level (FPL). In addition, through the demonstration, Hawaii has sought to provide coverage to Medicaid expansion populations through a variety of programs known as QUEST, QUEST-Net, and QUEST-ACE. The demonstration already covers non-pregnant, non-disabled adults up to and including 133% of the federal poverty level (FPL).

Further detail on the existing program is available at http://www.med-quest.us/. CMS also offers online resources regarding the QUEST Expanded Demonstration, which can be viewed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=hawaii

Under the "QUEST Integration" renewal, Hawaii seeks to continue to deliver services through managed care, while integrating the demonstration's programs and benefits to create a more patient-centered healthcare delivery system and to align the demonstration with ACA's new requirements. The State will eliminate all eligibility enrollment caps, and streamline its programs by consolidating the current programs under QUEST Integration. All eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be based on clinical criteria and medical necessity. Other renewal initiatives include:

- Incorporating the new simplified Medicaid eligibility structure and other changes in ACA.
- Offering new services to beneficiaries, including a home- and community-based services (HCBS) benefit to individuals who are assessed to be at risk of deteriorating to the institutional level of care (the "at risk" population).
- Expanding coverage of behavioral health services.
- Preparing for integration of care for Medicaid and Medicare enrollees.
- Modifying the health plan enrollment process.
- Covering certain Medicaid expansion populations.
- Expanding the qualified provider network to increase access to substance abuse treatment services.
- Modifying retroactive coverage.
- Changing the payment process when hospice care is furnished to individuals residing in nursing facilities.
- Eliminating the QUEST-ACE enrollment benchmarks for purposes of claiming FFP in uncompensated care costs.

The goals of QUEST Integration will be to:

- Improve the health and healthcare of the member population.
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits.
- Align the demonstration with ACA.

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

More detailed information about renewal initiatives and changes in QUEST Integration can be found in the draft application, which is available at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/, as well as in hard copy at the Department of Human Services, Med-QUEST, Policy and Program Development Office located at 601 Kamokila Blvd, Room 518, Kapolei, HI.

Beneficiaries Impacted, Eligibility Methodology, and Eligibility Requirements
QUEST Integration will utilize a new eligibility methodology called "modified gross adjusted income" (MAGI) to the extent required by ACA, which will not have an asset test. Other than the use of MAGI methodology, there will be no changes in eligibility methodology. Eligibility for the aged, blind, and disabled (ABD) groups will continue to be determined using current income and resource methodologies. Effective January 1, 2014, MAGI will be applied to new non-ABD applicants and annual eligibility re-determinations (no individual enrolled on January 1, 2014 will lose his or her eligibility prior to March 31, 2014 because of the implementation of MAGI).

Hawaii plans to cover the following groups in QUEST Integration:

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

Pregnant Women	§ 1902(a)(10)(A)(i)(III)-(IV) 42 C.F.R. § 435.116 (eff. Jan. 1, 2014)	Up to and including 185% FPL
Poverty Related Infants	§ 1902(a)(10)(A)(i)(IV) § 1902(l)(1)(B) 42 C.F.R. § 435.118(c) (eff. Jan. 1, 2014)	Infants up to age 1, up to and including 185% FPL
Poverty Related Children	§ 1902(a)(10)(A)(i)(VI)-(VII) § 1902(l)(1)(C)-(D) 42 C.F.R. § 435.118(a) (eff. Jan. 1, 2014)	Children ages 1 through 18, up to and including 133% FPL
ACA Mandatory Adults Age 19 Through 64 Group	§ 1902(a)(10)(A)(i)(VIII) 42 C.F.R. § 435.119(b) (eff. Jan. 1, 2014)	Up to and including 133% FPL
Children through the CHIP Medicaid expansion	Title XXI, § 2105	Title XIX limits up to and including 300% FPL and for whom the State is claiming Title XXI funding
Former Foster Children under age 26	§ 1902(a)(10)(A)(i)(IX)	No income limit
SSI Aged, Blind, or Disabled	§ 1902(a)(10)(A)(i)(II)(aa), as qualified by Section 1902(f) 42 C.F.R. § 435.121	SSI-related using SSI payment standard
Section 1925 Transitional Medicaid, Subject to Continued Congressional Authorization	§ 1925 § 1931(c)(2)	Coverage for two six-month periods due to increased earnings, or for four months due to receipt of child support, that would otherwise make the individual ineligible under Section 1931 - In the second six-month period, family income may not exceed 185% FPL

Optional State Plan Groups		
Eligibility Group Name	**Social Security Act and Code of Federal Regulations Citations**	**Income Level and Other Qualifying Criteria**
Aged or Disabled	§ 1902(a)(10)(ii)(X) § 1902(m) 42 C.F.R. § 435.230(c)(vi)	SSI-related net income up to and including 100% FPL
Independent Foster Care Adolescents (Age 19 and 20)	§ 1902(a)(10)(A)(ii)(XVII) § 1905(w)	No income limit
Certain Women Needing Treatment for Breast or Cervical Cancer	§ 1902(a)(10)(A)(ii)(XVIII) § 1902(aa)	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non-Aged, Blind, or Disabled Children and Adults	§ 1902(a)(10)(C) 42 C.F.R. § 435.301(b)(1) 42 C.F.R. § 435.308 42 C.F.R. § 435.310	Up to and including 300% FPL, if spend down to medically need income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	§ 1902(a)(10)(C) 42 C.F.R. §§ 435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology

Expansion Population	
Eligibility Group Name	**Federal Poverty Level and/or Other Qualifying**
Parents or caretaker relatives with an 18-year-old dependent child	Parents or caretaker relatives who (i) are living with an 18-year-old who would be a dependent child but for the fact that s/he has reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age
Individuals in the 42 C.F.R. § 435.217 group receiving HCBS	Income up to and including 100% FPL using the institutional income rules

Medically needy individuals receiving HCBS	Receiving HCBS and meet medically needy income standard using institutional rules for income, assets, and post-eligibility treatment of income
Medically needy ABD individuals whose spend-down exceeds the plans' capitation payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance	Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in the state plan or waiver while receiving adoption assistance payments

Benefit Coverage

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

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

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

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

Delivery System

Under QUEST Integration, the State will continue to provide most benefits through managed care, which will help ensure access to high-quality, cost-effective care. A discrete set of benefits will be provided fee-for-service.

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

Benefit(s)	Delivery System	Authority
State plan services	Managed Care - MCO	1115
QUEST Integration HCBS and long-term care benefits	Managed Care - MCO	1115
Cognitive rehabilitation therapy	Managed Care - MCO	1115 or State plan
Medical services to medically needy individuals who are aged, blind or disabled	Managed Care - MCO	1115
Medical services to medically needy individuals who are not aged, blind or disabled	Fee-for-service	1115
Long-term care services for individuals with developmental disabilities (DD) or intellectual disabilities (ID)	Fee-for-service	Section 1915(c) waiver
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID)	Fee-for-service	State plan
Medical services to applicants eligible for retroactive coverage only	Fee-for-service	State plan
Medical services under the State of Hawaii Organ and Tissue Transplant (SHOTT) program	Fee-for-service	State plan
Dental services	Fee-for-service	State plan
Targeted Case Management	Fee-for-service	State plan
School-based services	Fee-for-service	State plan
Early Intervention Services	Fee-for-service	State plan
Covered substance abuse treatment services provided by a certified substance abuse counselor	As described in the behavioral health protocol	1115

Specialized behavioral health services for qualified individuals with a SPMI, SMI, or SEBD	As described in the behavioral health protocol	1115 or State plan

Cost Sharing

The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan. The State plans to seek authority to continue to charge an enrollment fee to health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate (for the Medically Needy Aged, Blind, and Disabled), in the amount equal to the estimated spend-down or cost share amount.

Annual Enrollment and Annual Expenditures

From July 1, 2011 to June 30, 2012, state and federal expenditures in the demonstration totaled approximately $1.3 billion, and there was an average of 236,964 individuals enrolled in the demonstration (and covered in part by a federal match).

During the five-year renewal period, the annual increase in enrollment is expected to be 3% per year for non-ABD recipients and 1.2% for ABD recipients, or approximately 6,317 recipients per year for the existing population. In addition, 24,000 recipients may become eligible under the new ACA eligibility guidelines. Total aggregate expenditures for each renewal year are anticipated to be $2.0 billion in both State and federal funding. That is, the State expects the changes required by ACA, coupled with changes effective since June 30, 2012 and other State-requested changes to the demonstration, to result in approximately $700 million in increased State and federal annual expenditures during the renewal period.

Hypotheses and Evaluation Parameters

In QUEST Integration, the State will continue to test two overarching hypotheses about its demonstration:

- Capitated managed care delivers high quality care, while also slowing the rate of health care expenditure growth.

- Capitated managed care provides access to HCBS and facilitates rebalancing of provided long-term care services.

The State will test the following hypotheses about the changes implemented in QUEST Integration:

- Consolidating the current programs decreases administrative burdens for the health plans and the State.

- Consolidating the current programs improves access to appropriate care, such as HCBS, and ensures continuity of care when an enrollee's health status changes.

- Extending HCBS to the “at risk” population will decrease the percentage of at-risk enrollees whose health status deteriorates.

The State will also measure the outcomes in QUEST Integration based on the State Quality Improvement Strategy targets:

- Childhood Immunizations (CIS): Increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the Medicaid 75th percentile.

- Chlamydia Screening (CHL): Increase performance on the state aggregate HEDIS Chlamydia Screening measure to meet/exceed the Medicaid 75th percentile.

- Breast Cancer Screening (BCS): Increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the Medicaid 75th percentile.

- Comprehensive Diabetes Care (CDC):

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the HEDIS 75th percentile.

    - Improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c poor control (>9) to meet/fall below the HEDIS 25th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<7) to meet/exceed below the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL screening to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL control (<100) to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<140/90) to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for eye exams to meet/exceed the HEDIS 75th percentile.

- Cholesterol Management in Patients with Cardiovascular Conditions (CMC): Increase performance on the state aggregate HEDIS Cholesterol Screening measure to meet/exceed the HEDIS 75th percentile.

- Controlling High Blood Pressure (CBP): Increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the HEDIS 75th percentile.

- Use of Appropriate Medications for People with Asthma (ASM): Increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the HEDIS 75th percentile.

- Emergency Department Visits (AMB): Maintain performance on the state aggregate HEDIS Emergency Department Visits/1000 rate to fall below the HEDIS 10th percentile.

- Plan All-Cause Readmissions: Increase performance on the state aggregate HEDIS to meet/exceed the HEDIS 75th percentile.

- Getting Needed Care: Increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Rating of Health Plan: Increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- How well doctors communicate: Increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Home and Community Based Service (HCBS) beneficiaries: Increase the proportion of clients receiving HCBS to at least 70% of the population receiving long-term supports and services.

Waiver Authority

The State believes the following waiver authorities will be necessary to authorize the demonstration.

1. Medically Needy - Section 1902(a)(10)(C); Section 1902(a)(l7)

   To enable the State to limit medically needy spend-down eligibility to those non-ABD individuals whose gross incomes, before any spend-down calculation, are at or below 300% of the Federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which have no gross income limit.

2. Amount, Duration, and Scope - Section 1902(a)(10)(B)

   To enable the State to offer demonstration benefits that may not be available to all categorically eligible or other individuals.

   To enable the State to maintain waiting lists, through a health plan, for home and community-based services (including services for the "at risk" population). No waiting list is permissible for other services for health plan enrollees.

3. Retroactive Eligibility - Section 1902(a)(34)

To enable the State to limit retroactive eligibility to a ten (10) day period prior to application, or up to three months for individuals requesting long-term care services. Individuals will be considered eligible for any portion of the 10-day retroactive period that extends into a month prior to the month for which determined eligible.

4. Freedom of Choice - Section 1902(a)(23)

To enable Hawaii to restrict the freedom of choice of providers to groups that could not otherwise be mandated into managed care under Section 1932.

5. Hospice Care Payment - Section 1902(a)(13)(B)

To enable the State, when hospice care is furnished to an individual residing in a nursing facility, to make payments to the nursing facility (through the health plans rather than the hospice providers) for the room and board furnished by the facility.

Expenditure Authority

The State believes the following expenditure authorities will be necessary to authorize the demonstration.

1. Managed Care Payments. Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of Section 1903(m):

   a) Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to disenroll without cause within 60 days of initial enrollment in an MCO, as designated under Section 1903(m)(2)(A)(vi) and Section 1932(a)(4)(A)(ii)(l) of the Social Security Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at Section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single health plan in the absence of a choice of health plan on that particular island.

   b) Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more health plans, as required under Section 1903(m)(2)(A)(xii), Section 1932(a)(3) and Federal regulations at 42 CFR § 438.52.

2. Quality Review of Eligibility. Expenditures for Medicaid services that would have been disallowed under Section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

3. Demonstration Eligibility. Expenditures to provide coverage to the following populations:

   a) Parents or caretaker relatives who would otherwise be eligible if the dependent child was under 18 years of age.

   b) Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

   c) Individuals who would otherwise be eligible under the State plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of the health plan capitation payment, subject to an enrollment fee equal to the spend-down liability.

   d) Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance.

   e) Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program, are not eligible under any other eligibility group, and were enrolled in the State plan or waiver while receiving adoption assistance.

4. Hospital Uncompensated Care Costs. Expenditures to reimburse certain hospital and nursing facility providers for provider costs of inpatient and outpatient hospital services and long-term care services to the uninsured and/or underinsured, subject to certain restrictions placed on hospital and nursing facility uncompensated care costs. The State is seeking federal participation in the total of actual uncompensated care costs of private and public hospitals (including uncompensated long term care costs of public hospitals for serving QI enrollees) incurred in any given year, subject to the overall budget neutrality limitation.

5. Home and Community-Based Services (HCBS). Expenditures to provide HCBS not included in the Medicaid State plan and furnished to QUEST Integration enrollees, as follows:

   a) Expenditures for the provision of services, through health plans, that could be provided under the authority of Section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

   b) Expenditures for the provision of services, through health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, *i.e.*, the “at risk” population.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, will apply to the demonstration beginning January 1, 2014, through December 31, 2018, except those waived or listed below as not applicable.

Medicaid Requirements Not Applicable to Demonstration Populations

The State believes the following Medicaid requirement will need to be deemed not applicable to demonstration populations.

1. Cost Sharing - Section1902(a)(14)

   To enable the State to charge cost sharing with limits on cost-sharing amounts but no aggregate limit. To enable the State to charge an enrollment fee to Medically Needy Aged, Blind and Disabled health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate, in the amount equal to the estimated spend-down or cost share amount or, where applicable, the amount of patient income applied to the cost of long-term care.

Comments

We invite comments on this proposal. Please submit any comments or questions to Noreen Moon-Ng by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at nmoon-ng@ medicaid.dhs.state.hi.us.

Comments will be accepted for consideration between November 20, 2012, and December 21, 2012 (30 days from the date of this notice).

Public Hearings

The State will hold two public hearings to seek public input on this demonstration renewal application:

1. December 3, 2012 from 8:00 a.m.-12:00 p.m.:

Oahu	Keoni Ana Videoconference Center Keoni Ana Building 1177 Alakea Street, Room 302 Honolulu, Hawaii
Hawaii	Hilo Videoconference Center Hilo State Office Building 75 Aupuni Street, Basement Hilo, Hawaii

Kauai Lihue Videoconference Center
Lihue State Office Building
3060 Eiwa Street, Basement
Lihue, Hawaii

Maui Wailuku Videoconference Center
Wailuku Judiciary Building
2145 Main Street, First Floor
Wailuku, Hawaii

2. December 7, 2012 from 9:00 a.m. to 12:00 p.m.:

Department of Human Services
1390 Miller Street, Conference Rooms 1 & 2
Honolulu, Hawaii

Interested parties may alternatively participate by teleconference in the December 7, 2012 public hearing. Should you be interested in participating in the teleconference, please call 808-692-8056 by close of business on December 5, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (*e.g.*, sign or foreign language or wheelchair accessibility), please contact:

Oahu	Jeri Kido (808) 692-8056
Hawaii	Ann Stephenson (808) 933-0046
Kauai	Iris Venzon (808) 241-3582
Maui	Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

Email List of Individuals

NAME	ORGANIZATION
A. Garrett	HIPA Online
Alan Matsunami	CCMC
Phocused Hawaii	Phocused Hawaii Administration
A. Ige	DCCA
Aiona I. Rose	State of Hawaii Courts

A. Johnson	Hina Mauka
Amgoyal	Queens
A. Muraoka	Honolulu
Andreas Cravalho	HMSA
Anne Holton	DOH Hawaii
Antonette Torres	DOH Hawaii
Arensdora	Hawaii
Arnold Villafuerte	DOH Hawaii
A. Tashiro	DHS Hawaii
A. Y. Onemoto	HHSC
B. Brown	Queens
Brian	Arc of Maui
B. Ogawa	HLTCA
Brian D. Cade	Hawaii
B. Stanton	AARP
B. Marsh	HSAG
Candice Calhoun	DOH Hawaii
Carol Ganiron	KP
Cash Lopez	DOH Hawaii
Catherine J. Bailey	KP
Catherine Sorensen	DOH Hawaii
Charlie Schlather	MYFSs
Christina K.	Pacificil
C. Stewart	Outreach Services
C. Y. Hara	Queens
C. Young	Hawaii
Dana	C. C. Maui
Dara Rampersad	DOH Hawaii
David W. Heywood	UHC
Chun Oakland	Yahoo
C. Kelsey	Queens
C. L. Yee	Queens
C. Mehau	Bay Clinic
C. Meyer-Uyehara	HHSC
C. O. Liu	Lashaw
Cristina A.	Stop the Violence
C. Flanders	HMSA-ASSN
David Kanno	DOH Hawaii
Dawn Mendiola	DOH Hawaii
D. Derauf	KKV
Dean T.	Kapiolani.
Debbie Shimizu	Hawaii
Deja	LEJ Hawaii
Diana Lee	HMSA
D. Mahi	KKV

D. Tom	Good Beginnings
D. Ulima	Epic Ohana
E. Kealoha	Capitol Hawaii
E. Ching	Easter Seals Hawaii
Edna Azada	Gmail
Eileen Matsumoto	DOH Hawaii
E. Kintu	KPHC
Ellen Matoi	DOH Hawaii
Fenny Esther	Hotmail
F. Jack	Bay Clinic
Flanderscd	Gmail
Flick W. J.	AH
Florentina Salvail	DOH Hawaii
Frank P. Richardson	NSMTP KP
G. Greene	HAH
Ginny P.	Kapiolani
G. L. Wideman	Hotmail
G. Oconnor	Queens
Ohtahpha	Yahoo
Grace Miyata	DOH Hawaii
Gretchen	Arc of Kona
Guinan	Hawaii Education
Hali	Hawaii Education
	Hawaii Down Syndrome
	Hawaii Lobbyist
H. Dela Cruz	WCCHC
Heidi M. Rian	Hawaii
Helene Kaiwi	DOH Hawaii
H. Koop	CFS Hawaii
H. Spoehr	Papa Ola Lokahi
J. Kawasaki	Queens
Kerita	Queens
info	NASWHI
J. Adams, Esq	AOL
Jan Tateishi	DOH Hawaii
Anenamikonakama	Gmail
Janelle Curnan	Meo Inc.
Jarkylik	Gmail
Jeffrey Torres	Wellcare
Jevans	Palama Settlement
J. Howard	HI Goodwill
J. Kakuno	MDX Hawaii
J. Kawamoto	HAH
J. Nakamura3	Honolulu
J. O’Ddonnell	Family Programs HI

J. Patricio	Hawaii Disability Rights
J. Tomoso	HNKOP
J. Wilhoite	Family Programs HI
Judc	Aloha
K. Hooser	Capitol Hawaii
Kanoe	Hawaii Health Connector
Karen	Scott Gardner Co.
Kathleen Tom	DOH Hawaii
Kathi	MFSS
Kathy	Hawaii Disability Rights
	Kauai DDC
K. Delahi	Hotmail
Keola Diaz	Gmail
Keolani	Hotmail
Kimberly Click	HMSA
K. Ishihara	DHS Hawaii
K. Liumd	Gmail
K. Louis	Hale Mahaolu
K. Suzuki	HPCA
L. Cook	Kualoha
Levie Gray	Yahoo
Lila C. King	Hawaii
Lila Ota	DOH Hawaii
Linda Takai	Gmail
Lisa Nakao	DOH Hawaii
Lisama	Kapiolani
Loren Y.	Kapiolani
Lorrin Kim	DOH Hawaii
Louis	Hawaii Disability Rights
L. Tochiki	Epic Ohana
L. Watanabe	Queens
Lynn.Fallin	DOH Hawaii
Mary Rydell	CMS
Maylyn Tallett	DOH Hawaii
M. Espinda,	Queens
Mihalke	Hawaii Education
M. Iwana	Bay Clinic
Marline	WHW Maui
M. Kobayashi	HHSC
	MLPC Hawaii
M. May	Queens
Moira T.Chin	Courts
M. Molina	Queens
Molokai Rep	Yahoo
N. Vierra	Bayada

Nishimura	Capitol
Norma Circle	CO Maui
O. Gonzaga	Kualoha
O. Wades	Hawaii Education
Pamela Cunningham	DOH Hawaii
Parcena	Alohacare
Paula	The Maui Farm
Pat	Arc of Maui
Phyllis Dendle	KP
P. Laenui	Hawaiian Perspectives
P. Young	HAH
Q. Ogawa	Kuakini
Racob	Rehab Hospital
R. Drake	Honolulu
Rep. Cabanilla	Capitol
Rep. Manahan	Capitol
Rhodorar	Pacificil
Richard Dusendschon	DOH Hawaii
River Run	Hawaii
R. Keene	Queens
R. Katsuda	Hale Mahaolu
R. Lorin	Catholic Charities Hawaii
Romala.Radcliffe	DOH Hawaii
R. Sato-Yuen	Queens
R. Wong	HAH
Ryan	Capitol
Sasha	Balancing Birth
S. Beckham	Waikiki Health Center
S. Bernadette	Gmail
S. B. Kemble	Hawaii
S. Catalan	Alohacare Hawaii
Scorse	Alohacare Hawaii
Scott	Scott Gardner, Co.
Shani Naleieha	Gmail
Shirley Kidani	DOH Hawaii
Shirley Robinson	DOH Hawaii
Suzanne Noland	DHS
S. Tone	Full life Hawaii
S. Yoro	SECOH
S. Young	HAH
Susan Jackson	Wellcare
Suzie Mig	Gmail
T. Gonsalves	WCCHC
T. J. Solid	AOl
Troy Freitas	DOH Hawaii

Trudy Murakami	DOH Hawaii
T. Wakasugi	Queens
Valerie	Arc of Maui
V. Geminiani	Gmail
V. Tomooka	Waimanalo Health
Waynette Cabral	DOH Hawaii
Wendy Nihoa	DOH Hawaii
Wendys Cortez	Yahoo
W. Villareal	HI Goodwill
Wendy Nihoa	DOH Hawaii
Wendy S. Cortez	Yahoo

Attachment I

Statement of Public Notice
Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration

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   Honolulu, Hawaii

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Kauai	Iris Venzon (808) 241-3582
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at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

STATE OF HAWAII
COUNTY OF KAUAI
AFFIDAVIT OF PUBLICATION

THE GARDEN ISLAND

DHS/MED-QUEST DIV/FINANCE OFFI
601 KAMOKILA BLVD RM 518
KAPOLEI HI 96707

REFERENCE: 113004
7747476 SECTION 1115(a)
RENEWAL OF HAWAII

Cheri Bagain, being duly sworn, deposes and says, that she is an employee of "The Garden Island," a newspaper published in Lihue, County of Kauai, State of Hawaii; that the NOTICE in the above entitled matter of which the annexed is a true and correct copy, was published 1 time(s) in "The Garden Island" aforesaid and that this affiant is not a party to or in any way interested in the above entitled ma[redacted]

Subscribed and sworn to me this 20th day of November, 2012.

[redacted]

Notary Public, Fifth Judicial Ciruit
State of Hawaii County of Kauai
My Commission Expires: 04-05-15

Document Description: Affidavit of Publication
No. of pages: 1 Document Date: 11-20-12

PUBLISHED ON: 11/20/2012

FILED ON: ~~11/20/12~~ eg

SHERRI L. COLE NOTARY 99-139 PUBLIC STATE OF HAWAII

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at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

(November 20, 2012)

AFFIDAVIT OF PUBLICATION

State of Hawaii)
) SS:
County of Hawaii)

LEILANI K. R. HIGAKI, being first duly sworn, deposes and says:

1. That she is the BUSINESS MANAGER of HAWAII TRIBUNE-HERALD, a newspaper published in the City of HILO, State of Hawaii.

2. That the " Statement of Public Notice Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration...etc., ".

of which a clipping from the newspaper as published is attached hereto, was published in said newspaper on the following date(s) November 20, 2012, (etc.).

51892r1

[redacted]

Subscribed and sworn to before me
this 27th day of November, 2012.

[redacted]

SHARON H. P. OGATA
Notary Public, Third Circuit, State of Hawaii
My commission expires **October 1, 2016**

Page(s): 1

Statement of Public Notice
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(51892r1 Hawaii Tribune-Herald: November 20, 2012)

AFFIDAVIT OF PUBLICATION

IN THE MATTER OF }
Public Notice }
}
}
}
}
}
}

STATE OF HAWAII }
} SS.
City and County of Honolulu }

Doc. Date: 11/20/12 **# Pages:** 1
Notary Name: COLLEEN E. SORANAKA First Judicial Circuit
Doc. Description: Affidavit of Publication
[redacted] 11/20/12
Notary Signature Date

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-283 STATE OF HAWAII

Rose Rosales being duly sworn, deposes and says that she is a clerk, duly authorized to execute this affidavit of Oahu Publications, Inc. publisher of The Honolulu Star-Advertiser and MidWeek, that said newspapers are newspapers of general circulation in the State of Hawaii, and that the attached notice is true notice as was published in the aforementioned newspapers as follows:

Honolulu Star-Advertiser 1 times on:
11/20/2012

Midweek Wed. 0 times on:

_____ times on:

And that affiant is not a party to or in any way interested in the above entitled matter.

[redacted]
Rose Rosales

Subscribed to and sworn before me this 20th day
of Nov A.D. 20 12
[redacted]
Colleen E. Soranaka, Notary Public of the First Judicial Circuit,
State of Hawaii

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-283 STATE OF HAWAII

My commission expires: Jan 06 2016

Ad # 0000470262

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(SA470262 11/20/12)

AFFIDAVIT OF PUBLICATION

State of Hawaii)
) SS:
County of Hawaii)

M. R. Chavez, being first duly sworn, deposes and says:

1. That she is the Classified Accountant of WEST HAWAII TODAY, a newspaper published in the City of Kailua Kona, State of Hawaii.

2. That "**Statement of Public Notice Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration**" of which a clipping from the newspaper is attached hereto, was published in said newspaper on the following date(s) November 20, 2012 (etc.)

[redacted]

Subscribed and sworn to before me
This 20th day of November, 2012

[redacted]

Notary Public, Third Circuit
State of Hawaii

Henriann P. Kahananui

My Commission expires: June 6, 2015
Page(s): 1

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Department of Human Services
1390 Miller Street, Conference Rooms 1 & 2
Honolulu, Hawaii

Interested parties may alternatively participate by teleconference in the December 7 hearing. Should you be interested in participating in the teleconference, please call 808-692-8056 by close of business on December 5, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (e.g., sign or foreign language or wheelchair accessibility), please contact:

Oahu	Jeri Kido (808) 692-8056
Hawaii	Ann Stephenson (808) 933-0046
Kauai	Iris Venzon (808) 241-3582
Maui	Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

(No. 68469-West Hawaii Today: November 20, 2012)

AFFIDAVIT OF PUBLICATION

STATE OF HAWAII,
County of Maui. } ss.

Rhonda M. Kurohara being duly sworn deposes and says, that she is in Advertising Sales of the Maui Publishing Co., Ltd., publishers of THE MAUI NEWS, a newspaper published in Wailuku, County of Maui, State of Hawaii; that the ordered publication as to Statement of Public Notice Section 1115(a)

of which the annexed is a true and correct printed notice, was published 1 times in THE MAUI NEWS, aforesaid, commencing on the 20th day of November, 2012, and ending on the 20th day of November, 2012, (both days inclusive), to-wit: on November 20, 2012

and that affiant is not a party to or in any way interested in the above entitled matter.

[redacted]

This 1 page Statement of Public Notice, dated November 20, 2012, was subscribed and sworn to before me this 20th day of November, 2012, in the Second Circuit of the State of Hawaii, by Rhonda M. Kurohara

[redacted]

Notary Public, Second Judicial Circuit, State of Hawaii
BETTY E. UEHARA
My Commission expires 09-26-15

BETTY E. UEHARA NOTARY PUBLIC No. 83-344 STATE OF HAWAII

Statement of Public Notice

Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration

The State of Hawaii, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 demonstration project from the Centers for Medicare & Medicaid Services (CMS). The State expects the current demonstration to expire on December 31, 2013. The State is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. §431.408(a)(2)(ii).

Originally implemented as the QUEST program in 1994, QUEST Expanded is the current version of Hawaii's demonstration project to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. The demonstration covers Medicaid expansion populations through a variety of programs known as QUEST, QUEST-Net, and QUEST-ACE. The demonstration also covers aged, blind, or disabled Medicaid beneficiaries, including the provision of long-term supports and services, through the QUEST Expanded Access (QEXA) program.

Under the "QUEST Integration" renewal, Hawaii seeks to continue to deliver services through managed care, while integrating the demonstration's programs and benefits to create a more patient-centered care delivery system and to align the demonstration with the Affordable Care Act's (ACA) new requirements. The State will eliminate all eligibility enrollment caps, and streamline its programs by consolidating the current programs under QUEST Integration. All eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be based on clinical criteria and medical necessity.

Other initiatives in the proposed renewal include:

- Incorporating the new simplified Medicaid eligibility structure, the modified adjusted gross income eligibility methodology, and other changes in ACA.
- Offering new services to beneficiaries, including a home and community-based services (HCBS) benefit to individuals who are assessed to be at risk of deteriorating to an institutional level of care (the "at-risk" population).
- Expanding coverage of behavioral health services.
- Preparing for integration of care for Medicaid and Medicare enrollees.
- Modifying the health plan enrollment process.
- Covering certain Medicaid expansion populations.
- Expanding the qualified provider network to increase access to substance abuse treatment services.
- Modifying retroactive coverage.
- Changing the payment process when hospice care is furnished to individuals residing in nursing facilities.
- Eliminating the QUEST-ACE enrollment benchmarks for purposes of claiming federal financial participation in uncompensated care costs.

The draft renewal application and the State's full public notice, which describe the demonstration and the proposed renewal in more detail, can be found at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/hot/proposed_rules/. Hard copies are available for review at the Department of Human Services, Med-QUEST, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707.

The State will hold two public hearings to solicit comments from interested parties on the proposed renewal.

1. December 3, 2012 from 8:00 a.m.-12:00 p.m.:

Oahu	Keoni Ana Video Conference Center Keoni Ana Building 1177 Alakea Street, Room 302 Honolulu, Hawaii
Hawaii	Hilo Video Conference Center Hilo State Office Building 75 Aupuni Street, Basement Hilo, Hawaii
Kauai	Lihue Video Conference Center Lihue State Office Building 3060 Eiwa Street, Basement Lihue, Hawaii
Maui	Wailuku Video Conference Center Wailuku Judiciary Building 2145 Main Street, First Floor Wailuku, Hawaii

2. December 7, 2012 from 9:00 a.m.-12:00 p.m.:

Department of Human Services
1390 Miller Street, Conference Rooms 1 & 2
Honolulu, Hawaii

Interested parties may alternatively participate by teleconference in the December 7 hearing. Should you be interested in participating in the teleconference, please call 808-692-8056 by close of business on December 5, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (e.g., sign or foreign language or wheelchair accessibility), please contact:

Oahu	Jeri Kido (808) 692-8056
Hawaii	Ann Stephenson (808) 933-0046
Kauai	Iris Venzon (808) 241-3582
Maui	Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

(MN: Nov. 20, 2012)

Attachment J

Notice of Request for a Section 1115(a) Renewal of Hawaii's Section 1115 Demonstration (11-W-00001/9)

The State of Hawaii, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 demonstration from the Centers for Medicare & Medicaid Services (CMS). This renewal, which will be effective January 1, 2014, will be entitled "QUEST Integration."

By November 20, 2012, a copy of the proposed renewal application will be available at the Department of Human Services, Med-QUEST Division, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707, or at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/. We are providing this notice pursuant to CMS requirements in 42 C.F.R. §431.408.

QUEST Integration Renewal Application

The State's current demonstration, QUEST Expanded, is set to expire June 30, 2013, but the State expects it will be extended to December 31, 2013 pursuant to the extension request submitted in June 2012. QUEST Integration seeks to build on the successes of Hawaii's existing demonstration, while integrating the current programs to align with requirements in the Affordable Care Act (ACA) and deliver better health outcomes more efficiently.

Program Description, Goals, and Historical Context

Originally implemented as the QUEST program in 1994, QUEST Expanded is the current version of Hawaii's demonstration project to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. The provision of benefits through managed care has saved hundreds of millions of dollars in State and federal funds and has enabled the State to use some of the savings to provide coverage to individuals not otherwise eligible for Medicaid.

The Hawaii Medicaid program covers adults in certain categories and up to certain income levels, as well as all children up to 300% of the federal poverty level (FPL). In addition, through the demonstration, Hawaii has sought to provide coverage to Medicaid expansion populations through a variety of programs known as QUEST, QUEST-Net, and QUEST-ACE. The demonstration already covers non-pregnant, non-disabled adults up to and including 133% of the federal poverty level (FPL).

Further detail on the existing program is available at http://www.med-quest.us/. CMS also offers online resources regarding the QUEST Expanded Demonstration, which can be viewed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=hawaii

Under the "QUEST Integration" renewal, Hawaii seeks to continue to deliver services through managed care, while integrating the demonstration's programs and benefits to create a more

patient-centered healthcare delivery system and to align the demonstration with ACA's new requirements. The State will eliminate all eligibility enrollment caps, and streamline its programs by consolidating the current programs under QUEST Integration. All eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be based on clinical criteria and medical necessity. Other renewal initiatives include:

- Incorporating the new simplified Medicaid eligibility structure and other changes in ACA.
- Offering new services to beneficiaries, including a home- and community-based services (HCBS) benefit to individuals who are assessed to be at risk of deteriorating to the institutional level of care (the "at risk" population).
- Expanding coverage of behavioral health services.
- Preparing for integration of care for Medicaid and Medicare enrollees.
- Modifying the health plan enrollment process.
- Covering certain Medicaid expansion populations.
- Expanding the qualified provider network to increase access to substance abuse treatment services.
- Modifying retroactive coverage.
- Changing the payment process when hospice care is furnished to individuals residing in nursing facilities.
- Eliminating the QUEST-ACE enrollment benchmarks for purposes of claiming FFP in uncompensated care costs.

The goals of QUEST Integration will be to:

- Improve the health and healthcare of the member population.
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits.
- Align the demonstration with ACA.
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP).
- Expand access to HCBS and allow individuals to have a choice between institutional services and HCBS.
- Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations.
- Establish contractual accountability among the state health plans and health care providers.
- Continue the predictable and slower rate of expenditure growth associated with managed care.
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

More detailed information about renewal initiatives and changes in QUEST Integration can be found in the draft application, which is available at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/, as well as in hard copy at the Department of Human Services, Med-QUEST, Policy and Program Development Office located at 601 Kamokila Blvd, Room 518, Kapolei, HI.

Beneficiaries Impacted, Eligibility Methodology, and Eligibility Requirements

QUEST Integration will utilize a new eligibility methodology called "modified gross adjusted income" (MAGI) to the extent required by ACA, which will not have an asset test. Other than the use of MAGI methodology, there will be no changes in eligibility methodology. Eligibility for the aged, blind, and disabled (ABD) groups will continue to be determined using current income and resource methodologies. Effective January 1, 2014, MAGI will be applied to new non-ABD applicants and annual eligibility re-determinations (no individual enrolled on January 1, 2014 will lose his or her eligibility prior to March 31, 2014 because of the implementation of MAGI).

Hawaii plans to cover the following groups in QUEST Integration:

Mandatory State Plan Groups		
Eligibility Group Name	**Social Security Act and Code of Federal Regulations Citations**	**Income Level and Other Qualifying Criteria**
Parents or caretaker relatives	§ 1902(a)(10)(A)(i)(I), (IV), (V) § 1931(b), (d) 42 C.F.R.§ 435.110 (eff. Jan. 1, 2014)	Up to and including 100% FPL
Pregnant Women	§ 1902(a)(10)(A)(i)(III)-(IV) 42 C.F.R. § 435.116 (eff. Jan. 1, 2014)	Up to and including 185% FPL
Poverty Related Infants	§ 1902(a)(10)(A)(i)(IV) § 1902(l)(1)(B) 42 C.F.R. § 435.118(c) (eff. Jan. 1, 2014)	Infants up to age 1, up to and including 185% FPL
Poverty Related Children	§ 1902(a)(10)(A)(i)(VI)-(VII) § 1902(l)(1)(C)-(D) 42 C.F.R. § 435.118(a) (eff. Jan. 1, 2014)	Children ages 1 through 18, up to and including 133% FPL

ACA Mandatory Adults Age 19 Through 64 Group	§ 1902(a)(10)(A)(i)(VIII) 42 C.F.R. § 435.119(b) (eff. Jan. 1, 2014)	Up to and including 133% FPL
Children through the CHIP Medicaid expansion	Title XXI, § 2105	Title XIX limits up to and including 300% FPL and for whom the State is claiming Title XXI funding
Former Foster Children under age 26	§ 1902(a)(10)(A)(i)(IX)	No income limit
SSI Aged, Blind, or Disabled	§ 1902(a)(10)(A)(i)(II)(aa), as qualified by Section 1902(f) 42 C.F.R. § 435.121	SSI-related using SSI payment standard
Section 1925 Transitional Medicaid, Subject to Continued Congressional Authorization	§ 1925 § 1931(c)(2)	Coverage for two six-month periods due to increased earnings, or for four months due to receipt of child support, that would otherwise make the individual ineligible under Section 1931 - In the second six-month period, family income may not exceed 185% FPL
Optional State Plan Groups		
Eligibility Group Name	**Social Security Act and Code of Federal Regulations Citations**	**Income Level and Other Qualifying Criteria**
Aged or Disabled	§ 1902(a)(10)(ii)(X) § 1902(m) 42 C.F.R. § 435.230(c)(vi)	SSI-related net income up to and including 100% FPL
Independent Foster Care Adolescents (Age 19 and 20)	§ 1902(a)(10)(A)(ii)(XVII) § 1905(w)	No income limit

Certain Women Needing Treatment for Breast or Cervical Cancer	§ 1902(a)(10)(A)(ii)(XVIII) § 1902(aa)	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non-Aged, Blind, or Disabled Children and Adults	§ 1902(a)(10)(C) 42 C.F.R. § 435.301(b)(1) 42 C.F.R. § 435.308 42 C.F.R. § 435.310	Up to and including 300% FPL, if spend down to medically need income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	§ 1902(a)(10)(C) 42 C.F.R. §§ 435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology

Expansion Population	
Eligibility Group Name	**Federal Poverty Level and/or Other Qualifying**
Parents or caretaker relatives with an 18-year-old dependent child	Parents or caretaker relatives who (i) are living with an 18-year-old who would be a dependent child but for the fact that s/he has reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age
Individuals in the 42 C.F.R. § 435.217 group receiving HCBS	Income up to and including 100% FPL using the institutional income rules
Medically needy individuals receiving HCBS	Receiving HCBS and meet medically needy income standard using institutional rules for income, assets, and post-eligibility treatment of income
Medically needy ABD individuals whose spend-down exceeds the plans' capitation payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment

Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance	Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in the state plan or waiver while receiving adoption assistance payments

Benefit Coverage

Under QUEST Integration, Hawaii will combine the two benefit packages available under the current demonstration into one robust set of benefits available to all demonstration populations. Instead of offering different benefit packages to different eligibility groups, Hawaii will offer one package consisting of full primary and acute service State plan benefits and certain additional benefits based on clinical eligibility and medical necessity. This benefit structure will be easier for beneficiaries to navigate, better equipped to serve patients with changing needs, and less burdensome for the State to administer.

Individuals who meet institutional level of care ("1147 certified") will have access to a wide variety of HCBS and long-term services and supports (LTSS), including specialized case management, home maintenance, personal assistance, adult day health, respite care, and adult day care, among others. Moreover, Hawaii will provide HCBS to certain individuals who are assessed to be at risk of deteriorating to the institutional level of care, in order to prevent a decline in health status and maintain individuals safely in their homes and communities. These individuals (the "at risk" population) will have access to a set of HCBS that includes personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS) and skilled nursing.

Hawaii also plans to include in the QUEST Integration benefit package the following benefits, subject to clinical criteria and/or medical necessity:

- Cognitive rehabilitation therapy (either through the demonstration or the State plan);
- Covered substance abuse treatment services provided by a certified (as opposed to licensed) substance abuse counselor; and
- Specialized behavioral health services (Clubhouse, Supportive Employment, Peer Specialist, Supportive Housing and Representative Payee) for qualified individuals with a Serious and Persistent Mental Illness (SPMI), Severe Mental Illness (SMI), or Serious Emotional or Behavioral Disorder (SEBD) (either through the demonstration or the state plan).

Delivery System
Under QUEST Integration, the State will continue to provide most benefits through managed care, which will help ensure access to high-quality, cost-effective care. A discrete set of benefits will be provided fee-for-service.

The following table depicts the delivery system for each benefit offered through QUEST Integration.

Benefit(s)	Delivery System	Authority
State plan services	Managed Care - MCO	1115
QUEST Integration HCBS and long-term care benefits	Managed Care - MCO	1115
Cognitive rehabilitation therapy	Managed Care - MCO	1115 or State plan
Medical services to medically needy individuals who are aged, blind or disabled	Managed Care - MCO	1115
Medical services to medically needy individuals who are not aged, blind or disabled	Fee-for-service	1115
Long-term care services for individuals with developmental disabilities (DD) or intellectual disabilities (ID)	Fee-for-service	Section 1915(c) waiver
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID)	Fee-for-service	State plan
Medical services to applicants eligible for retroactive coverage only	Fee-for-service	State plan
Medical services under the State of Hawaii Organ and Tissue Transplant (SHOTT) program	Fee-for-service	State plan
Dental services	Fee-for-service	State plan
Targeted Case Management	Fee-for-service	State plan
School-based services	Fee-for-service	State plan
Early Intervention Services	Fee-for-service	State plan
Covered substance abuse treatment services provided by a certified substance abuse counselor	As described in the behavioral health protocol	1115
Specialized behavioral health services for qualified individuals with a SPMI, SMI, or SEBD	As described in the behavioral health protocol	1115 or State plan

Cost Sharing
The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan. The State plans to seek authority to continue to charge an enrollment fee to health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate (for the Medically Needy Aged, Blind, and Disabled), in the amount equal to the estimated spend-down or cost share amount.

Annual Enrollment and Annual Expenditures

From July 1, 2011 to June 30, 2012, state and federal expenditures in the demonstration totaled approximately $1.3 billion, and there was an average of 236,964 individuals enrolled in the demonstration (and covered in part by a federal match).

During the five-year renewal period, the annual increase in enrollment is expected to be 3% per year for non-ABD recipients and 1.2% for ABD recipients, or approximately 6,317 recipients per year for the existing population. In addition, 24,000 recipients may become eligible under the new ACA eligibility guidelines. Total aggregate expenditures for each renewal year are anticipated to be $2.0 billion in both State and federal funding. That is, the State expects the changes required by ACA, coupled with changes effective since June 30, 2012 and other State-requested changes to the demonstration, to result in approximately $700 million in increased State and federal annual expenditures during the renewal period.

Hypotheses and Evaluation Parameters

In QUEST Integration, the State will continue to test two overarching hypotheses about its demonstration:

- Capitated managed care delivers high quality care, while also slowing the rate of health care expenditure growth.
- Capitated managed care provides access to HCBS and facilitates rebalancing of provided long-term care services.

The State will test the following hypotheses about the changes implemented in QUEST Integration:

- Consolidating the current programs decreases administrative burdens for the health plans and the State.
- Consolidating the current programs improves access to appropriate care, such as HCBS, and ensures continuity of care when an enrollee's health status changes.
- Extending HCBS to the "at risk" population will decrease the percentage of at-risk enrollees whose health status deteriorates.

The State will also measure the outcomes in QUEST Integration based on the State Quality Improvement Strategy targets:

- Childhood Immunizations (CIS): Increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the Medicaid 75th percentile.

- Chlamydia Screening (CHL): Increase performance on the state aggregate HEDIS Chlamydia Screening measure to meet/exceed the Medicaid 75th percentile.

- Breast Cancer Screening (BCS): Increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the Medicaid 75th percentile.

- Comprehensive Diabetes Care (CDC):

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the HEDIS 75th percentile.

    - Improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c poor control (>9) to meet/fall below the HEDIS 25th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<7) to meet/exceed below the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL screening to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL control (<100) to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<140/90) to meet/exceed the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for eye exams to meet/exceed the HEDIS 75th percentile.

- Cholesterol Management in Patients with Cardiovascular Conditions (CMC): Increase performance on the state aggregate HEDIS Cholesterol Screening measure to meet/exceed the HEDIS 75th percentile.

- Controlling High Blood Pressure (CBP): Increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the HEDIS 75th percentile.

- Use of Appropriate Medications for People with Asthma (ASM): Increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the HEDIS 75th percentile.

- Emergency Department Visits (AMB): Maintain performance on the state aggregate HEDIS Emergency Department Visits/1000 rate to fall below the HEDIS 10th percentile.

- Plan All-Cause Readmissions: Increase performance on the state aggregate HEDIS to meet/exceed the HEDIS 75th percentile.

- Getting Needed Care: Increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Rating of Health Plan: Increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- How well doctors communicate: Increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Home and Community Based Service (HCBS) beneficiaries: Increase the proportion of clients receiving HCBS to at least 70% of the population receiving long-term supports and services.

Waiver Authority

The State believes the following waiver authorities will be necessary to authorize the demonstration.

1. Medically Needy - Section 1902(a)(10)(C); Section 1902(a)(l7)

   To enable the State to limit medically needy spend-down eligibility to those non-ABD individuals whose gross incomes, before any spend-down calculation, are at or below 300% of the Federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which have no gross income limit.

2. Amount, Duration, and Scope - Section 1902(a)(10)(B)

   To enable the State to offer demonstration benefits that may not be available to all categorically eligible or other individuals.

   To enable the State to maintain waiting lists, through a health plan, for home and community-based services (including services for the "at risk" population). No waiting list is permissible for other services for health plan enrollees.

3. Retroactive Eligibility - Section 1902(a)(34)

   To enable the State to limit retroactive eligibility to a ten (10) day period prior to application, or up to three months for individuals requesting long-term care services. Individuals will be considered eligible for any portion of the 10-day retroactive period that extends into a month prior to the month for which determined eligible.

4. Freedom of Choice - Section 1902(a)(23)

   To enable Hawaii to restrict the freedom of choice of providers to groups that could not otherwise be mandated into managed care under Section 1932.

5. Hospice Care Payment - Section 1902(a)(13)(B)

To enable the State, when hospice care is furnished to an individual residing in a nursing facility, to make payments to the nursing facility (through the health plans rather than the hospice providers) for the room and board furnished by the facility.

Expenditure Authority

The State believes the following expenditure authorities will be necessary to authorize the demonstration.

1. Managed Care Payments. Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of Section 1903(m):

   a) Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to disenroll without cause within 60 days of initial enrollment in an MCO, as designated under Section 1903(m)(2)(A)(vi) and Section 1932(a)(4)(A)(ii)(l) of the Social Security Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at Section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single health plan in the absence of a choice of health plan on that particular island.

   b) Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more health plans, as required under Section 1903(m)(2)(A)(xii), Section 1932(a)(3) and Federal regulations at 42 CFR § 438.52.

2. Quality Review of Eligibility. Expenditures for Medicaid services that would have been disallowed under Section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

3. Demonstration Eligibility. Expenditures to provide coverage to the following populations:

   a) Parents or caretaker relatives who would otherwise be eligible if the dependent child was under 18 years of age.

   b) Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules.

Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

c) Individuals who would otherwise be eligible under the State plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of the health plan capitation payment, subject to an enrollment fee equal to the spend-down liability.

d) Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance.

e) Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program, are not eligible under any other eligibility group, and were enrolled in the State plan or waiver while receiving adoption assistance.

4. Hospital Uncompensated Care Costs. Expenditures to reimburse certain hospital and nursing facility providers for provider costs of inpatient and outpatient hospital services and long-term care services to the uninsured and/or underinsured, subject to certain restrictions placed on hospital and nursing facility uncompensated care costs. The State is seeking federal participation in the total of actual uncompensated care costs of private and public hospitals (including uncompensated long term care costs of public hospitals for serving QI enrollees) incurred in any given year, subject to the overall budget neutrality limitation.

5. Home and Community-Based Services (HCBS). Expenditures to provide HCBS not included in the Medicaid State plan and furnished to QUEST Integration enrollees, as follows:

a) Expenditures for the provision of services, through health plans, that could be provided under the authority of Section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

b) Expenditures for the provision of services, through health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, *i.e.*, the “at risk” population.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, will apply to the demonstration beginning January 1, 2014, through December 31, 2018, except those waived or listed below as not applicable.

Medicaid Requirements Not Applicable to Demonstration Populations

The State believes the following Medicaid requirement will need to be deemed not applicable to demonstration populations.

1. Cost Sharing - Section1902(a)(14)

   To enable the State to charge cost sharing with limits on cost-sharing amounts but no aggregate limit. To enable the State to charge an enrollment fee to Medically Needy Aged, Blind and Disabled health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate, in the amount equal to the estimated spend-down or cost share amount or, where applicable, the amount of patient income applied to the cost of long-term care.

Comments

We invite comments on this proposal. Please submit any comments or questions to Noreen Moon-Ng by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at nmoon-ng@ medicaid.dhs.state.hi.us.

Comments will be accepted for consideration between November 20, 2012, and December 21, 2012 (30 days from the date of this notice).

Public Hearings

The State will hold two public hearings to seek public input on this demonstration renewal application:

1. December 3, 2012 from 8:00 a.m.-12:00 p.m.:

Oahu	Keoni Ana Videoconference Center Keoni Ana Building 1177 Alakea Street, Room 302 Honolulu, Hawaii
Hawaii	Hilo Videoconference Center Hilo State Office Building 75 Aupuni Street, Basement Hilo, Hawaii
Kauai	Lihue Videoconference Center Lihue State Office Building 3060 Eiwa Street, Basement Lihue, Hawaii

Maui	Wailuku Videoconference Center Wailuku Judiciary Building 2145 Main Street, First Floor Wailuku, Hawaii

2. December 7, 2012 from 9:00 a.m. to 12:00 p.m.:

   Department of Human Services
   1390 Miller Street, Conference Rooms 1 & 2
   Honolulu, Hawaii

Interested parties may alternatively participate by teleconference in the December 7, 2012 public hearing. Should you be interested in participating in the teleconference, please call 808-692-8056 by close of business on December 5, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (*e.g.*, sign or foreign language or wheelchair accessibility), please contact:

Oahu	Jeri Kido (808) 692-8056
Hawaii	Ann Stephenson (808) 933-0046
Kauai	Iris Venzon (808) 241-3582
Maui	Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

Attachment K

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Policy and Program Development Office
P.O. Box 700190
Kapolei, Hawaii 96709-0190

November 20, 2012

Ms. Joelene K. Lono, Executive Director
Ke Ola Mamo
Native Hawaiian
Health Care System-Oahu
1505 Dillingham Boulevard, Room 205
Honolulu, Hawaii 96817

Dear Ms. Lono:

RE: EXTENSION AND AMENDMENT TO HAWAII 1115 DEMONSTRATION PROJECT

Pursuant to the tribal consultation requirements in Section 1902(a)(73) of the Social Security Act as amended by Section 5006(e)(2) of the American Recovery and Reinvestment Act of 2009, the Department of Human Services, Med-QUEST Division (MQD) is soliciting your expedited consultation of the State's intent to seek a five-year extension of the QUEST Expanded Section 1115 demonstration project from the Centers for Medicare and Medicaid Services (CMS).

The current demonstration is expected to expire on December 31, 2013 pending approval by the CMS of a six-month extension submitted on June 29, 2012. MQD intends to submit the five-year Section 1115(a) renewal application to align its current demonstration with provisions in the Affordable Care Act (ACA). Under the renewal, "QUEST Integration" seeks to build on the success of a competitive managed care delivery system, while integrating the demonstration's programs and benefits to have a more patient-centered care delivery system and align the demonstration with ACA's new requirements. The State will eliminate all eligibility enrollment caps, and streamline its programs by consolidating the current programs under QUEST Integration. Nearly all eligible beneficiaries will be enrolled under QUEST Integration, and access to services will be determined by clinical criteria and medical necessity. Finally, QUEST Integration will offer new services to beneficiaries, including a home-and community-based services (HCBS) benefit to individuals who are assessed to be at risk of deteriorating to the institutional level of care (the "at risk" population) and additional specialized behavioral health services for adults with a severe mental illness or serious and persistent mental illness.

A copy of the full public notice, draft application and supporting documents are enclosed for your review and are also available at http://www.med-quest.us and http://hawaii.gov/dhs/main/har/propsed_rules. Please provide your written comments by December 10, 2012 to the:

Department of Human Services
Med-QUEST Division
P. O. Box 700190
Attn: Policy and Program Development Office

Should you have any questions or desire a meeting, please call Ms. Aileen Befitel at 692-8074 or email her at abefitel@medicaid.dhs.state.hi.us.

Thank you for your efforts, support and advocacy for the American Indian and Alaska Native communities and your continuing support of our Medicaid programs.

Sincerely,

Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

April 18, 2013

Mr. Kenneth Fink
Administrator
Medquest Division
601 Kamokila Blvd, Room 518
P.O. Box 700190
Kapolei, HI 96709-0190

Dear Mr. Fink:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has reviewed and approved the change to the Certified Public Expenditure (CPE)/ Government-Owned Hospital Uncompensated Care Cost (UCC) Protocol (Attachment D) to Hawaii's section 1115 demonstration entitled, QUEST Expanded Medicaid section 1115 demonstration (project number 11-W-00001/9).

Under Special Term and Condition (STC) 41, the state is authorized to make payments to government-owned hospitals for uncompensated care costs, provided that the payment amount is determined using the methodology in Attachment D. The inpatient and outpatient cost to charge ratios in Attachment D have been revised to better reflect the actual uncompensated care costs of the government-owned hospitals.

Written acceptance of the new STCs is needed for our administrative records within 30 days of the date of this letter. Please send the acceptance letter to your project officer, Ms. Megan Renfrew. Ms. Renfrew's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard
Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (202) 690-5413
Email: Megan.Renfrew@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Renfrew and to Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and

Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103 -6706

We look forward to continuing to work with your staff on the administration of this demonstration.

Sincerely,

/s/

Diane T. Gerrits
Director
Division of State Demonstrations and Waivers

Enclosures

Cc: Jennifer Ryan, CMCS
Jessica Schubel, CMCS
Gloria Nagel, ARA, San Francisco Regional Office

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00001/9**

TITLE: **QUEST Expanded Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration extension be regarded as expenditures under the State's title XIX plan but are further limited by the Special Terms and Conditions (STCs) for the QUEST Expanded (QEx) Section 1115 demonstration.

For enrollees in All Components of the Demonstration:

1. **Managed Care Payments.** Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m):

   Expenditures for capitation payments provided to managed care organizations (MCOs) in which the state restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.

   Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and Federal regulations at 42 CFR section 438.52, to the extent necessary if a plan exceeds its enrollment cap.

2. **Quality Review of Eligibility.** Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

3. **Demonstration Eligibility.** Expenditures to provide coverage to the following populations:

a) **Demonstration Eligibles Enrolled in QEx Eligibility Components other than Quest Expanded Access (QExA).**

i. TANF cash recipients, whose income is up to 100 percent FPL (using the TANF methodology), but are not otherwise eligible under the Medicaid state plan or enrolled in QUEST;

ii. Adults who have lost QUEST or Medicaid Fee-for-Service eligibility because they have income or assets in excess of the Medicaid limits (QUEST-Net Adults):

1. Effective through June 30, 2012: With income up to 200 percent of the FPL or, for individuals continuously enrolled since January 1, 2008, incomes up to 300 percent FPL;
2. Effective July 1, 2012 through December 31, 2013: With income up to 133 percent of the FPL;

iii. Adults with incomes or assets in excess of the Medicaid limits, but who are not otherwise Medicaid eligible (QUEST-ACE):

1. Effective through June 30, 2012: With income up to 200 percent of the FPL;
2. Effective July 1, 2012 through December 31, 2013: With income up to 133 percent of the FPL; and

iv. Adults with income up to 300 percent of the FPL who are not otherwise Medicaid eligible, and who:

1. Have aged out of the state of Hawaii's foster care system;
2. Received medical assistance under the state plan or the demonstration while in foster care; and
3. Are under age 26.

The state will not impose an asset limit on this population.

b) **Demonstration Eligibles Enrolled in the QExA eligibility component.**

i. Persons who would be eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR section 435.217 if the home and community-based services that they are receiving from a QExA plan were provided under a waiver that was granted to the State under section 1915(c) as of the initial approval date of the QExA component of this demonstration. This includes the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

ii. Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that

apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

iii. Individuals who would otherwise be eligible under the state plan or another QExA demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of the QExA capitation payment, subject to an enrollment fee equal to the spend-down liability.

4. **Hospital Uncompensated Care Costs.** Expenditures to reimburse certain hospital providers for provider costs of hospital services to the uninsured, and or underinsured, subject to the restrictions placed on hospital uncompensated care costs, as defined in the STCs.

5. **QExA Home and Community-Based Services (HCBS) and Personal Care Services**. Expenditures to provide HCBS and personal care services not included in the Medicaid state plan and furnished to QExA enrollees, as follows:

   a) Expenditures for the continued provision of services provided to individuals enrolled during the transition from fee-for-service to QExA in the State's Nursing Home Without Walls (NHWW), Residential Alternatives Community Care Program (RACCP), Medically Fragile Community Care Program (MFCCP) and HIV Community Care Program (HCCP) HCBS waiver programs as fee-for-service expenditures for the period beginning with the effective date of these authorities until QExA plan coverage (under the authority of subparagraphs b and c below) is operational;

   b) Expenditures for the provision of services, through QExA plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

   c) Expenditures for the provision of personal care services, through QExA plans, to individuals with less than a need for an institutional level of care, including personal care assistance services provided by a family member.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the demonstration beginning February 1, 2008, through December 31, 2013, except those waived or listed below as not applicable.

Title XIX Requirements Not Applicable to Demonstration Populations

Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable the state to maintain a waiting list, through a QExA plan, for home and community-based services and personal care services. No waiting list is permissible for other services for QExA enrollees.

Cost Sharing **Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**

To the extent necessary to enable the state to impose cost-sharing that is above the limits that would apply under the state plan. A qualifying Hawaii Prepaid Health Care Act employer must limit the employee's premium costs to no more than 1.5 percent of the employee's salary for employer sponsored insurance coverage. Co-payments and other cost-sharing will be consistent with the enrollee's specific health plan.

To enable the state to charge cost sharing up to 5 percent of annual family income.

To enable the state to charge an enrollment fee to QExA enrollees whose spend-down liability or cost share obligation is estimated to exceed the QExA capitation rate (Demonstration Population 3.b.iii.), in the amount equal to the estimated spend-down or cost share amount.

Expenditures for MCO Contracts **Section 1903(m)(2)(A)(vi)**

To enable the state to restrict an enrollees' right to disenroll without cause within 90 days of enrollment in a new MCO.

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.

In December 2012, the state requested to amend the demonstration to provide full Medicaid benefits to former foster children under age 26 with income up to 300 percent FPL. The state will not impose an asset limit on this population. The demonstration will enable the state to test the whether coverage under the Quest Expanded demonstration improves health outcomes for this population.

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; and

iii. Former foster children as described in paragraph 19.

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 applicable Medicaid limits for those programs:
   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 do not 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	Title XIX	State Plan Adults and Children

		individual ineligible for continued coverage under section 1931. • In the second 6-month period, family income may not exceed 185 percent FPL.		
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

[1] Reported under Title XXI Allotment Neutrality if allotment is available.

				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** 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 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	Title XIX	Demo Elig Adults

		eligible as of this date.		
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
Former Foster Children	QUEST	Up to 300 percent FPL who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not impose an asset limit on this population.	Title XIX	Demo Elig Adults
Individuals in the 42 CFR section 435.217 group who are receiving home and community-based services (HCBS)	QExA	Net income no more than 100 percent FPL using the institutional income rules	Title XIX	Aged with Medicare **Or** Aged without 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;
        v. The individual has been covered under COBRA and has applied for QUEST benefits within 45 days of losing COBRA coverage; and
        vi. The individual is eligible pursuant to his or her status as a former foster child.

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, Pregnant Women, and Former Foster Children
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.

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 in accordance to the Behavioral Health protocol which addresses 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 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
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 and long term care services to QEx 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 inpatient and outpatient hospital and long term care services to Medicaid fee-for-services (FFS) beneficiaries, reduced by any applicable Medicaid inpatient, outpatient and long term care 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 for critical access hospitals, 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. Any excess waiver payments will be redistributed to other qualifying hospitals.

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. Former Foster Children (Demonstration eligible adults) (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, RACCP, 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)	

Former Foster Children (QUEST)	
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 (Demonstration Years 16, 17, and 18 only)	

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.

Attachment B
Quarterly Report Format

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)				
Former Foster Children (QUEST)				
UCC - Governmental				
UCC - Private				
NHWW - (Demonstration Years 14 and 15 only)				
RACCP - (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 (Demonstration Years 16, 17, and 18 only)				

Benchmarks for QUEST ACE

Attachment B
Quarterly Report Format

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.

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.

Attachment B
Quarterly Report Format

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	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.

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

Routine Charges: Worksheet C, Part I, Column 6, lines 30 to 43 (Routine Acute Charges, excluding any LTC unit cost centers)
Routine Cost: Worksheet C, Part I, Column 1 lines 30 to 43 (Routine Acute Costs, excluding any LTC unit cost centers) – Line 201 (Observation Beds Cost)
Ancillary Inpatient Charges: Worksheet C, Part I, Column 6, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable
Ancillary Total Charges: Worksheet C, Part I, Column 8, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Inpatient Costs: (Ancillary Inpatient Charges/Ancillary Total Charges) x (Worksheet C Part 1, Column 1, line 200 (Total Cost) – Lines 30 to 45 (Routine Costs including LTC) – Any non-hospital component cost center if applicable (e.g., HHA))

Inpatient Cost to charge Ratio **=** *[Routine Cost + Ancillary Inpatient Costs]/[Routine Charge + Ancillary Inpatient Charges]*

2. Outpatient Cost to Charge Ratio

Ancillary Total Charges**:** Worksheet C, Part I, Column 8, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Outpatient Charge: Worksheet C, Part I, Column 7, line 200 – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Outpatient Cost: (Ancillary Outpatient Charges/Ancillary Total Charges) x (Worksheet C, Part 1, Column 1 line 200 (Total Cost) – Lines 30 to 45 (Routine Costs line LTC) – Any non-hospital component cost center if applicable (e.g., HHA))

Outpatient Cost to charge Ratio **=** *[Ancillary Outpatient Costs]/[Ancillary Outpatient Charges]*

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

OVERVIEW

The Med-QUEST Division (MQD) through its QUEST and QUEST Expanded Access (QExA) health plans are responsible for providing behavioral health services to all its members. MQD also provides additional behavioral health services to clients with serious mental illness (SMI) or serious emotional behavioral disorders (SEBD) that are in need of these additional behavioral services. This is depicted in the flow chart attached (Exhibit 1).

All clients have access to first line behavioral health services provided by the QUEST and QExA health plans. These first line services include services such as inpatient hospitalizations, ambulatory mental health services, diagnostic and treatment services, medications, medication management, medically necessary alcohol and chemical dependency services, and methadone management services.

In addition, some clients with serious mental illness (SMI) or serious emotional behavioral disorders (SEBD) may be in need of additional behavioral health services. These additional services are provided by the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD), the DOH Adult Mental Health Division (AMHD), the Community Care Services (CCS- MQD's behavioral health program), and/or the QUEST Health Plans, depending on whether the client is a child under the age of 21 or whether the client is a QUEST or QExA member. These additional services include services such as: for adults- crisis management, intensive care coordination/case management, partial or intensive outpatient hospitalization, psychosocial rehabilitation, therapeutic living supports, crisis and specialized residential treatment; and for children- multidimensional treatment foster care, family therapy, functional family therapy, parent skills training, intensive home and community based intervention, community-based residential programs, and hospital-based residential programs.

See Attachment B for a detailed list of services provided by the QUEST and QExA health plans, AMHD, CCS, and CAMHD.

Regardless of what type of behavioral health service a client receives or where the client receives his/her behavioral health services, the client continues to have access to primary and acute care services from his/her health plan. The client continues to have access to EPSDT services if he/she is under the age of 21. In addition, the client has access to home and community based services/long-term care (HCBS/LTC) services if he/she is a QExA member or a participant receiving services from the Developmental Disabilities Mental Retardation (DD/MR) 1915(c) waiver.

Attachment E
Behavioral Health Services Protocol

The QUEST and QExA health plans are responsible for providing basic, first line behavioral health services to ALL their clients. A list of behavioral health services that the QUEST and QExA health plans provide is detailed in Exhibit 2.

For clients with a diagnosis of serious emotional behavioral disorders (SEBD) or serious mental illness (SMI), who need additional behavioral health services, these are provided by:

- CAMHD if the client is <21 years old
- AMHD or CCS if the client is >/=21 years old and a QExA client*
- QUEST health plan if the client is >/=21 years old and a QUEST client

*Note that QExA clients include all the participants of the Developmental Disabilities and Mental Retardation (DDMR) waiver program.

Clients <21 years old with a diagnosis of SEBD are eligible for additional behavioral health services within CAMHD. The eligibility criteria are:

- The client or youth is age three through twenty (3-20) years; and
- The client falls under one of the qualifying diagnoses (see Exhibit 3); and
- The client demonstrates presence of a qualifying diagnosis for at least six (6) months or is expected to demonstrate the qualifying diagnosis for the next six (6) months; and
- The client's Child and Adolescent Functional Assessment Scale (CAFAS) score is > 80.
- Clients that do not meet the eligibility criteria, but based upon assessment by the CAMHD medical director that additional behavioral health services are medically necessary for the member's health and safety shall be evaluated on a case by case basis for provisional eligibility.

Clients >/=21 years old with a diagnosis of SMI are eligible for additional behavioral health services within AMHD or CCS or the QUEST health plan. The eligibility criteria are:

- The client falls under one of the qualifying diagnoses (see Exhibit 3); and
- The client demonstrates presence of qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The client meets at least one of the criteria below demonstrating instability and/or functional impairment:
  - Global Assessment of Functioning (GAF) < 50; or
  - Clinical records demonstrate that the client is currently unstable under current treatment or plan of care (ex. multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable to include but not limited to consistently noncompliant with medications and follow-up, unengaged with providers, significant and consistent isolation, resource deficit causing instability, significant co-occurring medical illness causing instability, poor coping/independent living/problem solving skills causing instability, at risk for hospitalization); or
  - Client is under Protective Services or requires intervention by housing or law enforcement officials.
- Clients that do not meet the requirements listed above, but based upon an assessment by the AMHD, QUEST health plan medical director, or MQD medical director that additional behavioral health services are medically necessary for the member's health and safety shall be evaluated on a case-by-case basis for provisional eligibility.

A. Qualified Mental Health Professional

The qualified mental health professionals in Hawaii that provide behavioral health services include psychiatrists, licensed psychologists, licensed clinical social workers, licensed mental health counselors, and licensed marriage family therapists.

B. Additional behavioral health services provided to SEBD children by CAMHD

The CAMHD is responsible for providing SEBD services to both QUEST and QExA health plan members age three through twenty (3-20) years. A list of CAMHD SEBD services are listed in Exhibit 2. Section (F) lists and describes the services in greater detail.

These additional behavioral health services include both intensive case management and targeted case management. These services are distinct from the services provided through the health plans. CAMHD bills these services to MQD through a fee-for-service (FFS) process effective October 1, 2008. The MQD informs the health plans, via the 834-transaction file, when an individual is receiving services through the CAMHD program. CAMHD provides services to approximately 900 children in both QUEST and QExA.

Referrals to CAMHD can occur through the school, parent, child, or the health plan. CAMHD considers all referrals through an assessment process. Even if a child qualifies for SEBD services, parents can choose to have their children's behavioral health services provided through the child's health plan. QUEST and QExA health plans are only able to provide the behavioral health services identified in their contract (see Exhibit 2). CAMHD would need to be involved for any specialized behavioral health services.

The QUEST and QExA health plans continue to provide any primary and acute care as well as EPSDT services for any child under the age of 21. For any child in QExA that qualifies for home and community based services, the QExA health plan continues to provide these services also.

See section (G) for more information about interaction between CAMHD and QUEST and QExA health plans.

C. Additional behavioral health services provided to SMI adults by the AMHD

The AMHD is responsible for providing behavioral health services to QExA health plan members who are at least eighteen (18) years old. A list of behavioral health services that AMHD provides is included in Exhibit 2. Section (F) lists and describes the services in greater detail.

These behavioral health services include both intensive case management and targeted case management. These services are distinct from the services provided through the QExA health plans. AMHD bills behavioral health services to the MQD through a FFS process.

AMHD provides services to approximately 2,300 adults in QExA.

Referrals to AMHD occur through either the client (self-referral) or the health plan calling the access line to make a referral for the client. AMHD considers all referrals through an assessment process. See section (G) for more information about interaction between AMHD and QExA health plans.

D. Additional behavioral health services provided to SMI adults by CCS

The MQD behavioral health services program, CCS, is for adults. No children receive services through the CCS program. All Medicaid clients in CCS have a diagnosis of SMI.

The CCS program was created in the mid-1990s due to the lack of behavioral health services (AMHD had a limited service package at that time) for Medicaid clients with a diagnosis of SMI. In the early 2000 timeframe, AMHD expanded their services significantly due to a mandated court decree that was withdrawn in 2006. AMHD modeled most of their services from CCS during their court decree. MQD continues to offer its CCS program despite the expansion of services within AMHD.

MQD awards the CCS program to a contractor through a Request for Proposals (RFP). The contractor of the CCS program until February 28, 2013 is APS Healthcare. As of March 1, 2013, the contractor is ‘Ohana Health Plan. A list of behavioral health services that CCS provides is included in Exhibit 2. All of the services that are accessible to clients in the CCS program are also available to clients in AMHD.

The DHS will pay a capitation rate to the contractor for Medicaid covered services provided through the CCS program.

An MQD physician determines eligibility for CCS. Health plans make referrals for the CCS program. All health plan referrals are considered. If a client is receiving services through AMHD, the client can choose to receive their behavioral health services through AMHD or CCS. In the absence of client choice, MQD will work with AMHD and CCS to determine the best “fit” for the client.

E. Additional behavioral health services for SMI adults by the QUEST health plans

Effective July 1, 2010, the MQD transitioned all behavioral health services provided to QUEST adult clients by AMHD and the CCS program into the QUEST health plans. The QUEST health plans now provide not only first line behavioral health services to all their clients but also additional behavioral health services to their adult SMI clients that used to be provided by AMHD and CCS. The integration of all behavioral health services into the QUEST health plans is an attempt to minimize fragmentation of clinical services and promote better health outcomes and financial efficiencies.

The QUEST health plans provide all their clients with first line behavioral health services. In addition, they also provide their SMI adults with additional behavioral health services. See

Exhibit 2 for a list of behavioral health services provided by the QUEST health plans.

CAMHD continues to provide additional behavioral health services for QUEST children under the age of 21 years old with SEBD who need these additional behavioral health services.

F. Description of additional behavioral health services provided by CAMHD, AMHD, CCS, and QUEST health plans, classified under the Medicaid State Plan approved services in which they are covered

See the Supplement to Attachment 3.1A and 3.1B in the Medicaid State Plan for language describing each of the seven approved State Plan services. MQD has authorized services to be provided by CAMHD, AMHD, CCS, and QUEST health plans based upon approved service definitions in the State Plan.

The additional behavioral health services for clients with SMI and SEBD needing additional behavioral health services are listed and described below, classified under the Medicaid State Plan approved services in which they are covered.

1) State plan approved services- Crisis Management
   a) State Plan- This service provides mobile assessment for individuals in an active state of crisis (24 hours per day, 7 days per week) and can occur in a variety of community settings including the consumer's home. Immediate response is required. Included in Crisis Management services are an assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation. If necessary, this may include referral to licensed psychiatrist, licensed psychologist, or to an inpatient acute care hospital. The presenting crisis situation may necessitate that the services be provided in the consumer's home or natural environment setting. Thus, crisis management services may be provided in the home, school, work environment or other community setting as well as in a health care setting. These services are provided through JCAHO, CARF, or COA accredited agencies. In addition, agencies must have staff that includes one or more qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.
   b) CAMHD services for SEBD clients <21yo
      i) Crisis management, including twenty-four (24) hour crisis telephone stabilization, mobile outreach services, and crisis stabilization services (assessment of risk, mental status, and medical stability that includes provision of immediate crisis resolution and de-escalation)
   c) AMHD and CCS services to SMI adults >/=21yo
      i) Crisis management, including 24 hour access line, mobile crisis response, and crisis stabilization (see description above)
   d) QUEST provides crisis management to its adult clients by contracting with AMHD crisis management services.

2) State plan approved services- Crisis Residential Services
   a) State Plan- Crisis Residential Services are short-term, interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization or inpatient hospital based psychiatric care at levels of care below acute psychiatric inpatient. Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, and daily living skills training. Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting. All crisis residential programs will have less than 16 beds. The services do not include payment for room and board. The staff providing crisis residential services must be qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.
   b) CAMHD services for SEBD clients <21yo:
      i) Therapeutic Foster and Group Homes- These homes provide intensive community-based treatment service provided in a home setting for youth with emotional challenges. Specialized therapeutic foster care incorporates evidence-based psychosocial treatment services. These homes provide a normative, community-based environment through therapeutic parental supervision, guidance, and support for youth capable of demonstrating growth in such a setting. Services include crisis management, individual restorative interventions for the development of interpersonal, community and independent living skills. Individual and family therapy are done once a week. Services are provided by qualified mental health professionals or under the supervision of a qualified mental health professional.
      ii) Multidimensional Treatment Foster Care (MTFC)- MTFC provide intensive family-based services in foster family settings for youth with delinquent/disruptive behaviors and emotional challenges. Services provided include crisis management 24 hours/day, 7 days/week as needed. MTFC Foster Parents provide closely supervised behavioral interventions via an individualized level and point system and contingent positive and negative consequences. MTFC Foster Parents are contacted daily by CAMHD staff that are supervised by either a clinical psychologist or licensed family therapist.
   c) AMHD services for SMI adults >/=21yo:
      i) Crisis residential services- short-term residential interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization. Clients are in a crisis residential setting for a little as one day to no more than ten days. The average length of stay is four days. Behavioral health services are provided on a daily basis by qualified mental health professionals or under the supervision of a qualified mental health professional in order to stabilize the individual during

their acute period of stress in order to allow the client to return to their normal life circumstances.

d) CCS and QUEST health plans do not provide services under this State Plan benefit.

3) State Plan approved service- Biopsychosocial Rehabilitation
   a) State Plan- A therapeutic day rehabilitative social skill building service which allows individuals with serious mental illness to gain the necessary social and communication skills necessary to allow them to remain in or return to naturally occurring community programs. Services include group skill building activities that focus on the development of problem-solving techniques, social skills and medication education and symptom management. All services provided must be part of the individual's plan of care. The therapeutic value of the specific therapeutic recreational activities must be clearly described and justified in the plan of care. At a minimum the plan of care must define the goals/objectives for the individual, educate the individual about his/her mental illness, how to avoid complications and relapse, and provide opportunities for him/her to learn basic living skills and improve interpersonal skills. Services are provided by qualified mental health professionals or staff that are under the supervision of a qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).
   b) CAMHD does not offer services within this State Plan benefit
   c) AMHD, CCS, and QUEST services for SMI adults >/=21yo:
      i) Psychosocial Rehabilitation (PSR)- PSR centers offer therapeutic day rehabilitative social skill building services that allow individuals with SPMI to gain the necessary social and communication skills to allow individuals to remain in and return to naturally occurring community programs. Services include group skill building activities that focus on development of problem solving skills, medication education, and symptom management. Individuals must have a plan of care that at a minimum defines the goals/objectives for the individual, educates them about their mental illness, avoiding complications and relapse, and provides opportunities to learn basic living and interpersonal skills. Services must be provided by a qualified mental health professional or under the supervision of a qualified mental health professional.

4) State Plan approved services- Intensive Family Intervention
   a) State Plan- These are time limited intensive interventions intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for children with serious emotional or behavioral disturbance or adults with serious mental illness. These services: 1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; 2) assess and monitor the service needs of the identified individual so that he/she can be safely maintained in the family; 3) ensure the clinical appropriateness of services provided; and 4) improve the individual's ability to care for self and the family's capacity to care for the individual. This service includes

focused evaluations and assessments, crisis case management, behavior management, counseling, and other therapeutic rehabilitative mental health services toward improving the individual's ability to function in the family. Services are directed towards the identified individual within the family. Services can be provided in-home, school or other natural environment. Services are provided by a multidisciplinary team comprised of qualified mental health professionals. If the services are provided by staff other than that listed above, the staff must be supervised by one of the licensed disciplines noted above and at a minimum be a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

b) CAMHD services for SEBD clients <21yo:
   i) Family Therapy- regularly scheduled face-to-face interventions with a young adult or youth and his/her family, designed to improve young adult or youth/family functioning and treat the young adult or youth's emotional challenges. The family therapist helps the young adult or youth and family increase their use of effective coping strategies, healthy communication, and constructive problem solving skills. The therapist also provides psycho-education about the nature of the young adult or youth's diagnosis.
   ii) Functional Family Tharapy- an evidenced-base family treatment system provided in a home or clinic setting for youth (10-18 years old) experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression). The goals of FFT are:
      (1) Phase I: Engagement of all family members and motivation of the youth and family to develop a shared family focus to the presenting problems;
      (2) Phase II: Behavior change – target and change specific risk behaviors of individuals and families; and
      (3) Phase III: Generalize or extend the application of these behavior changes to other areas of family relationships.
   iii) Parent Skills Training- The teaching of evidenced base behavior management interventions to parents or caregivers in order to develop effective parenting styles. These interventions are designed to promote more competencies in the parent/caregiver's ability to manage the youth's behavior. The focus of training is on the parent and adjusting their responses to the youth.
   iv) Intensive Home and Community-based Intervention, including home intervention and independent living programs- A multidisciplinary team of qualified mental health professionals meet with families and individuals face-to-face to stabilize and preserve the family's capacity to improve the youth's functioning in the current living environment and to prevent the need for placement outside the home. The goal is to 1) resolve the current crisis, evaluate its nature, and intervene in its likelihood to reoccur; 2) ensure the clinical appropriateness of services provided; and 3) improve the individual's ability to care for self and the family's capacity to care for the individual.

v) Multisystemic Therapy- time limited, intensive family and community-based treatment addressing multiple determinants of serious conduct disorder behaviors in juvenile offenders. Services include crisis management, evidence-based interventions, working with families in implementation of behavioral support plans, and parenting skills training to help the family build skills for coping with the youth's behavior. These services are provided by a multidisciplinary team comprised of qualified mental health professionals or under the supervision of a qualified mental health professional.

c) AMHD, CCS, and QUEST health plans do not offer services within this State Plan benefit.

5) State plan approved services- Therapeutic Living Supports and Therapeutic Foster Care Supports

a) State Plan- These are services covered in settings such as group living arrangements or therapeutic foster homes. Group living arrangements usually provide services for 3 to 6 individuals per home but not more than 15. Therapeutic foster homes provide services for a maximum of 15 individuals per home. Although these group living arrangements and therapeutic foster homes may provide 24 hour per day of residential care, only the therapeutic services provided are covered. There is no reimbursement of room and board charges. Covered therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home. The identified individual must be either a child with serious emotional or behavioral disturbance or the adult with a serious mental illness. Services provided in therapeutic group homes and therapeutic foster homes include: supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training (individual, group, family), directed at the amelioration of functional and behavioral deficits and based on the individual's plan of care developed by a team of licensed and qualified mental health professionals. Services are provided in a licensed facility and are provided by a qualified mental health professional or staff under the supervision of a qualified mental health professional with 24-hour on-call coverage by a licensed psychiatrist or psychologist.

b) CAMHD services for SEBD clients <21yo:

i) Therapeutic Foster and Group Homes (see description above)

ii) Multidimensional Treatment Foster Care (see description above)

c) AMHD and QUEST services for SMI clients >/=21yo:

i) Specialized Residential Treatment- Specialized Residential Treatment facility is a facility that provides a therapeutic residential program for care, diagnoses, treatment or rehabilitation services for persons who are socially or emotionally distressed, have a diagnosis of mental illness, substance abuse or developmental disability. These facilites develop rehabilitation plans with their clients to achieve goals that include social, emoitional, mental or physical restoration.

d) CCS does not provide therapeutic living supports but can refer to AMHD

6) State Plan approved services- Intensive Outpatient Hospital Services

a) State Plan- These are outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. Services are provided to an individual who is either a child with serious emotional or behavioral disturbance or an adult with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) are unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The goals of service are clearly identified in an individualized plan of care. The short term and long term goals and continuing care plan are established prior to admission through a comprehensive assessment of the consumer to include a severity-adjusted rating of each clinical issue and strength. Treatment is time-limited, ambulatory and active offering intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Services are available at least 20 hours per week. All services are provided by qualified mental health professionals, or by individuals under the supervision of a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Registered nurses or licensed practical nurses must be available for nursing interventions and administration of medications. Licensed psychiatrists or psychologist must be actively involved in the development, monitoring, and modification of the plan of care. The services must be provided in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for coverage of partial hospitalization/day treatment. These services area not provided to individuals in the inpatient hospital setting and do not include acute inpatient hospital stays.

b) CAMHD services for SEBD clients under 21yo:
   i) Partial Hospitalization- Day programming in the outpatient area or clinic of a licensed certified facility that allows for a more intensive milieu treatment with a focus on medical/psychiatric resources. This service is available to stabilize a youth's symptoms or as a transition step for youth who have been in more restrictive settings.

c) AMHD, CCS, and QUEST services for SMI clients >/= 21yo:
   i) Outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. The goals of the service are clearly articulated in each consumer's individualized plan of care. Treatment is time-limited, ambulatory and active offering intensive, coordinated clinical service provided by a multi-disciplinary team.

7) State Plan approved services- Assertive Community Treatment

a) State Plan- This is an intensive community rehabilitation service for individuals who are either children with serious emotional or behavioral disturbance or adults with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) is unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The ACT rehabilitative treatment services are to restore and rehabilitate the individual to his/her maximum functional level. Treatment interventions include crisis management (crisis assessment, intervention and stabilization); individual restorative interventions for the development of interpersonal, community coping and independent living skills; services to assist the individual develop symptom monitoring and management skills; medication prescription, administration and monitoring medication and self medication; and treatment for substance abuse or other co-occurring disorders. Services include 24 hours a day, 7 days a week coverage, crisis stabilization, treatment, and counseling. Also, individuals included in ACT receive case management to assist them in obtaining needed medical and rehabilitative treatment services within their ACT treatment plan. Services can be provided to individuals in their home, work or other community settings. ACT services are provided by agencies whose staffs include one or more licensed qualified mental health professionals. If the services are provided by staff other than a licensed qualified mental health professional, the staff must be supervised by a licensed qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Case management is an integral part of this service and reimbursement for case management as a separate service is not allowed. If biopsychosocial rehabilitation is part of the individual's plan of care under intensive case management, reimbursement for biopyschosocial rehabilitation as a separate service is not allowed.

b) CAMHD services for SEBD clients <21yo:
   i) Intensive Case Management , including comprehensive case assessment, planning, coordination, and monitoring. Case management is a community-based, behavioral health treatment service that links and coordinates segments of the service-delivery system to ensure comprehensive therapeutic planning and intervention to meet an individual youth's and family's needs for improved community functioning. Case management includes comprehensive case assessment, case planning, connecting, brokering, and ongoing monitoring of treatment services, while advocating for youth and families to address their needs and overcome barriers to receiving quality services. These services are provided to increase community tenure, improve functioning, minimize psychiatric symptoms and develop an enhanced quality of life for youth and their families. Outpatient Assessment, therapy, and medication management, including psychiatric evaluation, mental health assessments (comprehensive, focused, summary, and psychosexual), therapy (individual, group, and family), treatment service planning, school consultation (i.e., consultation of a qualified mental

health professional with regular and special education teachers, school administrators and other school personnel regarding the behavioral management of a young adult or youth within the school setting in the Individualized Education Plan team meeting), and case consultation by a qualified mental health professional.

ii) Community-based Residential Programs are provided for sexual offenders in a locked care facility, to sexual offending deviants in a non-locked unit, and to other individuals with an assortment of problems in a general residential environment. These programs provide twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression or deviance that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose needs can best be met in a structured program of small group living that includes educational, recreational, and occupational services. These programs provide twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression, or deviance, which prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services. Services include psychotherapy, medication management, and substance abuse treatment as needed. Services are provided by qualified mental health professionals.

c) AMHD, CCS, and QUEST health plans for SMI adults >/=21yo:

i) Intensive Case Management: see description above

8) State Plan approved service- Hospital-based Services

a) State Plan- Provides secure locked residential treatment consisting of highly structured daily programming, close supervision, educational services, and integrated service planning designed for severely emotionally/behaviorally disturbed to function in a less restrictive setting. Services include multi-disciplinary assessment of the child, skilled milieu of services by trained staff who are supervised by a licensed professional on a 24 hour per day basis, individual psychotherapy and/or counseling, individualized adjunctive therapies, and substance abuse education and counseling, as appropriate and as part of an interdisciplinary treatment plan. Services are required to be staff secure at all times. Hospital-based residential services are provided in a licensed inpatient facility serving individuals who are under the age of 21 and are provided by a qualified mental health professional. If the services are provided by staff other than that listed above, the staff must be supervised by a qualified mental health professional.

b) CAMHD services for SEBD clients <21yo:

i) Hospital-based Residential Services- Intensive inpatient treatment services to youth with severe emotional challenges who require short-term hospitalization for the purposes of receiving intensive diagnostic, assessment, and medication stabilization services. The highly structured program provides educational services, family therapy, and integrated services planning through a multi-disciplinary assessment of the youth, skilled milieu of services by trained staff

who are supervised by licensed professionals on a 24 hour per day basis. Services are provided in a locked unit of a licensed inpatient facility.

c) AMHD, CCS, and QUEST health plans do not provide hospital-based residential services for SMI adults >/= 21yo. Acute psychiatric hospitalization is provided for all clients by their QUEST or QExA health plan.

G. A memorandum of agreement (MOA) reflects the current interagency agreement for behavioral health services provided by the DOH to demonstration eligible clients.

Attached are MOAs between the MQD and CAMHD (Exhibit 4) and between the MQD and AMHD (Exhibit 5). These are the most current MOAs for both CAMHD and AMHD. Both of these MOAs are in the process of being revised. The MQD will provide revised MOAs to CMS when executed.

H. The process and protocol used for referral between the health plans and the DOH, as well as the DOH and the health plans, is as follows:

CAMHD

Health plans to DOH

1. The health plan can make a referral to CAMHD through use the SEBD Referral Form developed by CAMHD (Exhibit 6).
2. The health plan will continue to provide behavioral health services even after CAMHD admits the individual their program. In these cases, the health plan will not provide services offered by CAMHD; CAMHD will not provide services offered by the health plan.
3. The MQD will notify the health plan of the individual's admission into the CAMHD program via the 834-transaction file.

DOH to health plans

1. The DOH has a contact within the health plan for coordination of care.
2. The health plan will be notified that the individual is no longer receiving services via CAMHD via the 834-transaction file.

AMHD

Health plans to DOH

1. The health plan can make a referral to AMHD by calling the AMHD access line. The access line is available twenty-four hours a day. The referral line will gather information necessary to perform an assessment on the health plan's member.
2. The health plan will continue to provide behavioral health services even after AMHD admits the individual their program. In these cases, the health plan will not provide services offered by AMHD; AMHD will not provide services offered by the health plan.

DOH to health plans

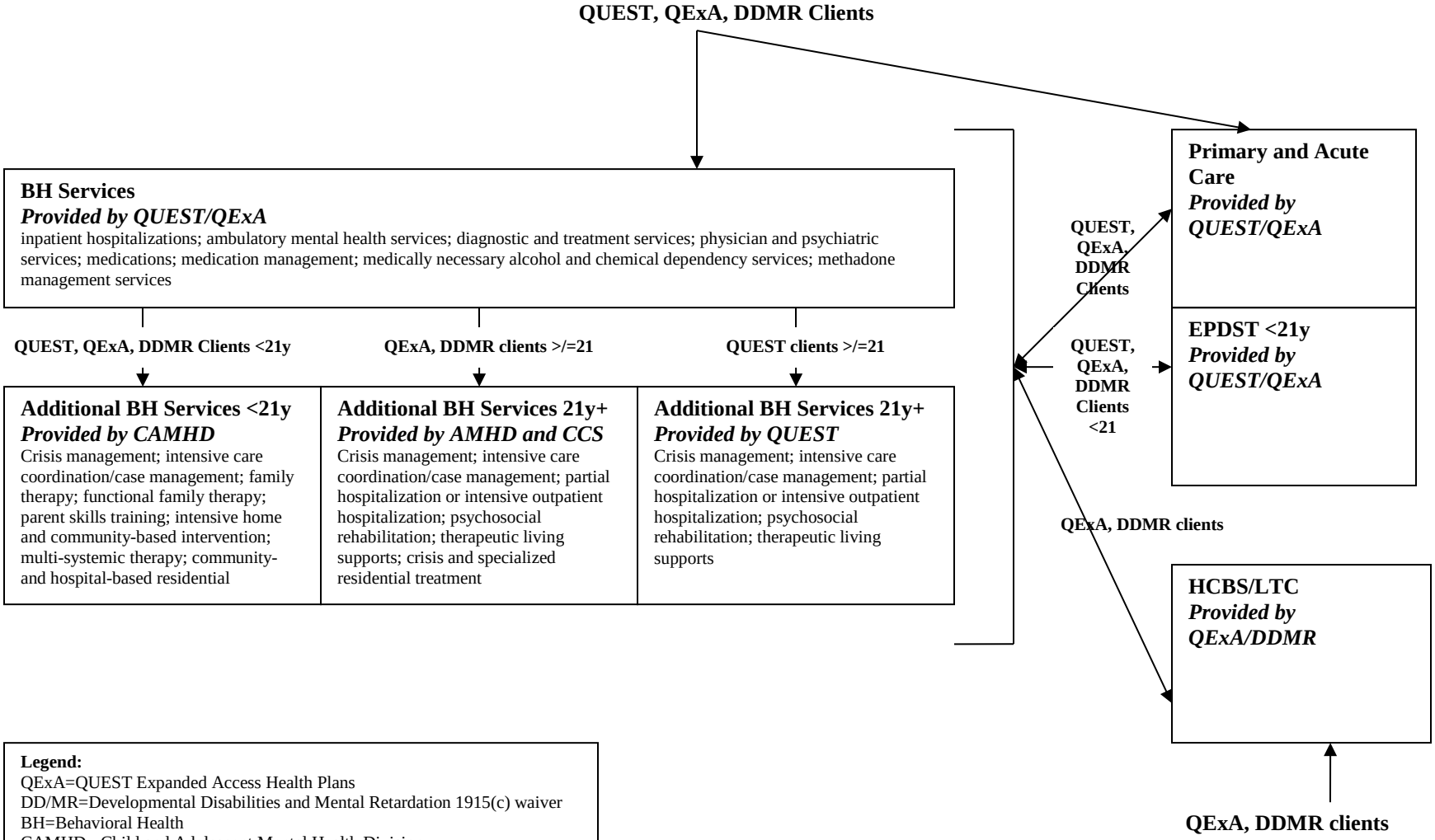
1. The DOH has a contact within the health plan for coordination of care.

CCS (‘Ohana Health Plan)

1. The health plans can make a referral to CCS through the MQD using the DHS 1157 form. A MQD physician will review the form and make a determination if the Medicaid client will benefit from services in the CCS program. Once MQD has accepted the client into CCS, MQD will inform the health plan of this acceptance.
2. The MQD will notify the health plan of the individual’s admission into the CCS program via the 834-transaction file.
3. MQD notifies ‘Ohana Health Plan of new client admissions or changes via an 834-transaction file.
4. Each health plan has behavioral health staff that communicates with ‘Ohana Health Plan directly regarding any concerns with their clients.

Attachment E
Behavioral Health Services Protocol

Exhibit 1 to Attachment E: Behavioral Flow Chart



Legend:
QExA=QUEST Expanded Access Health Plans
DD/MR=Developmental Disabilities and Mental Retardation 1915(c) waiver
BH=Behavioral Health
CAMHD= Child and Adolescent Mental Health Division
AMHD=Adult Mental Health Division
CCS=Community Care Services Behavioral Health Carve-out
EPSDT=Early Periodic Screening Diagnosis and Treatment program
HCBS=Home and Community-Based Services
LTC=Long Term Care services

Exhibit 2 to Attachment E

Behavioral Health Services in the QUEST and QUEST Expanded Access (QExA) Programs

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
Payment methodology	**Payment to health plans** Capitation	**Payment to health plans** Capitation	**Payment to DOH-AMHD** Billed FFS to MQD	**Payment to 'Ohana Health Plan** Capitation	**Payment to DOH-CAMHD** Billed FFS to MQD
Behavioral Health Services					
Acute psychiatric hospitalization	Twenty-four (24) hour care for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services as needed o Other medically necessary services o Pharmaceuticals o Occupational speech/language therapy, as needed	Twenty-four (24) hour care for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services as needed o Other medically necessary services o Pharmaceuticals o Occupational speech/language therapy, as needed	Provided by health plan	Twenty-four hour acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services, as needed o Other medically necessary services o Pharmaceuticals o Occupational speech/language therapy, as needed	Provided by health plan

Attachment E
Behavioral Health Services Protocol

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
Ambulatory Services-non- crisis services	Ambulatory services-non-crisis services	Ambulatory services-non-crisis services	Provided by health plan	Ambulatory services, non-crisis services	Outpatient behavioral health services
Crisis Management	Provided by AMHD to QUEST members	Not provided	Crisis Management a. 24-hour crisis telephone consultation b. Mobile outreach services c. Crisis intervention/ stabilization services	Crisis Management a. 24/7 Crisis hotline (through 800#) b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization	Crisis Management a. 24/7 Crisis hotline (through 800#) b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization d. No pre-authorization required for payment.
Intensive Outpatient Hospital Services	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and aftercare o Other medically	Not provided	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and aftercare o Other medically	Intensive Outpatient/Partial hospitalization including: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy	Intensive Outpatient/Partial hospitalization including: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
	necessary services		necessary services	and aftercare o Other medically necessary services	and aftercare o Other medically necessary services
Methadone treatment	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan
Prescription drugs	Prescribed drugs including medication management and patient counseling	Prescribed drugs including medication management and patient counseling	Provided by health plan	Prescribed drugs including medication management and patient counseling	Provided by health plan
Diagnostic/ laboratory services	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol problems o Other medically necessary diagnostic services	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol problems o Other medically necessary diagnostic services	Provided by health plan	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol o Other medically necessary diagnostic services	Provided by health plan
Psychiatric evaluation	Psychiatric or psychological evaluation	Psychiatric or psychological evaluation	Psychiatric or psychological evaluation	Psychiatric, psychological or neuropsychological	Psychiatric, psychological or neuropsychological

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
				evaluation	evaluation
Physician Services	Physician services	Physician services	Physician services	Physician services	Provided by health plan
Supported Employment	Not provided	Not provided	Supported Employment (service provided with State funds and not billed to Medicaid)	Occupational, pre-vocational services	None
Other medically necessary therapeutic services	Other medically necessary therapeutic services	Other medically necessary therapeutic services	Provided by health plan	Other medically necessary therapeutic services	Other medically necessary therapeutic services
Transportation	Transportation o Air o Ground for medically necessary services	Transportation o Air o Ground for medically necessary services	Provided by health plan	Transportation o Air o Ground for medically necessary services	Provided by health plan
ECT	ECT o Medically necessary, may do more than one/day o Inclusive of anesthesia	ECT o Medically necessary, may do more than one/day o Inclusive of anesthesia	Provided by health plan	ECT o Medically necessary, may do more than one/day o Inclusive of anesthesia	Provided by health plan
Substance Abuse	Substance Abuse o Use of substance abuse counselors o Encouraged to use treatment facilities that comply with	Substance Abuse o Use of substance abuse counselors o Encouraged to use treatment facilities that comply with	Provided by health plan	Substance Abuse - Residential o Medically necessary based on American Society of Addiction	Provided by health plan

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
	Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) o Coordinate with ADAD on substance abuse treatment • Providing assistance to members who wish to obtain a slot, either by helping them contact ADAD or its contractor or referring the member to a substance abuse residential treatment provider to arrange for the utilization of an ADAD slot; • Providing	Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) o Coordinate with ADAD on substance abuse treatment • Providing assistance to members who wish to obtain a slot, either by helping them contact ADAD or its contractor or referring the member to a substance abuse residential treatment provider to arrange for the utilization of an ADAD slot; • Providing		Medicine (ASAM) o In network benefits only o Detox: o Oahu: Detox center o NI: General hospital o Req. Psych. Care to psych facility Substance Abuse – Out-patient o Screening o Treatment and treatment planning o Therapy/ counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary	

Agency	QUEST Health Plans	QExA Health Plans	AMHD	‘Ohana Health Plan (CCS Program)	CAMHD
	appropriate medically necessary substance abuse treatment services while the member is awaiting an ADAD slot; • Covering all medical costs for the member while the member is in an ADAD slot; • Coordinating with the ADAD provider following the member’s discharge from the residential treatment program; and • Placing the member into other	appropriate medically necessary substance abuse treatment services while the member is awaiting an ADAD slot; • Covering all medical costs for the member while the member is in an ADAD slot; • Coordinating with the ADAD provider following the member’s discharge from the residential treatment program; and • Placing the member into other			

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
	appropriate substance abuse treatment programs following discharge from the residential treatment program. • Note: Med-QUEST Division does not manage wait-listed ADAD slots. Health plans shall assure that their members receive medically necessary substance abuse services while waiting for an ADAD slot to open. o Use of special	appropriate substance abuse treatment programs following discharge from the residential treatment program. • Note: Med-QUEST Division does not manage wait-listed ADAD slots. Health plans shall assure that their members receive medically necessary substance abuse services while waiting for an ADAD slot to open. o Use of special			

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
	treatment facilities for adolescents substance abuse therapy/ treatment o Note: Special Treatment Facilities are licensed by the DOH to provide substance abuse treatment. These facilities are a short-term option for substance abuse. o Screening for drugs and alcohol	treatment facilities for adolescents substance abuse therapy/ treatment o Note: Special Treatment Facilities are licensed by the DOH to provide substance abuse treatment. These facilities are a short-term option for substance abuse. o Screening for drugs and alcohol			
Member Education	Member Education o Specific areas not related to mental health o Disease specific education	Member Education o Specific areas not related to mental health o Disease specific education	Provided by health plan	Member Education Life Skills groups conducted daily such as Skills Building, ability to complete necessary paperwork, creation of videos as a creative outlet, Medication Education, Arts & Culture, Recreation, etc.	Transitional Age Group: Life Skills groups conducted daily such as Skills Building, ability to complete necessary paperwork, creation of videos as a creative outlet, Medication Education, Arts & Culture, Recreation, etc.

Attachment E
Behavioral Health Services Protocol

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
Crisis Residential Services	Provided by AMHD to QUEST members	Not provided	Crisis Residential Services	Not provided	Crisis Residential Services
Therapeutic Living Supports	Therapeutic Living Supports provided in Specialized Residential Treatment facilities	Not provided	Therapeutic Living Supports provided in Specialized Residential Treatment facilities	Not provided, but can refer make a request to AMHD for services	Therapeutic living and therapeutic foster care supports
Biopsychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Not provided	Psychosocial Rehabilitative Programs	Biopsychosocial Rehabilitative Programs	Not provided
Case Management	Intensive case management/ community based case management	Service Coordination for primay, acute, behavioral health, and LTC services for QExA members	o Intensive case management/ community based case management o Targeted Case Management	Care Coordination/Case Management o Case assessment o Case planning (service planning, care planning) o Outreach o Ongoing monitoring and service coordination	o Intensive case management/ community based case management o Targeted Case Management
Hospital based residential treatment	Not provided	Not provided	Not provided	Not provided	Hospital based residential treatment
Intensive family intervention	Not provided	Not provided	Not provided	Not provided	Intensive family intervention

Exhibit 3 to Attachment E

Eligibility Diagnoses for CAMHD Support for Emotional and Behavioral Development (SEBD) Program

Eligible Diagnoses:

- Demonstrates the presence of a primary DSM (most current edition) Axis I diagnosis for at least six (6) months or is expected to demonstrate the diagnosis for the next six (6) months. See excluded diagnoses in the next section.

Excluded Diagnoses

If the diagnoses listed below are the **ONLY** DSM (most current edition) diagnoses, the child/youth is ineligible for SEBD services. However, these diagnoses may and often do co-exist with other DSM diagnoses, which make the child/youth eligible for SEBD services.

- *Mental Retardation (317, 318.0, 318.1, 318.2, 319)
- *Pervasive Developmental Disorders (299.0, 299.80, 299.10)
- Learning Disorders (315.0, 315.1, 315.2, 315.9)
- Motor Skills Disorders (315.3)
- Communication Disorders (315.31, 315.32, 315.39, 307.0, 307.9)
- Substance Abuse Disorders
- Mental Disorders Due to a General Medical Condition
- Delirium, Dementia, Amnestic, and other Cognitive Disorders
- Factitious Disorders
- Feeding Disorders of Infancy or Childhood
- Elimination Disorders
- Sexual Dysfunctions
- Sleep Disorders

*Co-occurring diagnoses of Mental Retardation and Pervasive Developmental Disorders require close collaboration and coordination with State of Hawaii Department of Health (DOH) and State of Hawaii Department of Education (DOE) services. The health plan, with CAMHD, is responsible for coordinating these services. These diagnoses may be subject to a forty-five (45) day limit on hospital-based residential services, after which utilization review and coordination of services with DOE need to occur.

Eligibility Diagnoses for Additional Behavioral Health Services for Adults

Eligible Diagnoses:

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)
- Delusional Disorders (297.1)
- Mood Disorders- Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders- Depressive Disorders (296.24, 296.33, 296.34)

Exhibit 4 to Attachment E

`LINDA LINGLE

GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

September 28, 2004

MEMORANDUM OF AGREEMENT

BETWEEN
DEPARTMENT OF HUMAN SERVICES
AND
DEPARTMENT OF HEALTH

This MEMORANDUM OF AGREEMENT (MOA) between the Med-QUEST Division (MQD) of the Department of Human Services (DHS) and the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health (DOH) is to provide behavioral services for QUEST and Medicaid Fee-For-Service (FFS) children and adolescents age 3 through age 20 who are eligible and determined to be Seriously Emotionally and Behaviorally Disturbed (SEBD) and in need of intensive mental health services. This MOA covers the period from July 1, 2004 to June 30, 2005. The above-mentioned State agencies agree to the following provisions specified herein.

I. THE CAMHD OF THE DEPARTMENT OF HEALTH SHALL:

A. Provide the following services to youth covered under this MOA as specified in Attachment I.

B. Determine level and medical appropriateness of behavioral health managed care services as documented in the client's individualized behavioral health treatment plan in accordance with State quality assurance and utilization review standards.

C. Have an internal Grievance and Appeals process in place. All grievances and appeals should be resolved within thirty (30) days from the receipt of the written or verbal expression of dissatisfaction, unless a fourteen (14) day Extension or Expedited appeal is initiated. The policies and procedures for resolution of grievances and appeals shall be included as part of the CAMHD Quality Assurance Program and be in compliance with the grievance and appeal requirements of the MQD. CAMHD shall provide MQD with a quarterly grievance and appeals report in a format determined by the MQD.

D. Comply with any DHS Administrative Appeals Office (AAO) decision relating to the provision of behavioral health services covered by the MOA. A recipient shall utilize the CAMHD Grievance System before appealing to the DHS AAO. CAMHD shall notify the recipient/family of the right to appeal to DHS. Appeals shall be limited to Medicaid covered services. Any appeal to DHS shall not waive the recipient's right to judicial appeal.

E. Provide a continuation of benefits during an appeal or State Fair Hearing.

F. Implement in full the Quality Assurance Program (QAP) approved by the MQD. CAMHD shall implement changes to operations, policies and procedures, and provider contracts to remain in compliance with the approved QAP.

G. Maintain staffing level and proficiency and an adequate provider network to provide the quality and extent of services and activities required under the State and Federal regulations applicable to a Prepaid Inpatient Health Plan. CAMHD clinical staff and providers shall be qualified and trained in the principles and techniques of mental health treatment and services. Providers shall meet State licensing requirements for professions where licensing is required to provide mental health services.

H. Establish monitoring schedules and criteria, and monitor CAMHD providers of services and staff on a regular basis to ensure compliance with the QUEST program.

I. Maintain documentation that CAMHD providers are maintaining records of services provided by providers' staff and contractors in compliance with the QAP requirements. Maintain confidentiality of such records as required by State and Federal laws.

J. Comply with requests from the State and Federal Government and/or their representatives to review all medical and financial records of CAMHD, and its

subcontractors and providers, and CAMHD staff to ensure compliance with the terms and condition of this Agreement and the State and Federal rules and regulations.

K. Process electronic transmission of daily and monthly rosters for eligibility for QUEST and Medicaid FFS youth covered under this MOA and support the electronic transmission of daily and monthly rosters for eligibility.

L. Submit a monthly invoice to support billing for QUEST and Medicaid FFS youth covered under this Agreement.

M. Provide a monthly (if network changes take place) or a quarterly submission of CAMHD's provider network in accordance with instructions and filing requirements established by the MQD.

N. Provide a monthly submission of encounter data in accordance with instructions and filing requirements established by the MQD.

O. Provide a signed Letter of Certification at the time of the encounter and provider data submission. The letter of certification shall be signed by the Chief Executive Officer, Chief Financial Officer or an individual who has been delegated authority to sign for and who reports directly to one of the above organizational officers. The letter must certify that the data is accurate, complete and truthful.

P. Pay for behavioral health services for eligible children and adolescents that CAMHD determines to be necessary but are not covered under this agreement.

Q. Inform MQD of recipients who are accepted into or disenrolled from CAMHD services within thirty (30) days. CAMHD shall be responsible to verify the enrollment and disenrollment date of recipients from the daily and/or daily and monthly rosters provided by MQD.

R. Minimize the disruption of behavioral health services during the transition of care for recipients covered under this Agreement when transitioning from the QUEST plans to CAMHD. Assure the continued provision of comparable services and preserve existing therapeutic relationships between the child and provider as medically necessary for the child/adolescent.

S. CAMHD shall inform the QUEST plan when a transition or termination of a recipient's services is to occur due to a change in their status and pay for all behavioral health services provided by a QUEST plan prior to the transition or termination. CAMHD will be responsible for notifying MQD of referrals between CAMHD and the QUEST plan.

T. If a recipient is enrolled in the CAMHD plan under this MOA and is in need of urgent care and/or crisis intervention and a CAMHD provider is not available to provide the services, CAMHD agrees that the QUEST plan shall provide the service if possible and if it is determined to be medically necessary by the QUEST plan. The CAMHD shall be

responsible to reimburse the QUEST plan through MQD for the service(s) provided plus a 10 % administrative fee.

U. Provide written information to recipients and their families informing them of their benefits, rights, and responsibilities within the acceptable timeframe established by the MQD.

V. Meet the terms of the medical Request for Proposal (RFP) rules and requirements as they apply to CAMHD as a Prepaid Inpatient Health Plan.

W. Comply with all Federal and State rules and regulations to include the Balanced Budget Act of 2002, implemented August 13, 2004.

II. THE MQD OF THE DEPARTMENT OF HUMAN SERVICES SHALL:

A. Pay the CAMHD a monthly reimbursement rate of $ 542.87 per member per month for each youth/adolescent covered under this MOA that are not classified under Section 504 as needing mental health services. Payment shall be made no later than thirty (30) calendar days subsequent to receiving the submission of encounter data and shall be reconciled annually to actual costs based on utilization reported as encounters and priced at Medicaid rates. Any adjustment for the year will be applied retroactively.

- The monthly reimbursement rate payment shall be paid on a prorated basis for the number of days during the month in which the child was enrolled with CAMHD.

- The date of disenrollment from CAMHD shall be effective at the end of the month in which DHS is notified through use of the Enrollment/Disenrollment

B. Pay for services on a Fee-For-Service basis for behavioral health services provided by CAMHD to Medicaid eligibles that are classified as blind or disabled and are not enrolled in a QUEST health plan. FFS claims for behavioral health services covered under the Hawaii State Medicaid program shall be submitted to the MQD's fiscal agent. Claims billing and processing shall be conducted in accordance with established billing and payment procedures.

C. Review the operations and policies of the CAMHD on a continuing basis to determine if Hawaii QUEST quality assurance (QA) standards for a written QAP are

met. The MQD reserves the right to delay re-implementation of this MOA until all quality assurance standards are met.

D. Monitor CAMHD to ensure that it has implemented its written QAP. MQD reserves the right to withhold and/or deny payments if CAMHD cannot implement its QAP.

E. Ensure that clients meet eligibility and enrollment criteria for Medicaid.

F. Ensure that enrollments and disenrollments of youth covered under this MOA are done accurately and in an efficient and timely manner and in accordance with agreed upon procedures.

G. Provide the directives to CAMHD during the transition period of youth covered under this MOA into CAMHD to assure the continued provision of comparable services and to preserve existing therapeutic relationships if it is medically necessary for the child/adolescent.

H. Inform other QUEST plans regarding their responsibility to transition indicated youth to the CAMHD behavioral health plan.

Reimbursement for Services:

a) The CAMHD shall submit a monthly invoice and be reimbursed by DHS for behavioral health services provided to recipients who are covered by this MOA at the Monthly Reimbursement rate of $ 542.87 per member per month subject to annual reconciliation to actual costs. DHS shall pay CAMHD based on the monthly eligibility roster. The above rate includes Federal and State funding.

b) The monthly reimbursement rate is calculated based on the estimated per member per month based on historical encounters and enrollments, and will be reconciled to actual costs incurred by CAMHD on an annual basis. Within ninety (90) days of the end of the fiscal year, or by September 30th of each year, CAMHD shall supply MQD with encounters, in the format specified in the Health Plan Manual, for all services provided to children covered under this agreement during the fiscal year for purposes of reconciliation. The costs indicated by the encounter data shall be the sole source of reporting costs incurred by CAMHD to the MQD.

MQD shall then reconcile monthly payments against the federally funded portion of the actual costs incurred. If the total payments exceed the federally funded portion of actual costs, CAMHD shall refund the difference to MQD. If the total payments are less than the federally funded portion of actual costs, MQD shall pay the difference to CAMHD. At the end of each reconciliation, the reimbursement rate will be re-determined for the next Fiscal Year based on the previous years federally funded actual costs for similar services.

c) Federal funds are not available for children classified as needing mental health treatment services under Section 504; therefore CAMHD shall not receive reimbursement from DHS for these children. CAMHD will be responsible for determining whether individuals who require 504 accommodations include mental health services.

d) The DHS shall pay the DOH for the Federal share at the Hawaii Federal Medical Assistance Percentage (FMAP) in place for the month for which reimbursement is made. The DOH is responsible for the State's share of the expenditures.

e) The total amount of this AGREEMENT shall not exceed $7.5 million in Federal funds per State fiscal year.

f) The CAMHD shall reimburse MQD any amount disallowed by CMS for services provided under this MOA.

g) For services covered by this MOA, MQD agrees to coordinate reimbursement from CAMHD for intensive behavioral health services provided by QUEST plans plus a 10% administrative fee for services provided to CAMHD recipients covered under this MOA during their assessment and transition. The reimbursement shall be a net against the capitation payment.

h) For services not covered by this MOA, if CAMHD provides and pays for services for which the QUEST medical plans are financially responsible, MQD agrees to coordinate reimbursement from the QUEST medical plans plus a 10% administrative fee to CAMHD for services provided to QUEST recipients.

i) The MOA period shall be for a period of one year. For purposes of continuity of care the DHS shall have the option to renew and/or extend the contract with CAMHD for the next fiscal year. Any renewal or extension of the contract will be subject to available funding.

This Agreement is for the sole benefit of the parties hereto, and is not for the benefit of any third party beneficiaries, including any members of the Hawaii QUEST Program. The MEMORANDUM OF AGREEMENT may also be terminated by either party for any reason with thirty (30) calendar days written notice to the other party. Amendments, as mutually agreed upon, may be made, as appropriate, in writing.

DEPARTMENT OF HUMAN SERVICES	DEPARTMENT OF HEALTH
_____/s/_____	_____/s/_____
Lillian B. Koller, Esq.	Chiyome Fukino, M.D.
Director	Director
Date: _____	Date: _____

FY04-FY05

Scope of Services

To be included but not limited to:

1. CRISIS MANAGEMENT

    a. 24-hour crisis telephone consultation

    b. Mobile outreach/stabilization services

    c. Crisis intervention/stabilization services

2. OUTPATIENT BEHAVIORAL HEALTH SERVICES

    a. Psychosexual assessments/evaluations

3. INTENSIVE FAMILY INTERVENTION SERVICES

    a. Intensive Family Intervention

    b. Multi-systemic Therapy (MST)

4. CRISIS RESIDENTIAL SERVICES

5. INTENSIVE OUTPATIENT HOSPITAL SERVICES

6. THERAPEUTIC LIVING SUPPORTS AND THERAPEUTIC FOSTER CARE SUPPORTS

    a. Foster Homes with Therapeutic Services

    b. Mental Health Respite Homes

    c. Community-Based Residential Programs

    d. Therapeutic Group Homes

7. RESIDENTIAL TREATMENT IN A HOSPITAL SETTING

Exhibit 5 to Attachment E

LINDA LINGLE

GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

November 5, 2010

MEMORANDUM OF AGREEMENT

BETWEEN

DEPARTMENT OF HUMAN SERVICES AND DEPARTMENT OF HEALTH

This MEMORANDUM OF AGREEMENT (MOA) between the Med-QUEST Division (MQD) of the Department of Human Services (DHS) and the Adult Mental Health Division (AMHD) of the Department of Health (DOH) is to provide mental health services for all Medicaid recipients over 18 years old with serious mental illness. This MOA covers the period from **July 1, 2009 through June 30, 2012**. At the end of the MOA, MQD shall have the option to renew the MOA for another defined term. The above-mentioned state agencies agree to the following provisions specified herein.

I. THE AMHD OF THE DEPARTMENT OF HEALTH SHALL:

A. Implement processes for certifying Provider Agencies or State Operated Facilities to determine eligibility for participation in the Community Mental Health Program. Any revisions to the current process shall be approved by MQD. Specifically, the AMHD agrees to:

1. Determine Provider Agencies' or State Operated Facilities' eligibility for participation in the Community Mental Health Program subject to Hawaii Administrative Rules (HAR) chapter 11-172 .

2. Gather and review all applications from Provider Agencies or State Operated

Facilities seeking eligibility for participation in the Community Mental Health Program. AMHD will provide MQD information on Provider Agencies or State Operated Facilities who have been approved to participate in the Community Mental Health Program. AMHD will be responsible for communicating decisions regarding eligibility to the Provider Agencies or State Operated Facilities submitting an application.

3. Notify MQD immediately regarding changes in the Provider Agencies' or State Operated Facilities' eligibility.

4. Recertify Provider Agencies or State Operated Facilities every three years. Annually, AMHD will perform on-site reviews of each eligible Provider Agency or State Operated Facility to ensure they comply with programmatic, operational and fiscal requirements established in HAR chapters 11-172 and 17-1736. AMHD will establish monitoring schedules and criteria, and provide information on these reviews to MQD on a annual basis.

5. AMHD may submit claims to the MQD for qualified mental health providers (QMHP) to include psychiatrists, licensed psychologists, licensed clinical social workers, licensed mental health counselors, and licensed marriage family therapists as long as the QMHP is a Medicaid provider.

B. Implement a utilization management process to evaluate the appropriateness of services, lengths of stay and quality of services. AMHD will utilize established utilization management policies and procedures for conducting these reviews. All utilization management decisions will be provided to Provider Agencies or State Operated Facilities in accordance with the AMHD utilization management policies. Appeals by Provider Agencies or State Operated Facilities regarding these decisions will be reviewed in accordance with AMHD due process procedures set forth in AMHD Policy 60.908.

C. Coordinate within the Department of Health, in general, to develop methodology and receive approval from the Department of Health and Human Services, Division of Cost Allocation for claiming the federal reimbursement for administrative services.

D. Receive and pay all claims for MQD covered mental health services from Provider Agencies or State Operated Facilities eligible for participation in the Community Mental Health Program based on the fee schedule in Attachment II. Covered mental health services are provided in Attachment I.

E. Submit a list of all Medicaid clients receiving services through the AMHD to the MQD on a monthly basis. The format shall be 834 or similar format mutually agreed upon by MQD and AMHD. MQD shall use this information to assure that claims are processed in accordance with established Medicaid standards.

F. Provide a paid, adjusted, and voided claims file to the MQD or its fiscal agent on a bi-monthly basis or as otherwise agreed to by the parties, in accordance with instructions and filing requirements established by MQD. The format shall be *837/835* or similar format mutually agreed upon by MQD and AMHD. As required by 42 CFR §433.51 (a), (b), and (c), the AMHD will certify that the public funds expended as the State's share represent expenditures eligible for Federal Financial Participation (FFP) for each filing. This certification also requires the claims data supporting the payment and proof of the AMHD payments made to the providers. Targeted Case Management services provided by the AMHD Community Mental Health Centers (CMHC) will be submitted to the MQD on a regular basis using a valid HIPAA format.

G. Maintain a current provider manual for the Community Mental Health Program, as approved by MQD. AMHD will distribute the manual to eligible Provider Agencies and State Operated Facilities.

H. Ensure the provision of services to consumers between the age of eighteen (18) and twenty-one (21) are in accordance with federal Early, Periodic, Screening, Detection, and Treatment (EPSDT) requirements.

I. Provide sufficient professional staff to coordinate, supervise and implement their responsibilities under this MOA.

J. Agree to pay the state share for Community Mental Health Program services, which are determined to be eligible for Federal Financial Participation and furnished to Medicaid recipients.

K. Agree to return any federal share that is disallowed by the federal government, or determined to be inappropriate for reimbursement by the MQD. Cooperate with the activities of the MQD Fraud Unit and assist in recovering any overpayments or inappropriate payments from certified AMHD providers and State Operated Facilities. AMHD shall monitor AMHD providers for fraud and report suspected fraudulent activity in writing to MQD and the Department of the Attorney General, Medicaid Investigations Division within thirty (30) days of discovery.

II. <u>THE MQD OF THE DEPARTMENT OF HUMAN SERVICES SHALL</u>:

A. Pay the AMHD on a monthly basis the federal reimbursement for eligible paid claims based on the paid claims file and the Targeted Case Management file submitted by AMHD. Reimbursement shall be allowed on clean claims determined payable after review by the edits in the MQD claims processing system. Clean claims reimbursement shall be paid within thirty (30) days of submittal by AMHD. Claims denied by MQD's claims processing system will be returned to AMHD for resolution.

B. Establish and/or terminate Provider Agencies or State Operated Facilities within

thirty (30) days of receipt of information from AMHD.

C. Provide eligibility information to AMHD on a regular basis, but no less than monthly, using a batch process agreed upon by MQD and AMHD.

D. Pay AMHD the federal reimbursement based upon the methodology approved by the Department of Health and Human Services, Division of Cost Allocation for the Medicaid Administration activities performed by AMHD staff, including skilled medical professional staff, to coordinate, supervise, and implement its responsibilities under this MOA.

E. Review, during the term of this MOA, the operations and policies of AMHD as necessary to determine if the terms of this MOA are met.

F. Conduct desk reviews and audits of Provider Agencies' and State Operated Facilities' claims and inform AMHD of the results of such reviews and audits within thirty (30) days of their completion.

Either party for any reason may terminate this MEMORANDUM OF AGREEMENT upon ninety (90) calendar day's written notice to the other party. Amendments, as mutually agreed upon, may be made, as appropriate, in writing.

DEPARTMENT OF HUMAN SERVICES	DEPARTMENT OF HEALTH
/s/	_____/s/_____
Lillian B. Koller, Esq.	Chioyme Leinaala Fukino, M.D.
Director of Human Services	Director of Health
_____	_____
Date	Date

ATTACHMENT I

1. Crisis Management

    a. 24-hour crisis telephone consultation
    b. Mobile outreach services
    c. Crisis intervention/stabilization services

2. Crisis Residential Services

3. Intensive Outpatient Hospital Services

4. Therapeutic Living Supports

    a. Community-Based Specialized Residential

5. Biopsychosocial Rehabilitative Programs

6. Assertive Community Treatment

7. Intensive Case Management/Community Based Case Management

8. Targeted Case Management

    Targeted case management shall be provided in accordance with Hawaii Administrative Rules 17-1738 http://hawaii.gov/dhs/main/har/har_current/AdminRules/document_view. In the event any of the terms of this agreement conflict with or are not required by HAR §17-1738, the HAR shall control.

ATTACHMENT II

DOH—AMHD
With MQD rates and HCPCS Codes

SPA	AMHD Service	HCPCS Code	Unit	MQD Rate	Comments
Crisis Management	Crisis Mobile Outreach (CMO)	H2011	15 minutes	$ 27.50	
	Crisis Support Management (CSM)	H2015	15 minutes	$ 20.25	Must bill as Intensive Case Management/ Community Based Case Management
Crisis Residential	Licensed Crisis Residential Services (LCRS)	H0018	Daily	$211.80	Must be licensed, only treatment covered
Biopsychosocial Rehabilitation	Psychosocial Rehabilitation	H201 7	15 minutes	$ 3.30	Clubhouse not included
Intensive outpatient hospital services	Intensive Outpatient Hospital Services	H0035	Daily	$250.00	
Therapeutic Living Supports	Community Based Specialized Residential	H0019	Daily	$236.14	Must be licensed, only treatment covered
Assertive Community Treatment	Assertive Community Treatment, face-to-face contact	H0039	15 minutes	$ 27.00	75% of Assertive Community Treatment claims must be face-to-face
	Assertive Community Treatment, case assessment	H0039U1	15 minutes	$ 27.00	
	Assertive Community Treatment, treatment planning	H0039U2	15 minutes	$ 27.00	
	Assertive Community Treatment, collateral contact with no consumer contact	H0039U3	15 minutes	$ 27.00	
	Assertive Community Treatment, telephonic treatment planning with **11311,** Kahi Mohala	H0039HT	15 minutes	$ 27.00	
	Assertive Community Treatment, telephonic consultation with consumer	H0039U5	15 minutes	$ 27.00	

DOH—AMHD
With MQD rates and HCPCS Codes

SPA	AMHD Service	HPCPS Code	Unit	MQD Rate	Comments
Intensive Case Management/ Community Based Case Management	Intensive Case Management/Community Based Case Management, face-to-face contact	H2015	15 minutes	$20.25	75% of Intensive Case - Management/Community Based Case Management claims must be face-to-face.
	Intensive Case Management/Community Based Case Management, case assessment	H2015U1	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, treatment planning	H2015U2	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, collateral contact with no consumer contact	H2015U3	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, telephone treatment planning with HSH, Kahi Mohala	H2OI5HT	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, telephone consultation with consumer	H2015U5	15 minutes	$20.25	
	Targeted Case Management	T1017U5	15 minutes	$9.75	
	Targeted Case Management	T1017U6	15 minutes	$9.75	

Exhibit 6 to Attachment E

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

Name _____ ☐ MALE ☐ FEMALE
Last First MI

Home Address _____ Phone No. _____
_____ Case No. _____
Mailing Address _____ Client ID No. _____
_____ Social Security No. _____
Date of Birth _____ Age _____ COUNTY ☐ OAHU ☐ HAWAII ☐ MAUI ☐ KAUAI

Health Plan: ☐ Ohana ☐ UnitedHealthcare ☐ OTHER: _____
Primary Diagnosis _____ DSMIV Code _____
Secondary Diagnosis _____ DSMIV Code _____
Current Medical Conditions (Indicate, if none) _____

Date of Referral: _____ Name of PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	**CURRENTLY AT:** ☐ **Castle** ☐ **Queen's** ☐ **Other:** _____ (list) **Admitted on** _____/_____/_____			
Past Hospitalizations- Facility	Location	Date Admitted	Date Discharged	Diagnosis

MEDICATIONS	Strength	Dosage	Start Date	End Date

OUTPATIENT THERAPISTS	Diagnosis	Start Date	End Date

Section below to be completed by MQD/CSO Evaluation Panel

Date of Evaluation _____ Date of Enrollment/Disenrollment of CCS Services_____

Approved for CCS Referral: ☐ Yes ☐ No ☐ Additional Information Needed
Re-Evaluation Required: ☐ Yes ☐ No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments _____
_____
_____

Signature: _____

Client Name: _____ **Client I.D. No.:** _____

I. MENTAL STATES

A. *GENERAL*

1. Appearance: Within normal limits [ ] Other [ ] _____

2. Dress: Appropriate [ ]Bizarre [ ] Clean [ ] Dirty [ ]

3. Grooming: Neat [ ]Disheveled [ ] Needs improvement [ ]

B. *BEHAVIOR*

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]

2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] __

3. Body Mvemts: None [ ]Involuntary [ ]Akathisia [ ] Other [ ] _____

C. *SPEECH:* Clear [ ] Mumbled[ ] Rapid [ ] Whispers[ ] Monotone[ ]

Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]

Other [ ] _____

D. *MOOD*: Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]

Aggressive [ ] Hostile [ ] Depressed [ ]

Other [ ] _____

E. *AFFECT:* Full range [ ] Flat [ ] Constricted [ ] Inappropriate [ ]

Other [ ] _____

F. *THOUGHT*

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas[ ]

Neologism [ ] Perseveration [ ] Blocking [ ]

2. Content: Delusions [ ] Thought broadcasting [ ] Thought insertion [ ]
Thought withdrawal [ ] Other [ ] _____

G. *PERCEPTION – HALLUCINATIONS:*

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

H. *REALITY ORIENTATION:*

1. Mark all areas which the recipient can name:

Time: Day [ ] Month [ ] Year [ ]

Place: (can describe location) Yes [ ] No [ ]

Person: Self [ ] Family or friend [ ]

2. Memory: Recent intact? Yes[ ] No [ ]Remote intact: Yes [ ] No[ ]

I. *INSIGHT:* Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. *JUDGMENT:* Good [ ] Fair [ ] Poor [ ]

Client Name: _____ Client I.D. No.: _____

II. FUNCTIONAL SCALES: ***(check and <u>specify</u> any problem(s) in the following areas)***

[ ]Medical/Physical _____

_____

[ ] Family/Living _____

_____

[ ] Interpersonal Relations _____

_____

[ ] Role Performance _____

_____

[ ] Socio-Legal _____

_____

[ ] Self-Care/Basic Needs _____

_____

III. **ADDITIONAL COMMENTS:** Please supply any additional information which would be of assistance in reaching a decision with regard to this patient's evaluation.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name)*: _____

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

Medical Director or Attending Physician for in-patients *(Print Name)*: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SHO # 09-001

February 6, 2009

Dear State Health Official:

On February 4, 2009, President Barack Obama signed Public Law 111-3, The Children's Health Insurance Program Reauthorization Act of 2009, and issued a Presidential Memorandum directing the Secretary of Health and Human Services to withdraw the August 17, 2007, and May 07, 2008, letters issued to State Health Officials. Therefore, the Centers for Medicare & Medicaid Services is withdrawing these letters and will no longer apply the policies in those letters when reviewing Children's Health Insurance Program State plan amendments or section 1115 demonstration waivers.

If you have any questions regarding this letter, please contact Ms. Dianne Heffron, Acting Director, Family and Children's Health Programs, who may be reached at (410) 786-3247.

Sincerely,

/s/

Jackie Garner
Acting Director, Center for Medicaid and State Operations

cc:

CMS Regional Administrators

CMS Associate Regional Administrators,
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Directory for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Council

Barbara W. Levine
Chief, Government Relations and Legal Affairs
Association of State and Territorial Health Officials

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Office of the Director
P. O. Box 339
Honolulu, Hawaii 96809-0339

June 10, 2013

Ms. Cindy Mann, Director
Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Children and Adults Health Programs Group
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Dear Director Mann:

On behalf of the State of Hawaii, this letter serves as the State's acceptance of the revised UCC cost protocol for the QUEST section 1115 demonstration (11-W-00001/9).

Thank you for partnering with the State to provide quality healthcare for our residents.

Sincerely,

Patricia McManaman
Director

c: Jennifer Ryan, CMCS
Dr. Gloria Nagle, Associate Regional Administrator, Region IX
Diane Gerits, CMCS
Jessica Schubel, CMCS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

March 7, 2013

Ms. Patricia McManaman
Director
Hawaii Department of Human Services
P.O. Box 339
Honolulu, Hawaii 96809-0339

Dear Ms. McManaman:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your request to amend Hawaii's Medicaid section 1115 demonstration, the QUEST Expanded demonstration (project number 11-W-00001/9). Approval of the amendment to this demonstration is under the authority of section 1115(a) of the Social Security Act and is effective from the date of this letter through December 31, 2013.

This award approves the state's request to expand coverage to former foster children under age 26 with income up to 300 percent of the federal poverty level (FPL) through the demonstration. No asset test will be applied to this population when determining eligibility. In addition to the coverage expansion, CMS is also approving technical changes to the state's behavioral health protocol.

The CMS approval of the QUEST Expanded demonstration amendment is conditioned upon continued compliance with the enclosed set of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the revised STCs and expenditure authorities are enclosed. The waivers for the demonstration are unchanged by this amendment, and remain in force.

Your project officer for this demonstration is Ms. Jessica Schubel. She is available to answer any questions concerning your section 1115 demonstration and this amendment. Ms. Schubel's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3032
Facsimile: (410) 786-5882
E-mail: Jessica.Schubel@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Schubel and to Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103 -6706

If you have questions regarding this approval, please contact Ms. Jennifer Ryan, Acting Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP and Services, at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Jennifer Ryan, CMCS
Gloria Nagle, Associate Regional Administrator, Region IX
Diane Gerrits, CMCS
Jessica Schubel, CMCS

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.

In December 2012, the state requested to amend the demonstration to provide full Medicaid benefits to former foster children under age 26 with income up to 300 percent FPL. The state will not impose an asset limit on this population. The demonstration will enable the state to test the whether coverage under the Quest Expanded demonstration improves health outcomes for this population.

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; and

iii. Former foster children as described in paragraph 19.

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 applicable Medicaid limits for those programs:
   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 do not 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	Title XIX	State Plan Adults and Children

		individual ineligible for continued coverage under section 1931. • In the second 6-month period, family income may not exceed 185 percent FPL.		
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

[1] Reported under Title XXI Allotment Neutrality if allotment is available.

				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** 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 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	Title XIX	Demo Elig Adults

		eligible as of this date.		
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
Former Foster Children	QUEST	Up to 300 percent FPL who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not impose an asset limit on this population.	Title XIX	Demo Elig Adults
Individuals in the 42 CFR section 435.217 group who are receiving home and community-based services (HCBS)	QExA	Net income no more than 100 percent FPL using the institutional income rules	Title XIX	Aged with Medicare **Or** Aged without 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;
        v. The individual has been covered under COBRA and has applied for QUEST benefits within 45 days of losing COBRA coverage; and
        vi. The individual is eligible pursuant to his or her status as a former foster child.

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, Pregnant Women, and Former Foster Children
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.

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 in accordance to the Behavioral Health protocol which addresses 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 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
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 and long term care services to QEx 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 inpatient and outpatient hospital and long term care services to Medicaid fee-for-services (FFS) beneficiaries, reduced by any applicable Medicaid inpatient, outpatient and long term care 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 for critical access hospitals, 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. Any excess waiver payments will be redistributed to other qualifying hospitals.

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. Former Foster Children (Demonstration eligible adults) (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, RACCP, 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)	

Former Foster Children (QUEST)	
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 (Demonstration Years 16, 17, and 18 only)	

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)				
Former Foster Children (QUEST)				
UCC - Governmental				
UCC - Private				
NHWW - (Demonstration Years 14 and 15 only)				
RACCP - (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 (Demonstration Years 16, 17, and 18 only)				

Benchmarks for QUEST ACE

Attachment B
Quarterly Report Format

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.

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.

Attachment B
Quarterly Report Format

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.

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

OVERVIEW

The Med-QUEST Division (MQD) through its QUEST and QUEST Expanded Access (QExA) health plans are responsible for providing behavioral health services to all its members. MQD also provides additional behavioral health services to clients with serious mental illness (SMI) or serious emotional behavioral disorders (SEBD) that are in need of these additional behavioral services. This is depicted in the flow chart attached (Exhibit 1).

All clients have access to first line behavioral health services provided by the QUEST and QExA health plans. These first line services include services such as inpatient hospitalizations, ambulatory mental health services, diagnostic and treatment services, medications, medication management, medically necessary alcohol and chemical dependency services, and methadone management services.

In addition, some clients with serious mental illness (SMI) or serious emotional behavioral disorders (SEBD) may be in need of additional behavioral health services. These additional services are provided by the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD), the DOH Adult Mental Health Division (AMHD), the Community Care Services (CCS- MQD's behavioral health program), and/or the QUEST Health Plans, depending on whether the client is a child under the age of 21 or whether the client is a QUEST or QExA member. These additional services include services such as: for adults- crisis management, intensive care coordination/case management, partial or intensive outpatient hospitalization, psychosocial rehabilitation, therapeutic living supports, crisis and specialized residential treatment; and for children- multidimensional treatment foster care, family therapy, functional family therapy, parent skills training, intensive home and community based intervention, community-based residential programs, and hospital-based residential programs.

See Attachment B for a detailed list of services provided by the QUEST and QExA health plans, AMHD, CCS, and CAMHD.

Regardless of what type of behavioral health service a client receives or where the client receives his/her behavioral health services, the client continues to have access to primary and acute care services from his/her health plan. The client continues to have access to EPSDT services if he/she is under the age of 21. In addition, the client has access to home and community based services/long-term care (HCBS/LTC) services if he/she is a QExA member or a participant receiving services from the Developmental Disabilities Mental Retardation (DD/MR) 1915(c) waiver.

Attachment E
Behavioral Health Services Protocol

The QUEST and QExA health plans are responsible for providing basic, first line behavioral health services to ALL their clients. A list of behavioral health services that the QUEST and QExA health plans provide is detailed in Exhibit 2.

For clients with a diagnosis of serious emotional behavioral disorders (SEBD) or serious mental illness (SMI), who need additional behavioral health services, these are provided by:

- CAMHD if the client is <21 years old
- AMHD or CCS if the client is >/=21 years old and a QExA client*
- QUEST health plan if the client is >/=21 years old and a QUEST client

*Note that QExA clients include all the participants of the Developmental Disabilities and Mental Retardation (DDMR) waiver program.

Clients <21 years old with a diagnosis of SEBD are eligible for additional behavioral health services within CAMHD. The eligibility criteria are:

- The client or youth is age three through twenty (3-20) years; and
- The client falls under one of the qualifying diagnoses (see Exhibit 3); and
- The client demonstrates presence of a qualifying diagnosis for at least six (6) months or is expected to demonstrate the qualifying diagnosis for the next six (6) months; and
- The client's Child and Adolescent Functional Assessment Scale (CAFAS) score is > 80.
- Clients that do not meet the eligibility criteria, but based upon assessment by the CAMHD medical director that additional behavioral health services are medically necessary for the member's health and safety shall be evaluated on a case by case basis for provisional eligibility.

Clients >/=21 years old with a diagnosis of SMI are eligible for additional behavioral health services within AMHD or CCS or the QUEST health plan. The eligibility criteria are:

- The client falls under one of the qualifying diagnoses (see Exhibit 3); and
- The client demonstrates presence of qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The client meets at least one of the criteria below demonstrating instability and/or functional impairment:
  - Global Assessment of Functioning (GAF) < 50; or
  - Clinical records demonstrate that the client is currently unstable under current treatment or plan of care (ex. multiple hospitalizations in the last year and currently unstable, substantial history of crises and currently unstable to include but not limited to consistently noncompliant with medications and follow-up, unengaged with providers, significant and consistent isolation, resource deficit causing instability, significant co-occurring medical illness causing instability, poor coping/independent living/problem solving skills causing instability, at risk for hospitalization); or
  - Client is under Protective Services or requires intervention by housing or law enforcement officials.
- Clients that do not meet the requirements listed above, but based upon an assessment by the AMHD, QUEST health plan medical director, or MQD medical director that additional behavioral health services are medically necessary for the member's health and safety shall be evaluated on a case-by-case basis for provisional eligibility.

A. Qualified Mental Health Professional

The qualified mental health professionals in Hawaii that provide behavioral health services include psychiatrists, licensed psychologists, licensed clinical social workers, licensed mental health counselors, and licensed marriage family therapists.

B. Additional behavioral health services provided to SEBD children by CAMHD

The CAMHD is responsible for providing SEBD services to both QUEST and QExA health plan members age three through twenty (3-20) years. A list of CAMHD SEBD services are listed in Exhibit 2. Section (F) lists and describes the services in greater detail.

These additional behavioral health services include both intensive case management and targeted case management. These services are distinct from the services provided through the health plans. CAMHD bills these services to MQD through a fee-for-service (FFS) process effective October 1, 2008. The MQD informs the health plans, via the 834-transaction file, when an individual is receiving services through the CAMHD program. CAMHD provides services to approximately 900 children in both QUEST and QExA.

Referrals to CAMHD can occur through the school, parent, child, or the health plan. CAMHD considers all referrals through an assessment process. Even if a child qualifies for SEBD services, parents can choose to have their children's behavioral health services provided through the child's health plan. QUEST and QExA health plans are only able to provide the behavioral health services identified in their contract (see Exhibit 2). CAMHD would need to be involved for any specialized behavioral health services.

The QUEST and QExA health plans continue to provide any primary and acute care as well as EPSDT services for any child under the age of 21. For any child in QExA that qualifies for home and community based services, the QExA health plan continues to provide these services also.

See section (G) for more information about interaction between CAMHD and QUEST and QExA health plans.

C. Additional behavioral health services provided to SMI adults by the AMHD

The AMHD is responsible for providing behavioral health services to QExA health plan members who are at least eighteen (18) years old. A list of behavioral health services that AMHD provides is included in Exhibit 2. Section (F) lists and describes the services in greater detail.

These behavioral health services include both intensive case management and targeted case management. These services are distinct from the services provided through the QExA health plans. AMHD bills behavioral health services to the MQD through a FFS process.

AMHD provides services to approximately 2,300 adults in QExA.

Referrals to AMHD occur through either the client (self-referral) or the health plan calling the access line to make a referral for the client. AMHD considers all referrals through an assessment process. See section (G) for more information about interaction between AMHD and QExA health plans.

D. Additional behavioral health services provided to SMI adults by CCS

The MQD behavioral health services program, CCS, is for adults. No children receive services through the CCS program. All Medicaid clients in CCS have a diagnosis of SMI.

The CCS program was created in the mid-1990s due to the lack of behavioral health services (AMHD had a limited service package at that time) for Medicaid clients with a diagnosis of SMI. In the early 2000 timeframe, AMHD expanded their services significantly due to a mandated court decree that was withdrawn in 2006. AMHD modeled most of their services from CCS during their court decree. MQD continues to offer its CCS program despite the expansion of services within AMHD.

MQD awards the CCS program to a contractor through a Request for Proposals (RFP). The contractor of the CCS program until February 28, 2013 is APS Healthcare. As of March 1, 2013, the contractor is ‘Ohana Health Plan. A list of behavioral health services that CCS provides is included in Exhibit 2. All of the services that are accessible to clients in the CCS program are also available to clients in AMHD.

The DHS will pay a capitation rate to the contractor for Medicaid covered services provided through the CCS program.

An MQD physician determines eligibility for CCS. Health plans make referrals for the CCS program. All health plan referrals are considered. If a client is receiving services through AMHD, the client can choose to receive their behavioral health services through AMHD or CCS. In the absence of client choice, MQD will work with AMHD and CCS to determine the best “fit” for the client.

E. Additional behavioral health services for SMI adults by the QUEST health plans

Effective July 1, 2010, the MQD transitioned all behavioral health services provided to QUEST adult clients by AMHD and the CCS program into the QUEST health plans. The QUEST health plans now provide not only first line behavioral health services to all their clients but also additional behavioral health services to their adult SMI clients that used to be provided by AMHD and CCS. The integration of all behavioral health services into the QUEST health plans is an attempt to minimize fragmentation of clinical services and promote better health outcomes and financial efficiencies.

The QUEST health plans provide all their clients with first line behavioral health services. In addition, they also provide their SMI adults with additional behavioral health services. See

Exhibit 2 for a list of behavioral health services provided by the QUEST health plans.

CAMHD continues to provide additional behavioral health services for QUEST children under the age of 21 years old with SEBD who need these additional behavioral health services.

F. Description of additional behavioral health services provided by CAMHD, AMHD, CCS, and QUEST health plans, classified under the Medicaid State Plan approved services in which they are covered

See the Supplement to Attachment 3.1A and 3.1B in the Medicaid State Plan for language describing each of the seven approved State Plan services. MQD has authorized services to be provided by CAMHD, AMHD, CCS, and QUEST health plans based upon approved service definitions in the State Plan.

The additional behavioral health services for clients with SMI and SEBD needing additional behavioral health services are listed and described below, classified under the Medicaid State Plan approved services in which they are covered.

1) State plan approved services- Crisis Management
   a) State Plan- This service provides mobile assessment for individuals in an active state of crisis (24 hours per day, 7 days per week) and can occur in a variety of community settings including the consumer's home. Immediate response is required. Included in Crisis Management services are an assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation. If necessary, this may include referral to licensed psychiatrist, licensed psychologist, or to an inpatient acute care hospital. The presenting crisis situation may necessitate that the services be provided in the consumer's home or natural environment setting. Thus, crisis management services may be provided in the home, school, work environment or other community setting as well as in a health care setting. These services are provided through JCAHO, CARF, or COA accredited agencies. In addition, agencies must have staff that includes one or more qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.
   b) CAMHD services for SEBD clients <21yo
      i) Crisis management, including twenty-four (24) hour crisis telephone stabilization, mobile outreach services, and crisis stabilization services (assessment of risk, mental status, and medical stability that includes provision of immediate crisis resolution and de-escalation)
   c) AMHD and CCS services to SMI adults >/=21yo
      i) Crisis management, including 24 hour access line, mobile crisis response, and crisis stabilization (see description above)
   d) QUEST provides crisis management to its adult clients by contracting with AMHD crisis management services.

2) State plan approved services- Crisis Residential Services
   a) State Plan- Crisis Residential Services are short-term, interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization or inpatient hospital based psychiatric care at levels of care below acute psychiatric inpatient. Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, and daily living skills training. Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting. All crisis residential programs will have less than 16 beds. The services do not include payment for room and board. The staff providing crisis residential services must be qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.
   b) CAMHD services for SEBD clients <21yo:
      i) Therapeutic Foster and Group Homes- These homes provide intensive community-based treatment service provided in a home setting for youth with emotional challenges. Specialized therapeutic foster care incorporates evidence-based psychosocial treatment services. These homes provide a normative, community-based environment through therapeutic parental supervision, guidance, and support for youth capable of demonstrating growth in such a setting. Services include crisis management, individual restorative interventions for the development of interpersonal, community and independent living skills. Individual and family therapy are done once a week. Services are provided by qualified mental health professionals or under the supervision of a qualified mental health professional.
      ii) Multidimensional Treatment Foster Care (MTFC)- MTFC provide intensive family-based services in foster family settings for youth with delinquent/disruptive behaviors and emotional challenges. Services provided include crisis management 24 hours/day, 7 days/week as needed. MTFC Foster Parents provide closely supervised behavioral interventions via an individualized level and point system and contingent positive and negative consequences. MTFC Foster Parents are contacted daily by CAMHD staff that are supervised by either a clinical psychologist or licensed family therapist.
   c) AMHD services for SMI adults >/=21yo:
      i) Crisis residential services- short-term residential interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization. Clients are in a crisis residential setting for a little as one day to no more than ten days. The average length of stay is four days. Behavioral health services are provided on a daily basis by qualified mental health professionals or under the supervision of a qualified mental health professional in order to stabilize the individual during

their acute period of stress in order to allow the client to return to their normal life circumstances.

d) CCS and QUEST health plans do not provide services under this State Plan benefit.

3) State Plan approved service- Biopsychosocial Rehabilitation
   a) State Plan- A therapeutic day rehabilitative social skill building service which allows individuals with serious mental illness to gain the necessary social and communication skills necessary to allow them to remain in or return to naturally occurring community programs. Services include group skill building activities that focus on the development of problem-solving techniques, social skills and medication education and symptom management. All services provided must be part of the individual's plan of care. The therapeutic value of the specific therapeutic recreational activities must be clearly described and justified in the plan of care. At a minimum the plan of care must define the goals/objectives for the individual, educate the individual about his/her mental illness, how to avoid complications and relapse, and provide opportunities for him/her to learn basic living skills and improve interpersonal skills. Services are provided by qualified mental health professionals or staff that are under the supervision of a qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).
   b) CAMHD does not offer services within this State Plan benefit
   c) AMHD, CCS, and QUEST services for SMI adults >/=21yo:
      i) Psychosocial Rehabilitation (PSR)- PSR centers offer therapeutic day rehabilitative social skill building services that allow individuals with SPMI to gain the necessary social and communication skills to allow individuals to remain in and return to naturally occurring community programs. Services include group skill building activities that focus on development of problem solving skills, medication education, and symptom management. Individuals must have a plan of care that at a minimum defines the goals/objectives for the individual, educates them about their mental illness, avoiding complications and relapse, and provides opportunities to learn basic living and interpersonal skills. Services must be provided by a qualified mental health professional or under the supervision of a qualified mental health professional.

4) State Plan approved services- Intensive Family Intervention
   a) State Plan- These are time limited intensive interventions intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for children with serious emotional or behavioral disturbance or adults with serious mental illness. These services: 1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; 2) assess and monitor the service needs of the identified individual so that he/she can be safely maintained in the family; 3) ensure the clinical appropriateness of services provided; and 4) improve the individual's ability to care for self and the family's capacity to care for the individual. This service includes

focused evaluations and assessments, crisis case management, behavior management, counseling, and other therapeutic rehabilitative mental health services toward improving the individual's ability to function in the family. Services are directed towards the identified individual within the family. Services can be provided in-home, school or other natural environment. Services are provided by a multidisciplinary team comprised of qualified mental health professionals. If the services are provided by staff other than that listed above, the staff must be supervised by one of the licensed disciplines noted above and at a minimum be a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

b) CAMHD services for SEBD clients <21yo:
   i) Family Therapy- regularly scheduled face-to-face interventions with a young adult or youth and his/her family, designed to improve young adult or youth/family functioning and treat the young adult or youth's emotional challenges. The family therapist helps the young adult or youth and family increase their use of effective coping strategies, healthy communication, and constructive problem solving skills. The therapist also provides psycho-education about the nature of the young adult or youth's diagnosis.
   ii) Functional Family Tharapy- an evidenced-base family treatment system provided in a home or clinic setting for youth (10-18 years old) experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression). The goals of FFT are:
      (1) Phase I: Engagement of all family members and motivation of the youth and family to develop a shared family focus to the presenting problems;
      (2) Phase II: Behavior change – target and change specific risk behaviors of individuals and families; and
      (3) Phase III: Generalize or extend the application of these behavior changes to other areas of family relationships.
   iii) Parent Skills Training- The teaching of evidenced base behavior management interventions to parents or caregivers in order to develop effective parenting styles. These interventions are designed to promote more competencies in the parent/caregiver's ability to manage the youth's behavior. The focus of training is on the parent and adjusting their responses to the youth.
   iv) Intensive Home and Community-based Intervention, including home intervention and independent living programs- A multidisciplinary team of qualified mental health professionals meet with families and individuals face-to-face to stabilize and preserve the family's capacity to improve the youth's functioning in the current living environment and to prevent the need for placement outside the home. The goal is to 1) resolve the current crisis, evaluate its nature, and intervene in its likelihood to reoccur; 2) ensure the clinical appropriateness of services provided; and 3) improve the individual's ability to care for self and the family's capacity to care for the individual.

v) Multisystemic Therapy- time limited, intensive family and community-based treatment addressing multiple determinants of serious conduct disorder behaviors in juvenile offenders. Services include crisis management, evidence-based interventions, working with families in implementation of behavioral support plans, and parenting skills training to help the family build skills for coping with the youth's behavior. These services are provided by a multidisciplinary team comprised of qualified mental health professionals or under the supervision of a qualified mental health professional.

c) AMHD, CCS, and QUEST health plans do not offer services within this State Plan benefit.

5) State plan approved services- Therapeutic Living Supports and Therapeutic Foster Care Supports

a) State Plan- These are services covered in settings such as group living arrangements or therapeutic foster homes. Group living arrangements usually provide services for 3 to 6 individuals per home but not more than 15. Therapeutic foster homes provide services for a maximum of 15 individuals per home. Although these group living arrangements and therapeutic foster homes may provide 24 hour per day of residential care, only the therapeutic services provided are covered. There is no reimbursement of room and board charges. Covered therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home. The identified individual must be either a child with serious emotional or behavioral disturbance or the adult with a serious mental illness. Services provided in therapeutic group homes and therapeutic foster homes include: supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training (individual, group, family), directed at the amelioration of functional and behavioral deficits and based on the individual's plan of care developed by a team of licensed and qualified mental health professionals. Services are provided in a licensed facility and are provided by a qualified mental health professional or staff under the supervision of a qualified mental health professional with 24-hour on-call coverage by a licensed psychiatrist or psychologist.

b) CAMHD services for SEBD clients <21yo:

i) Therapeutic Foster and Group Homes (see description above)

ii) Multidimensional Treatment Foster Care (see description above)

c) AMHD and QUEST services for SMI clients >/=21yo:

i) Specialized Residential Treatment- Specialized Residential Treatment facility is a facility that provides a therapeutic residential program for care, diagnoses, treatment or rehabilitation services for persons who are socially or emotionally distressed, have a diagnosis of mental illness, substance abuse or developmental disability. These facilites develop rehabilitation plans with their clients to achieve goals that include social, emoitional, mental or physical restoration.

d) CCS does not provide therapeutic living supports but can refer to AMHD

6) State Plan approved services- Intensive Outpatient Hospital Services

a) State Plan- These are outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. Services are provided to an individual who is either a child with serious emotional or behavioral disturbance or an adult with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) are unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The goals of service are clearly identified in an individualized plan of care. The short term and long term goals and continuing care plan are established prior to admission through a comprehensive assessment of the consumer to include a severity-adjusted rating of each clinical issue and strength. Treatment is time-limited, ambulatory and active offering intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Services are available at least 20 hours per week. All services are provided by qualified mental health professionals, or by individuals under the supervision of a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Registered nurses or licensed practical nurses must be available for nursing interventions and administration of medications. Licensed psychiatrists or psychologist must be actively involved in the development, monitoring, and modification of the plan of care. The services must be provided in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for coverage of partial hospitalization/day treatment. These services area not provided to individuals in the inpatient hospital setting and do not include acute inpatient hospital stays.

b) CAMHD services for SEBD clients under 21yo:
   i) Partial Hospitalization- Day programming in the outpatient area or clinic of a licensed certified facility that allows for a more intensive milieu treatment with a focus on medical/psychiatric resources. This service is available to stabilize a youth's symptoms or as a transition step for youth who have been in more restrictive settings.

c) AMHD, CCS, and QUEST services for SMI clients >/= 21yo:
   i) Outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. The goals of the service are clearly articulated in each consumer's individualized plan of care. Treatment is time-limited, ambulatory and active offering intensive, coordinated clinical service provided by a multi-disciplinary team.

7) State Plan approved services- Assertive Community Treatment

a) State Plan- This is an intensive community rehabilitation service for individuals who are either children with serious emotional or behavioral disturbance or adults with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) is unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The ACT rehabilitative treatment services are to restore and rehabilitate the individual to his/her maximum functional level. Treatment interventions include crisis management (crisis assessment, intervention and stabilization); individual restorative interventions for the development of interpersonal, community coping and independent living skills; services to assist the individual develop symptom monitoring and management skills; medication prescription, administration and monitoring medication and self medication; and treatment for substance abuse or other co-occurring disorders. Services include 24 hours a day, 7 days a week coverage, crisis stabilization, treatment, and counseling. Also, individuals included in ACT receive case management to assist them in obtaining needed medical and rehabilitative treatment services within their ACT treatment plan. Services can be provided to individuals in their home, work or other community settings. ACT services are provided by agencies whose staffs include one or more licensed qualified mental health professionals. If the services are provided by staff other than a licensed qualified mental health professional, the staff must be supervised by a licensed qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Case management is an integral part of this service and reimbursement for case management as a separate service is not allowed. If biopsychosocial rehabilitation is part of the individual's plan of care under intensive case management, reimbursement for biopyschosocial rehabilitation as a separate service is not allowed.

b) CAMHD services for SEBD clients <21yo:
   i) Intensive Case Management , including comprehensive case assessment, planning, coordination, and monitoring. Case management is a community-based, behavioral health treatment service that links and coordinates segments of the service-delivery system to ensure comprehensive therapeutic planning and intervention to meet an individual youth's and family's needs for improved community functioning. Case management includes comprehensive case assessment, case planning, connecting, brokering, and ongoing monitoring of treatment services, while advocating for youth and families to address their needs and overcome barriers to receiving quality services. These services are provided to increase community tenure, improve functioning, minimize psychiatric symptoms and develop an enhanced quality of life for youth and their families. Outpatient Assessment, therapy, and medication management, including psychiatric evaluation, mental health assessments (comprehensive, focused, summary, and psychosexual), therapy (individual, group, and family), treatment service planning, school consultation (i.e., consultation of a qualified mental

health professional with regular and special education teachers, school administrators and other school personnel regarding the behavioral management of a young adult or youth within the school setting in the Individualized Education Plan team meeting), and case consultation by a qualified mental health professional.

ii) Community-based Residential Programs are provided for sexual offenders in a locked care facility, to sexual offending deviants in a non-locked unit, and to other individuals with an assortment of problems in a general residential environment. These programs provide twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression or deviance that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose needs can best be met in a structured program of small group living that includes educational, recreational, and occupational services. These programs provide twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression, or deviance, which prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services. Services include psychotherapy, medication management, and substance abuse treatment as needed. Services are provided by qualified mental health professionals.

c) AMHD, CCS, and QUEST health plans for SMI adults >/=21yo:

i) Intensive Case Management: see description above

8) State Plan approved service- Hospital-based Services

a) State Plan- Provides secure locked residential treatment consisting of highly structured daily programming, close supervision, educational services, and integrated service planning designed for severely emotionally/behaviorally disturbed to function in a less restrictive setting. Services include multi-disciplinary assessment of the child, skilled milieu of services by trained staff who are supervised by a licensed professional on a 24 hour per day basis, individual psychotherapy and/or counseling, individualized adjunctive therapies, and substance abuse education and counseling, as appropriate and as part of an interdisciplinary treatment plan. Services are required to be staff secure at all times. Hospital-based residential services are provided in a licensed inpatient facility serving individuals who are under the age of 21 and are provided by a qualified mental health professional. If the services are provided by staff other than that listed above, the staff must be supervised by a qualified mental health professional.

b) CAMHD services for SEBD clients <21yo:

i) Hospital-based Residential Services- Intensive inpatient treatment services to youth with severe emotional challenges who require short-term hospitalization for the purposes of receiving intensive diagnostic, assessment, and medication stabilization services. The highly structured program provides educational services, family therapy, and integrated services planning through a multi-disciplinary assessment of the youth, skilled milieu of services by trained staff

who are supervised by licensed professionals on a 24 hour per day basis. Services are provided in a locked unit of a licensed inpatient facility.

c) AMHD, CCS, and QUEST health plans do not provide hospital-based residential services for SMI adults >/= 21yo. Acute psychiatric hospitalization is provided for all clients by their QUEST or QExA health plan.

G. A memorandum of agreement (MOA) reflects the current interagency agreement for behavioral health services provided by the DOH to demonstration eligible clients.

Attached are MOAs between the MQD and CAMHD (Exhibit 4) and between the MQD and AMHD (Exhibit 5). These are the most current MOAs for both CAMHD and AMHD. Both of these MOAs are in the process of being revised. The MQD will provide revised MOAs to CMS when executed.

H. The process and protocol used for referral between the health plans and the DOH, as well as the DOH and the health plans, is as follows:

CAMHD

Health plans to DOH

1. The health plan can make a referral to CAMHD through use the SEBD Referral Form developed by CAMHD (Exhibit 6).
2. The health plan will continue to provide behavioral health services even after CAMHD admits the individual their program. In these cases, the health plan will not provide services offered by CAMHD; CAMHD will not provide services offered by the health plan.
3. The MQD will notify the health plan of the individual's admission into the CAMHD program via the 834-transaction file.

DOH to health plans

1. The DOH has a contact within the health plan for coordination of care.
2. The health plan will be notified that the individual is no longer receiving services via CAMHD via the 834-transaction file.

AMHD

Health plans to DOH

1. The health plan can make a referral to AMHD by calling the AMHD access line. The access line is available twenty-four hours a day. The referral line will gather information necessary to perform an assessment on the health plan's member.
2. The health plan will continue to provide behavioral health services even after AMHD admits the individual their program. In these cases, the health plan will not provide services offered by AMHD; AMHD will not provide services offered by the health plan.

DOH to health plans

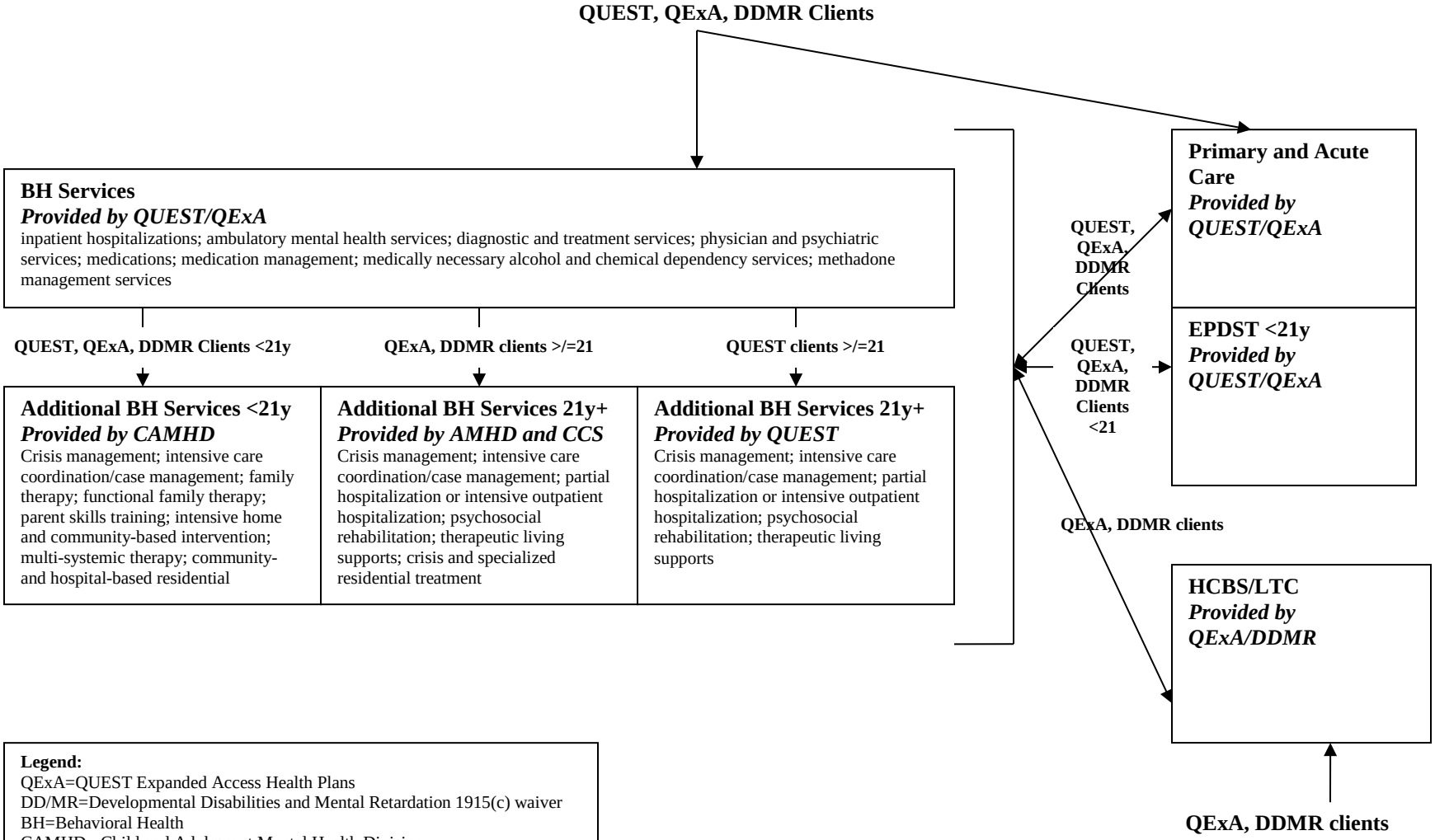
1. The DOH has a contact within the health plan for coordination of care.

CCS (‘Ohana Health Plan)

1. The health plans can make a referral to CCS through the MQD using the DHS 1157 form. A MQD physician will review the form and make a determination if the Medicaid client will benefit from services in the CCS program. Once MQD has accepted the client into CCS, MQD will inform the health plan of this acceptance.
2. The MQD will notify the health plan of the individual’s admission into the CCS program via the 834-transaction file.
3. MQD notifies ‘Ohana Health Plan of new client admissions or changes via an 834-transaction file.
4. Each health plan has behavioral health staff that communicates with ‘Ohana Health Plan directly regarding any concerns with their clients.

Attachment E
Behavioral Health Services Protocol

Exhibit 1 to Attachment E: Behavioral Flow Chart



Legend:
QExA=QUEST Expanded Access Health Plans
DD/MR=Developmental Disabilities and Mental Retardation 1915(c) waiver
BH=Behavioral Health
CAMHD= Child and Adolescent Mental Health Division
AMHD=Adult Mental Health Division
CCS=Community Care Services Behavioral Health Carve-out
EPSDT=Early Periodic Screening Diagnosis and Treatment program
HCBS=Home and Community-Based Services
LTC=Long Term Care services

Exhibit 2 to Attachment E

Behavioral Health Services in the QUEST and QUEST Expanded Access (QExA) Programs

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
Payment methodology	**Payment to health plans** Capitation	**Payment to health plans** Capitation	**Payment to DOH-AMHD** Billed FFS to MQD	**Payment to 'Ohana Health Plan** Capitation	**Payment to DOH-CAMHD** Billed FFS to MQD
Behavioral Health Services					
Acute psychiatric hospitalization	Twenty-four (24) hour care for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services as needed o Other medically necessary services o Pharmaceuticals o Occupational speech/language therapy, as needed	Twenty-four (24) hour care for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services as needed o Other medically necessary services o Pharmaceuticals o Occupational speech/language therapy, as needed	Provided by health plan	Twenty-four hour acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services, as needed o Other medically necessary services o Pharmaceuticals o Occupational speech/language therapy, as needed	Provided by health plan

Attachment E
Behavioral Health Services Protocol

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
Ambulatory Services-non- crisis services	Ambulatory services-non-crisis services	Ambulatory services-non-crisis services	Provided by health plan	Ambulatory services, non-crisis services	Outpatient behavioral health services
Crisis Management	Provided by AMHD to QUEST members	Not provided	Crisis Management a. 24-hour crisis telephone consultation b. Mobile outreach services c. Crisis intervention/ stabilization services	Crisis Management a. 24/7 Crisis hotline (through 800#) b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization	Crisis Management a. 24/7 Crisis hotline (through 800#) b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization d. No pre-authorization required for payment.
Intensive Outpatient Hospital Services	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and aftercare o Other medically	Not provided	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and aftercare o Other medically	Intensive Outpatient/Partial hospitalization including: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy	Intensive Outpatient/Partial hospitalization including: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
	necessary services		necessary services	and aftercare o Other medically necessary services	and aftercare o Other medically necessary services
Methadone treatment	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan
Prescription drugs	Prescribed drugs including medication management and patient counseling	Prescribed drugs including medication management and patient counseling	Provided by health plan	Prescribed drugs including medication management and patient counseling	Provided by health plan
Diagnostic/ laboratory services	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol problems o Other medically necessary diagnostic services	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol problems o Other medically necessary diagnostic services	Provided by health plan	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol o Other medically necessary diagnostic services	Provided by health plan
Psychiatric evaluation	Psychiatric or psychological evaluation	Psychiatric or psychological evaluation	Psychiatric or psychological evaluation	Psychiatric, psychological or neuropsychological	Psychiatric, psychological or neuropsychological

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
				evaluation	evaluation
Physician Services	Physician services	Physician services	Physician services	Physician services	Provided by health plan
Supported Employment	Not provided	Not provided	Supported Employment (service provided with State funds and not billed to Medicaid)	Occupational, pre-vocational services	None
Other medically necessary therapeutic services	Other medically necessary therapeutic services	Other medically necessary therapeutic services	Provided by health plan	Other medically necessary therapeutic services	Other medically necessary therapeutic services
Transportation	Transportation o Air o Ground for medically necessary services	Transportation o Air o Ground for medically necessary services	Provided by health plan	Transportation o Air o Ground for medically necessary services	Provided by health plan
ECT	ECT o Medically necessary, may do more than one/day o Inclusive of anesthesia	ECT o Medically necessary, may do more than one/day o Inclusive of anesthesia	Provided by health plan	ECT o Medically necessary, may do more than one/day o Inclusive of anesthesia	Provided by health plan
Substance Abuse	Substance Abuse o Use of substance abuse counselors o Encouraged to use treatment facilities that comply with	Substance Abuse o Use of substance abuse counselors o Encouraged to use treatment facilities that comply with	Provided by health plan	Substance Abuse - Residential o Medically necessary based on American Society of Addiction	Provided by health plan

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
	Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) o Coordinate with ADAD on substance abuse treatment • Providing assistance to members who wish to obtain a slot, either by helping them contact ADAD or its contractor or referring the member to a substance abuse residential treatment provider to arrange for the utilization of an ADAD slot; • Providing	Department of Health (DOH), Alcohol and Drug Abuse Division (ADAD) o Coordinate with ADAD on substance abuse treatment • Providing assistance to members who wish to obtain a slot, either by helping them contact ADAD or its contractor or referring the member to a substance abuse residential treatment provider to arrange for the utilization of an ADAD slot; • Providing		Medicine (ASAM) o In network benefits only o Detox: o Oahu: Detox center o NI: General hospital o Req. Psych. Care to psych facility Substance Abuse – Out-patient o Screening o Treatment and treatment planning o Therapy/ counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary	

Agency	QUEST Health Plans	QExA Health Plans	AMHD	‘Ohana Health Plan (CCS Program)	CAMHD
	appropriate medically necessary substance abuse treatment services while the member is awaiting an ADAD slot; • Covering all medical costs for the member while the member is in an ADAD slot; • Coordinating with the ADAD provider following the member’s discharge from the residential treatment program; and • Placing the member into other	appropriate medically necessary substance abuse treatment services while the member is awaiting an ADAD slot; • Covering all medical costs for the member while the member is in an ADAD slot; • Coordinating with the ADAD provider following the member’s discharge from the residential treatment program; and • Placing the member into other			

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
	appropriate substance abuse treatment programs following discharge from the residential treatment program. • Note: Med-QUEST Division does not manage wait-listed ADAD slots. Health plans shall assure that their members receive medically necessary substance abuse services while waiting for an ADAD slot to open. o Use of special	appropriate substance abuse treatment programs following discharge from the residential treatment program. • Note: Med-QUEST Division does not manage wait-listed ADAD slots. Health plans shall assure that their members receive medically necessary substance abuse services while waiting for an ADAD slot to open. o Use of special			

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
	treatment facilities for adolescents substance abuse therapy/ treatment o Note: Special Treatment Facilities are licensed by the DOH to provide substance abuse treatment. These facilities are a short-term option for substance abuse. o Screening for drugs and alcohol	treatment facilities for adolescents substance abuse therapy/ treatment o Note: Special Treatment Facilities are licensed by the DOH to provide substance abuse treatment. These facilities are a short-term option for substance abuse. o Screening for drugs and alcohol			
Member Education	Member Education o Specific areas not related to mental health o Disease specific education	Member Education o Specific areas not related to mental health o Disease specific education	Provided by health plan	Member Education Life Skills groups conducted daily such as Skills Building, ability to complete necessary paperwork, creation of videos as a creative outlet, Medication Education, Arts & Culture, Recreation, etc.	Transitional Age Group: Life Skills groups conducted daily such as Skills Building, ability to complete necessary paperwork, creation of videos as a creative outlet, Medication Education, Arts & Culture, Recreation, etc.

Attachment E
Behavioral Health Services Protocol

Agency	QUEST Health Plans	QExA Health Plans	AMHD	'Ohana Health Plan (CCS Program)	CAMHD
Crisis Residential Services	Provided by AMHD to QUEST members	Not provided	Crisis Residential Services	Not provided	Crisis Residential Services
Therapeutic Living Supports	Therapeutic Living Supports provided in Specialized Residential Treatment facilities	Not provided	Therapeutic Living Supports provided in Specialized Residential Treatment facilities	Not provided, but can refer make a request to AMHD for services	Therapeutic living and therapeutic foster care supports
Biopsychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Not provided	Psychosocial Rehabilitative Programs	Biopsychosocial Rehabilitative Programs	Not provided
Case Management	Intensive case management/ community based case management	Service Coordination for primay, acute, behavioral health, and LTC services for QExA members	o Intensive case management/ community based case management o Targeted Case Management	Care Coordination/Case Management o Case assessment o Case planning (service planning, care planning) o Outreach o Ongoing monitoring and service coordination	o Intensive case management/ community based case management o Targeted Case Management
Hospital based residential treatment	Not provided	Not provided	Not provided	Not provided	Hospital based residential treatment
Intensive family intervention	Not provided	Not provided	Not provided	Not provided	Intensive family intervention

Exhibit 3 to Attachment E

Eligibility Diagnoses for CAMHD Support for Emotional and Behavioral Development (SEBD) Program

Eligible Diagnoses:

- Demonstrates the presence of a primary DSM (most current edition) Axis I diagnosis for at least six (6) months or is expected to demonstrate the diagnosis for the next six (6) months. See excluded diagnoses in the next section.

Excluded Diagnoses

If the diagnoses listed below are the **ONLY** DSM (most current edition) diagnoses, the child/youth is ineligible for SEBD services. However, these diagnoses may and often do co-exist with other DSM diagnoses, which make the child/youth eligible for SEBD services.

- *Mental Retardation (317, 318.0, 318.1, 318.2, 319)
- *Pervasive Developmental Disorders (299.0, 299.80, 299.10)
- Learning Disorders (315.0, 315.1, 315.2, 315.9)
- Motor Skills Disorders (315.3)
- Communication Disorders (315.31, 315.32, 315.39, 307.0, 307.9)
- Substance Abuse Disorders
- Mental Disorders Due to a General Medical Condition
- Delirium, Dementia, Amnestic, and other Cognitive Disorders
- Factitious Disorders
- Feeding Disorders of Infancy or Childhood
- Elimination Disorders
- Sexual Dysfunctions
- Sleep Disorders

*Co-occurring diagnoses of Mental Retardation and Pervasive Developmental Disorders require close collaboration and coordination with State of Hawaii Department of Health (DOH) and State of Hawaii Department of Education (DOE) services. The health plan, with CAMHD, is responsible for coordinating these services. These diagnoses may be subject to a forty-five (45) day limit on hospital-based residential services, after which utilization review and coordination of services with DOE need to occur.

Eligibility Diagnoses for Additional Behavioral Health Services for Adults

Eligible Diagnoses:

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)
- Delusional Disorders (297.1)
- Mood Disorders- Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders- Depressive Disorders (296.24, 296.33, 296.34)

Exhibit 4 to Attachment E

`LINDA LINGLE

GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

September 28, 2004

MEMORANDUM OF AGREEMENT

BETWEEN
DEPARTMENT OF HUMAN SERVICES
AND
DEPARTMENT OF HEALTH

This MEMORANDUM OF AGREEMENT (MOA) between the Med-QUEST Division (MQD) of the Department of Human Services (DHS) and the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health (DOH) is to provide behavioral services for QUEST and Medicaid Fee-For-Service (FFS) children and adolescents age 3 through age 20 who are eligible and determined to be Seriously Emotionally and Behaviorally Disturbed (SEBD) and in need of intensive mental health services. This MOA covers the period from July 1, 2004 to June 30, 2005. The above-mentioned State agencies agree to the following provisions specified herein.

I. THE CAMHD OF THE DEPARTMENT OF HEALTH SHALL:

A. Provide the following services to youth covered under this MOA as specified in Attachment I.

B. Determine level and medical appropriateness of behavioral health managed care services as documented in the client's individualized behavioral health treatment plan in accordance with State quality assurance and utilization review standards.

C. Have an internal Grievance and Appeals process in place. All grievances and appeals should be resolved within thirty (30) days from the receipt of the written or verbal expression of dissatisfaction, unless a fourteen (14) day Extension or Expedited appeal is initiated. The policies and procedures for resolution of grievances and appeals shall be included as part of the CAMHD Quality Assurance Program and be in compliance with the grievance and appeal requirements of the MQD. CAMHD shall provide MQD with a quarterly grievance and appeals report in a format determined by the MQD.

D. Comply with any DHS Administrative Appeals Office (AAO) decision relating to the provision of behavioral health services covered by the MOA. A recipient shall utilize the CAMHD Grievance System before appealing to the DHS AAO. CAMHD shall notify the recipient/family of the right to appeal to DHS. Appeals shall be limited to Medicaid covered services. Any appeal to DHS shall not waive the recipient's right to judicial appeal.

E. Provide a continuation of benefits during an appeal or State Fair Hearing.

F. Implement in full the Quality Assurance Program (QAP) approved by the MQD. CAMHD shall implement changes to operations, policies and procedures, and provider contracts to remain in compliance with the approved QAP.

G. Maintain staffing level and proficiency and an adequate provider network to provide the quality and extent of services and activities required under the State and Federal regulations applicable to a Prepaid Inpatient Health Plan. CAMHD clinical staff and providers shall be qualified and trained in the principles and techniques of mental health treatment and services. Providers shall meet State licensing requirements for professions where licensing is required to provide mental health services.

H. Establish monitoring schedules and criteria, and monitor CAMHD providers of services and staff on a regular basis to ensure compliance with the QUEST program.

I. Maintain documentation that CAMHD providers are maintaining records of services provided by providers' staff and contractors in compliance with the QAP requirements. Maintain confidentiality of such records as required by State and Federal laws.

J. Comply with requests from the State and Federal Government and/or their representatives to review all medical and financial records of CAMHD, and its

subcontractors and providers, and CAMHD staff to ensure compliance with the terms and condition of this Agreement and the State and Federal rules and regulations.

K. Process electronic transmission of daily and monthly rosters for eligibility for QUEST and Medicaid FFS youth covered under this MOA and support the electronic transmission of daily and monthly rosters for eligibility.

L. Submit a monthly invoice to support billing for QUEST and Medicaid FFS youth covered under this Agreement.

M. Provide a monthly (if network changes take place) or a quarterly submission of CAMHD's provider network in accordance with instructions and filing requirements established by the MQD.

N. Provide a monthly submission of encounter data in accordance with instructions and filing requirements established by the MQD.

O. Provide a signed Letter of Certification at the time of the encounter and provider data submission. The letter of certification shall be signed by the Chief Executive Officer, Chief Financial Officer or an individual who has been delegated authority to sign for and who reports directly to one of the above organizational officers. The letter must certify that the data is accurate, complete and truthful.

P. Pay for behavioral health services for eligible children and adolescents that CAMHD determines to be necessary but are not covered under this agreement.

Q. Inform MQD of recipients who are accepted into or disenrolled from CAMHD services within thirty (30) days. CAMHD shall be responsible to verify the enrollment and disenrollment date of recipients from the daily and/or daily and monthly rosters provided by MQD.

R. Minimize the disruption of behavioral health services during the transition of care for recipients covered under this Agreement when transitioning from the QUEST plans to CAMHD. Assure the continued provision of comparable services and preserve existing therapeutic relationships between the child and provider as medically necessary for the child/adolescent.

S. CAMHD shall inform the QUEST plan when a transition or termination of a recipient's services is to occur due to a change in their status and pay for all behavioral health services provided by a QUEST plan prior to the transition or termination. CAMHD will be responsible for notifying MQD of referrals between CAMHD and the QUEST plan.

T. If a recipient is enrolled in the CAMHD plan under this MOA and is in need of urgent care and/or crisis intervention and a CAMHD provider is not available to provide the services, CAMHD agrees that the QUEST plan shall provide the service if possible and if it is determined to be medically necessary by the QUEST plan. The CAMHD shall be

responsible to reimburse the QUEST plan through MQD for the service(s) provided plus a 10 % administrative fee.

U. Provide written information to recipients and their families informing them of their benefits, rights, and responsibilities within the acceptable timeframe established by the MQD.

V. Meet the terms of the medical Request for Proposal (RFP) rules and requirements as they apply to CAMHD as a Prepaid Inpatient Health Plan.

W. Comply with all Federal and State rules and regulations to include the Balanced Budget Act of 2002, implemented August 13, 2004.

II. THE MQD OF THE DEPARTMENT OF HUMAN SERVICES SHALL:

A. Pay the CAMHD a monthly reimbursement rate of $ 542.87 per member per month for each youth/adolescent covered under this MOA that are not classified under Section 504 as needing mental health services. Payment shall be made no later than thirty (30) calendar days subsequent to receiving the submission of encounter data and shall be reconciled annually to actual costs based on utilization reported as encounters and priced at Medicaid rates. Any adjustment for the year will be applied retroactively.

- The monthly reimbursement rate payment shall be paid on a prorated basis for the number of days during the month in which the child was enrolled with CAMHD.

- The date of disenrollment from CAMHD shall be effective at the end of the month in which DHS is notified through use of the Enrollment/Disenrollment

B. Pay for services on a Fee-For-Service basis for behavioral health services provided by CAMHD to Medicaid eligibles that are classified as blind or disabled and are not enrolled in a QUEST health plan. FFS claims for behavioral health services covered under the Hawaii State Medicaid program shall be submitted to the MQD's fiscal agent. Claims billing and processing shall be conducted in accordance with established billing and payment procedures.

C. Review the operations and policies of the CAMHD on a continuing basis to determine if Hawaii QUEST quality assurance (QA) standards for a written QAP are

met. The MQD reserves the right to delay re-implementation of this MOA until all quality assurance standards are met.

D. Monitor CAMHD to ensure that it has implemented its written QAP. MQD reserves the right to withhold and/or deny payments if CAMHD cannot implement its QAP.

E. Ensure that clients meet eligibility and enrollment criteria for Medicaid.

F. Ensure that enrollments and disenrollments of youth covered under this MOA are done accurately and in an efficient and timely manner and in accordance with agreed upon procedures.

G. Provide the directives to CAMHD during the transition period of youth covered under this MOA into CAMHD to assure the continued provision of comparable services and to preserve existing therapeutic relationships if it is medically necessary for the child/adolescent.

H. Inform other QUEST plans regarding their responsibility to transition indicated youth to the CAMHD behavioral health plan.

Reimbursement for Services:

a) The CAMHD shall submit a monthly invoice and be reimbursed by DHS for behavioral health services provided to recipients who are covered by this MOA at the Monthly Reimbursement rate of $ 542.87 per member per month subject to annual reconciliation to actual costs. DHS shall pay CAMHD based on the monthly eligibility roster. The above rate includes Federal and State funding.

b) The monthly reimbursement rate is calculated based on the estimated per member per month based on historical encounters and enrollments, and will be reconciled to actual costs incurred by CAMHD on an annual basis. Within ninety (90) days of the end of the fiscal year, or by September 30th of each year, CAMHD shall supply MQD with encounters, in the format specified in the Health Plan Manual, for all services provided to children covered under this agreement during the fiscal year for purposes of reconciliation. The costs indicated by the encounter data shall be the sole source of reporting costs incurred by CAMHD to the MQD.

MQD shall then reconcile monthly payments against the federally funded portion of the actual costs incurred. If the total payments exceed the federally funded portion of actual costs, CAMHD shall refund the difference to MQD. If the total payments are less than the federally funded portion of actual costs, MQD shall pay the difference to CAMHD. At the end of each reconciliation, the reimbursement rate will be re-determined for the next Fiscal Year based on the previous years federally funded actual costs for similar services.

c) Federal funds are not available for children classified as needing mental health treatment services under Section 504; therefore CAMHD shall not receive reimbursement from DHS for these children. CAMHD will be responsible for determining whether individuals who require 504 accommodations include mental health services.

d) The DHS shall pay the DOH for the Federal share at the Hawaii Federal Medical Assistance Percentage (FMAP) in place for the month for which reimbursement is made. The DOH is responsible for the State's share of the expenditures.

e) The total amount of this AGREEMENT shall not exceed $7.5 million in Federal funds per State fiscal year.

f) The CAMHD shall reimburse MQD any amount disallowed by CMS for services provided under this MOA.

g) For services covered by this MOA, MQD agrees to coordinate reimbursement from CAMHD for intensive behavioral health services provided by QUEST plans plus a 10% administrative fee for services provided to CAMHD recipients covered under this MOA during their assessment and transition. The reimbursement shall be a net against the capitation payment.

h) For services not covered by this MOA, if CAMHD provides and pays for services for which the QUEST medical plans are financially responsible, MQD agrees to coordinate reimbursement from the QUEST medical plans plus a 10% administrative fee to CAMHD for services provided to QUEST recipients.

i) The MOA period shall be for a period of one year. For purposes of continuity of care the DHS shall have the option to renew and/or extend the contract with CAMHD for the next fiscal year. Any renewal or extension of the contract will be subject to available funding.

This Agreement is for the sole benefit of the parties hereto, and is not for the benefit of any third party beneficiaries, including any members of the Hawaii QUEST Program. The MEMORANDUM OF AGREEMENT may also be terminated by either party for any reason with thirty (30) calendar days written notice to the other party. Amendments, as mutually agreed upon, may be made, as appropriate, in writing.

DEPARTMENT OF HUMAN SERVICES	DEPARTMENT OF HEALTH
_____/s/_____	_____/s/_____
Lillian B. Koller, Esq.	Chiyome Fukino, M.D.
Director	Director
Date: _____	Date: _____

FY04-FY05

Scope of Services

To be included but not limited to:

1. CRISIS MANAGEMENT

    a. 24-hour crisis telephone consultation

    b. Mobile outreach/stabilization services

    c. Crisis intervention/stabilization services

2. OUTPATIENT BEHAVIORAL HEALTH SERVICES

    a. Psychosexual assessments/evaluations

3. INTENSIVE FAMILY INTERVENTION SERVICES

    a. Intensive Family Intervention

    b. Multi-systemic Therapy (MST)

4. CRISIS RESIDENTIAL SERVICES

5. INTENSIVE OUTPATIENT HOSPITAL SERVICES

6. THERAPEUTIC LIVING SUPPORTS AND THERAPEUTIC FOSTER CARE SUPPORTS

    a. Foster Homes with Therapeutic Services

    b. Mental Health Respite Homes

    c. Community-Based Residential Programs

    d. Therapeutic Group Homes

7. RESIDENTIAL TREATMENT IN A HOSPITAL SETTING

Exhibit 5 to Attachment E

LINDA LINGLE

GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

November 5, 2010

MEMORANDUM OF AGREEMENT

BETWEEN

DEPARTMENT OF HUMAN SERVICES AND DEPARTMENT OF HEALTH

This MEMORANDUM OF AGREEMENT (MOA) between the Med-QUEST Division (MQD) of the Department of Human Services (DHS) and the Adult Mental Health Division (AMHD) of the Department of Health (DOH) is to provide mental health services for all Medicaid recipients over 18 years old with serious mental illness. This MOA covers the period from **July 1, 2009 through June 30, 2012**. At the end of the MOA, MQD shall have the option to renew the MOA for another defined term. The above-mentioned state agencies agree to the following provisions specified herein.

I. THE AMHD OF THE DEPARTMENT OF HEALTH SHALL:

A. Implement processes for certifying Provider Agencies or State Operated Facilities to determine eligibility for participation in the Community Mental Health Program. Any revisions to the current process shall be approved by MQD. Specifically, the AMHD agrees to:

1. Determine Provider Agencies' or State Operated Facilities' eligibility for participation in the Community Mental Health Program subject to Hawaii Administrative Rules (HAR) chapter 11-172 .

2. Gather and review all applications from Provider Agencies or State Operated

Facilities seeking eligibility for participation in the Community Mental Health Program. AMHD will provide MQD information on Provider Agencies or State Operated Facilities who have been approved to participate in the Community Mental Health Program. AMHD will be responsible for communicating decisions regarding eligibility to the Provider Agencies or State Operated Facilities submitting an application.

3. Notify MQD immediately regarding changes in the Provider Agencies' or State Operated Facilities' eligibility.

4. Recertify Provider Agencies or State Operated Facilities every three years. Annually, AMHD will perform on-site reviews of each eligible Provider Agency or State Operated Facility to ensure they comply with programmatic, operational and fiscal requirements established in HAR chapters 11-172 and 17-1736. AMHD will establish monitoring schedules and criteria, and provide information on these reviews to MQD on a annual basis.

5. AMHD may submit claims to the MQD for qualified mental health providers (QMHP) to include psychiatrists, licensed psychologists, licensed clinical social workers, licensed mental health counselors, and licensed marriage family therapists as long as the QMHP is a Medicaid provider.

B. Implement a utilization management process to evaluate the appropriateness of services, lengths of stay and quality of services. AMHD will utilize established utilization management policies and procedures for conducting these reviews. All utilization management decisions will be provided to Provider Agencies or State Operated Facilities in accordance with the AMHD utilization management policies. Appeals by Provider Agencies or State Operated Facilities regarding these decisions will be reviewed in accordance with AMHD due process procedures set forth in AMHD Policy 60.908.

C. Coordinate within the Department of Health, in general, to develop methodology and receive approval from the Department of Health and Human Services, Division of Cost Allocation for claiming the federal reimbursement for administrative services.

D. Receive and pay all claims for MQD covered mental health services from Provider Agencies or State Operated Facilities eligible for participation in the Community Mental Health Program based on the fee schedule in Attachment II. Covered mental health services are provided in Attachment I.

E. Submit a list of all Medicaid clients receiving services through the AMHD to the MQD on a monthly basis. The format shall be 834 or similar format mutually agreed upon by MQD and AMHD. MQD shall use this information to assure that claims are processed in accordance with established Medicaid standards.

F. Provide a paid, adjusted, and voided claims file to the MQD or its fiscal agent on a bi-monthly basis or as otherwise agreed to by the parties, in accordance with instructions and filing requirements established by MQD. The format shall be *837/835* or similar format mutually agreed upon by MQD and AMHD. As required by 42 CFR §433.51 (a), (b), and (c), the AMHD will certify that the public funds expended as the State's share represent expenditures eligible for Federal Financial Participation (FFP) for each filing. This certification also requires the claims data supporting the payment and proof of the AMHD payments made to the providers. Targeted Case Management services provided by the AMHD Community Mental Health Centers (CMHC) will be submitted to the MQD on a regular basis using a valid HIPAA format.

G. Maintain a current provider manual for the Community Mental Health Program, as approved by MQD. AMHD will distribute the manual to eligible Provider Agencies and State Operated Facilities.

H. Ensure the provision of services to consumers between the age of eighteen (18) and twenty-one (21) are in accordance with federal Early, Periodic, Screening, Detection, and Treatment (EPSDT) requirements.

I. Provide sufficient professional staff to coordinate, supervise and implement their responsibilities under this MOA.

J. Agree to pay the state share for Community Mental Health Program services, which are determined to be eligible for Federal Financial Participation and furnished to Medicaid recipients.

K. Agree to return any federal share that is disallowed by the federal government, or determined to be inappropriate for reimbursement by the MQD. Cooperate with the activities of the MQD Fraud Unit and assist in recovering any overpayments or inappropriate payments from certified AMHD providers and State Operated Facilities. AMHD shall monitor AMHD providers for fraud and report suspected fraudulent activity in writing to MQD and the Department of the Attorney General, Medicaid Investigations Division within thirty (30) days of discovery.

II. <u>THE MQD OF THE DEPARTMENT OF HUMAN SERVICES SHALL</u>:

A. Pay the AMHD on a monthly basis the federal reimbursement for eligible paid claims based on the paid claims file and the Targeted Case Management file submitted by AMHD. Reimbursement shall be allowed on clean claims determined payable after review by the edits in the MQD claims processing system. Clean claims reimbursement shall be paid within thirty (30) days of submittal by AMHD. Claims denied by MQD's claims processing system will be returned to AMHD for resolution.

B. Establish and/or terminate Provider Agencies or State Operated Facilities within

thirty (30) days of receipt of information from AMHD.

C. Provide eligibility information to AMHD on a regular basis, but no less than monthly, using a batch process agreed upon by MQD and AMHD.

D. Pay AMHD the federal reimbursement based upon the methodology approved by the Department of Health and Human Services, Division of Cost Allocation for the Medicaid Administration activities performed by AMHD staff, including skilled medical professional staff, to coordinate, supervise, and implement its responsibilities under this MOA.

E. Review, during the term of this MOA, the operations and policies of AMHD as necessary to determine if the terms of this MOA are met.

F. Conduct desk reviews and audits of Provider Agencies' and State Operated Facilities' claims and inform AMHD of the results of such reviews and audits within thirty (30) days of their completion.

Either party for any reason may terminate this MEMORANDUM OF AGREEMENT upon ninety (90) calendar day's written notice to the other party. Amendments, as mutually agreed upon, may be made, as appropriate, in writing.

DEPARTMENT OF HUMAN SERVICES	DEPARTMENT OF HEALTH
/s/	_____/s/_____
Lillian B. Koller, Esq.	Chioyme Leinaala Fukino, M.D.
Director of Human Services	Director of Health
_____	_____
Date	Date

ATTACHMENT I

1. Crisis Management

    a. 24-hour crisis telephone consultation
    b. Mobile outreach services
    c. Crisis intervention/stabilization services

2. Crisis Residential Services

3. Intensive Outpatient Hospital Services

4. Therapeutic Living Supports

    a. Community-Based Specialized Residential

5. Biopsychosocial Rehabilitative Programs

6. Assertive Community Treatment

7. Intensive Case Management/Community Based Case Management

8. Targeted Case Management

    Targeted case management shall be provided in accordance with Hawaii Administrative Rules 17-1738 http://hawaii.gov/dhs/main/har/har_current/AdminRules/document_view. In the event any of the terms of this agreement conflict with or are not required by HAR §17-1738, the HAR shall control.

ATTACHMENT II

DOH—AMHD
With MQD rates and HCPCS Codes

SPA	AMHD Service	HCPCS Code	Unit	MQD Rate	Comments
Crisis Management	Crisis Mobile Outreach (CMO)	H2011	15 minutes	$ 27.50	
	Crisis Support Management (CSM)	H2015	15 minutes	$ 20.25	Must bill as Intensive Case Management/ Community Based Case Management
Crisis Residential	Licensed Crisis Residential Services (LCRS)	H0018	Daily	$211.80	Must be licensed, only treatment covered
Biopsychosocial Rehabilitation	Psychosocial Rehabilitation	H201 7	15 minutes	$ 3.30	Clubhouse not included
Intensive outpatient hospital services	Intensive Outpatient Hospital Services	H0035	Daily	$250.00	
Therapeutic Living Supports	Community Based Specialized Residential	H0019	Daily	$236.14	Must be licensed, only treatment covered
Assertive Community Treatment	Assertive Community Treatment, face-to-face contact	H0039	15 minutes	$ 27.00	75% of Assertive Community Treatment claims must be face-to-face
	Assertive Community Treatment, case assessment	H0039U1	15 minutes	$ 27.00	
	Assertive Community Treatment, treatment planning	H0039U2	15 minutes	$ 27.00	
	Assertive Community Treatment, collateral contact with no consumer contact	H0039U3	15 minutes	$ 27.00	
	Assertive Community Treatment, telephonic treatment planning with **11311,** Kahi Mohala	H0039HT	15 minutes	$ 27.00	
	Assertive Community Treatment, telephonic consultation with consumer	H0039U5	15 minutes	$ 27.00	

DOH—AMHD
With MQD rates and HCPCS Codes

SPA	AMHD Service	HPCPS Code	Unit	MQD Rate	Comments
Intensive Case Management/ Community Based Case Management	Intensive Case Management/Community Based Case Management, face-to-face contact	H2015	15 minutes	$20.25	75% of Intensive Case - Management/Community Based Case Management claims must be face-to-face.
	Intensive Case Management/Community Based Case Management, case assessment	H2015U1	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, treatment planning	H2015U2	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, collateral contact with no consumer contact	H2015U3	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, telephone treatment planning with HSH, Kahi Mohala	H2OI5HT	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, telephone consultation with consumer	H2015U5	15 minutes	$20.25	
	Targeted Case Management	T1017U5	15 minutes	$9.75	
	Targeted Case Management	T1017U6	15 minutes	$9.75	

Exhibit 6 to Attachment E

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

Name _____ ☐ MALE ☐ FEMALE
Last First MI

Home Address _____ Phone No. _____
_____ Case No. _____
Mailing Address _____ Client ID No. _____
_____ Social Security No. _____
Date of Birth _____ Age _____ COUNTY ☐ OAHU ☐ HAWAII ☐ MAUI ☐ KAUAI

Health Plan: ☐ Ohana ☐ UnitedHealthcare ☐ OTHER: _____
Primary Diagnosis _____ DSMIV Code _____
Secondary Diagnosis _____ DSMIV Code _____
Current Medical Conditions (Indicate, if none) _____

Date of Referral: _____ Name of PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	**CURRENTLY AT:** ☐ **Castle** ☐ **Queen's** ☐ **Other:** _____ (list) **Admitted on** _____/_____/_____			
Past Hospitalizations- Facility	Location	Date Admitted	Date Discharged	Diagnosis

MEDICATIONS	Strength	Dosage	Start Date	End Date

OUTPATIENT THERAPISTS	Diagnosis	Start Date	End Date

Section below to be completed by MQD/CSO Evaluation Panel

Date of Evaluation _____ Date of Enrollment/Disenrollment of CCS Services_____

Approved for CCS Referral: ☐ Yes ☐ No ☐ Additional Information Needed
Re-Evaluation Required: ☐ Yes ☐ No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments _____
_____
_____

Signature: _____

Client Name: _____ **Client I.D. No.:** _____

I. MENTAL STATES

A. *GENERAL*

1. Appearance: Within normal limits [ ] Other [ ] _____

2. Dress: Appropriate [ ]Bizarre [ ] Clean [ ] Dirty [ ]

3. Grooming: Neat [ ]Disheveled [ ] Needs improvement [ ]

B. *BEHAVIOR*

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]

2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] __

3. Body Mvemts: None [ ]Involuntary [ ] Akathisia [ ] Other [ ] _____

C. *SPEECH:* Clear [ ] Mumbled[ ] Rapid [ ] Whispers[ ] Monotone[ ]

Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]

Other [ ] _____

D. *MOOD*: Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]

Aggressive [ ] Hostile [ ] Depressed [ ]

Other [ ] _____

E. *AFFECT:* Full range [ ] Flat [ ] Constricted [ ] Inappropriate [ ]

Other [ ] _____

F. *THOUGHT*

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas[ ]

Neologism [ ] Perseveration [ ] Blocking [ ]

2. Content: Delusions [ ] Thought broadcasting [ ] Thought insertion [ ]
Thought withdrawal [ ] Other [ ] _____

G. *PERCEPTION – HALLUCINATIONS:*

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

H. *REALITY ORIENTATION:*

1. Mark all areas which the recipient can name:

Time: Day [ ] Month [ ] Year [ ]

Place: (can describe location) Yes [ ] No [ ]

Person: Self [ ] Family or friend [ ]

2. Memory: Recent intact? Yes[ ] No [ ]Remote intact: Yes [ ] No[ ]

I. *INSIGHT:* Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. *JUDGMENT:* Good [ ] Fair [ ] Poor [ ]

Client Name: _____ Client I.D. No.: _____

II. FUNCTIONAL SCALES: ***(check and <u>specify</u> any problem(s) in the following areas)***

[ ]Medical/Physical _____

_____

[ ] Family/Living _____

_____

[ ] Interpersonal Relations _____

_____

[ ] Role Performance _____

_____

[ ] Socio-Legal _____

_____

[ ] Self-Care/Basic Needs _____

_____

III. **ADDITIONAL COMMENTS:** Please supply any additional information which would be of assistance in reaching a decision with regard to this patient's evaluation.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name)*: _____

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

Medical Director or Attending Physician for in-patients *(Print Name)*: _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SHO # 09-001

February 6, 2009

Dear State Health Official:

On February 4, 2009, President Barack Obama signed Public Law 111-3, The Children's Health Insurance Program Reauthorization Act of 2009, and issued a Presidential Memorandum directing the Secretary of Health and Human Services to withdraw the August 17, 2007, and May 07, 2008, letters issued to State Health Officials. Therefore, the Centers for Medicare & Medicaid Services is withdrawing these letters and will no longer apply the policies in those letters when reviewing Children's Health Insurance Program State plan amendments or section 1115 demonstration waivers.

If you have any questions regarding this letter, please contact Ms. Dianne Heffron, Acting Director, Family and Children's Health Programs, who may be reached at (410) 786-3247.

Sincerely,

/s/

Jackie Garner
Acting Director, Center for Medicaid and State Operations

cc:

CMS Regional Administrators

CMS Associate Regional Administrators,
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Directory for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Council

Barbara W. Levine
Chief, Government Relations and Legal Affairs
Association of State and Territorial Health Officials

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Office of the Director
P. O. Box 339
Honolulu, Hawaii 96809-0339

December 19, 2012

Ms. Jessica Schubel, MPH
Centers for Medicare and Medicaid Services
Centers for Medicaid, CHIP, and Survey & Certification
Mail Stop S2-26-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Schubel:

RE: AMENDMENT TO THE HAWAII QUEST EXPANDED MEDICAID SECTION 1115 DEMONSTRATION (11-W-00001/9)

The Hawaii Department of Human Services (DHS) requests approval of an amendment to the QUEST Expanded Section 1115 demonstration project to provide Medicaid coverage for certain young adults who have aged out of foster care. Specifically, effective January 1, 2013, the State wishes to provide full State plan Medicaid benefits to individuals who:

- are under age 26;
- have household income not exceeding 300 percent of the federal poverty level (FPL);
- have aged out of foster care;
- were enrolled in Medicaid while in foster care; and
- are not eligible or enrolled under existing Medicaid eligibility groups (or would be eligible but have income that exceeds the upper income eligibility limit under any such group).

The former foster children covered under this amendment will be Medicaid-eligible under Section 2004 of the Affordable Care Act (ACA), effective January 1, 2014. See 42 U.S.C. §1396a(a)(10)(A)(i)(IX). As part of the State's ongoing efforts to ease the transition for young adults leaving foster homes, the State seeks to extend Medicaid coverage to this group of individuals as soon as possible, *i.e.*, one year in advance of the ACA provision, or January 1, 2013.

The State estimates that this amendment would extend eligibility to approximately 200 individuals, at a total cost of approximately $406,000 a year. Enclosed is a chart showing the budget neutrality analysis for QUEST Expanded both with the proposed amendment and without it.

This amendment will require changes to the demonstration's Special Terms and Conditions and expenditure authorities. Enclosed are redlined versions of the demonstration documents that incorporate the requisite changes, which we also summarize here:

1. In Section II, Program Description, Objectives and Historical Context, add: "In December 2012, the State of Hawaii submitted an amendment proposal to provide full Medicaid benefits to former foster children up to age 26 with income not exceeding 300 percent FPL and no asset limit."

2. In Section IV, Demonstration Scope, add the following language to the group of individuals who are covered by QUEST, at new paragraph 18.a.iii: "Effective, January 1, 2013, former foster children up to age 26 with income not exceeding 300 percent FPL and no asset limit."

3. In Section IV, Demonstration Scope, at the end of paragraph 18.b.i, replace the term "Medicaid limits" with "applicable Medicaid limits for those programs".

4. In the eligibility charts, in the "Federal Poverty Level and/or Other Qualifying Criteria" column, in the "Adults in Quest-Net" row, delete the word "Medicaid".

5. In the eligibility charts, add a group for "Former Foster Children" under the "Demonstration Eligibles" Category. This group should be listed under the QUEST eligibility component, and its qualifying eligibility criteria should be described as follows: "Up to 300 percent FPL with no asset limit who (i) have aged out of foster care; (ii) were receiving medical assistance under the State plan or a waiver while in foster care; (iii) are under age 26; and (iv) are not described or enrolled in an existing mandatory Medicaid eligibility group, or are described in such a group but have income that exceeds the income level for that group.

6. In Section V, Enrollment, add the following as paragraph 24.a.vi (adding a category of adults not subject to the enrollment cap): "The individual is eligible pursuant to his or her status as a former foster child."

7. In Section VI, Benefits, add "and Former Foster Children" to the list of groups eligible for full State plan benefits. Specifically, paragraph 26.a.i should now read: "QUEST Families, Children, Pregnant Women, and Former Foster Children".

8. In Section XII, General Financial Reporting Requirements for Defined Authorized Expenditures, add the following to the list, in paragraph 53.d, of separate waiver forms that the State must complete each year to report expenditures for individuals enrolled in the demonstration: "Former Foster Children (Demonstration eligible adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);".

9. In Attachment B, Quarterly Report Format, "Enrollment Counts" chart, add "Demonstration Eligible Adults Former Foster Children (QUEST)" to the charts listing groups for which the State must submit quarterly reports.

10. In Attachment B, Quarterly Report Format, member months reporting chart, add "Demonstration Eligible Adults Former Foster Children (QUEST)" to the charts listing groups for which the State must submit quarterly reports.

11. Add the following to the Section 1115 Expenditure Authority: Adults up to 300 percent FPL with no asset limit who (i) have aged out of foster care; (ii) were receiving medical assistance under the State plan or a waiver while in foster care; (iii) are under age 26; and (iv) are not described or enrolled in an existing mandatory Medicaid eligibility group, or are described in such a group but have income that exceeds the income level for that group.

As requested by the Centers for Medicare & Medicaid Services (CMS), in proposing this amendment the State based its public notice and input processes, as well as its tribal notice and consultation processes, on those described in 42 C.F.R. § 431.408. The State published a public notice document (enclosed) on the DHS and Med-QUEST Division websites and in local newspapers; published a redline draft of the proposed changes to the waiver documents (enclosed) on the DHS and Med-QUEST Division websites; e-mailed the notice to interested parties; and solicited public input during a 30-day public comment period. (Instead of utilizing an abbreviated public notice, the State published its full public notice document in local newspapers, which met all the requirements of an abbreviated public notice.)

The State solicited tribal consultation as described in the State Plan on September 21, 2012 (enclosed). No comments have been received to date.

In addition, the State held two public hearings on this amendment, as described in the public notice document. Six individuals testified at these hearings, all of whom voiced support for the amendment. The State also received four emails, and two mailed letters, about the amendment, all of which were in favor of the proposed amendment.

Finally, the State has included a technical amendment to item 26 (f) of the Standard Terms and Conditions to coincide with the amended Behavioral Health protocol recently approved by CMS. A housekeeping action, the amendment assures pristine consistency with the protocol.

We request your favorable response at your earliest convenience; DHS is hoping to cover the individuals subject to this amendment effective January 1, 2013. If you have any questions or would like to discuss this request, please contact Dr. Kenneth Fink, Med-QUEST Division Administrator, at 808-692-8050, or Ms. Noreen Moon-Ng, Med-QUEST Division Policy and Program Development Officer, at 808-692-8134.

Sincerely,

Patricia McManaman
Director

Enclosures

c: Dr. Gloria Nagel, CMS San Francisco Regional Office

The State proposes the following amendments to the terms and conditions for the QUEST Expanded Section 1115 Demonstration:

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 June 30, 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 December 2012, the State of Hawaii submitted an amendment proposal to provide full Medicaid benefits to former foster children up to age 26 with income not exceeding 300 percent FPL and no asset limit.

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 CIDP 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 CIDP 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 CIDP 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 CIDP 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.

        iii. Effective January 1, 2013, former foster children up to age 26 with income not exceeding 300 percent FPL and no asset limit.

    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~~ applicable Medicaid limits for those programs:

            1. 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;

2. Effective July 1, 2012 through June 30, 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 June 30, 2013: With income up to 133 percent of 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 (MRIDD) 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 Children
Children 1-5	Quest	Up to and including 185 percent FPL	Title XIX	State Plan Children
Children 6-18	Quest	Up to and including 185 percent FPL	Title XIX	State Plan Children
AFDC-related family members eligible under Section 1931	Quest	Up to and including 185 percent FPL	Title XIX	State Plan 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 man and 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 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**

[1] Reported under Title XXI Allotment Neutrality if allotment is available.

Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	Quest	Up to and including 100 percent PPL	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 Search**	**Expenditure and Eligibility Group Reporting**

Aged, Blind, and Disabled Medically Needy Adults and Children	QExA	Medically need income standard for household size using SSI income methodology	Title XIX	Aged with Medicare OR Aged without Medicare OR 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 and Children
Children 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

Former Foster Children	QUEST	Up to 300 percent FPL with no asset limit who (i) have aged out of foster care; (ii) were receiving medical assistance under the State plan or a waiver while in foster care; (iii) are under age 26; and (iv) are not described or enrolled in an existing mandatory Medicaid eligibility group, or are described in such a group but have income that exceeds the income level for that group.	Title XIX	Demo Elig Adults
Individuals in the 42 CFR section 435.217 group who are receiving home and community-based services (HCBS)	QExA	Net income no more than 100 percent FPL using the institutional income rules	Title XIX	Aged with Medicare OR Aged without 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, adults in 2-parent families ages 18-64 years, who must be either temporarily disabled or meet work-search requirements;

        iii. 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;

v. The individual has been covered under COBRA and has applied for QUEST benefits within 45 days of losing COBRA coverage; and

vi. The individual is eligible pursuant to his or her status as a former foster child.

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, Pregnant Women, and Former Foster Children

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 (ICFIMR). 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 MRIDD 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 according to the Behavioral Health protocol. ~~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 addresses ~~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 bas an emergency room visit, hospital visit, or any change in condition, will receive an HFA within 15 days of the 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 States 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 MRIDD 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 June 30, 2012	$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 200 8) 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 (SPY 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 und.er 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 Jong-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 I. 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 CIDP Budget and Expenditure System (MB S/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, 20 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 (BID w/Mcare)(CMS 64.9 Waiver and/or CMS 64.9P Waiver);

xvii. Blind/Disabled without Medicare (BID 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);

xix. Hawaii Premium Plus (Premium Plus) (CMS 64.9 Waiver and/or CMS 64.9P Waiver); and

xx. Former Foster Children (Demonstration eligible adults) (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 fur 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 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 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 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 CIDP 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 no-immigrant/non-COFA title XXI children (HI-01) must be reported on separate Forms CMS.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 time frames 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 1through4 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 185 percent FPL
Children 6-18	Up to and including 185 percent FPL
Foster children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	Up to and including 185 percent FPL
EG 2 – Adults	
Pregnant women	Up to and including 185 percent FPL
Section 1931 Adults	Up to and including 185 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	DY16 PMPM	DY17 PMPM	DY 18 PMPM	DY 19 PMPM
		FYY 2013	FYY 2013	FYY 2013	FYY 2013	FYY 2013
EG 1 –Children	1.066	$322.62	$343.98	$366.75	$391.03	$416.92
EG 2 – Adults	1.064	$564.90	$600.88	$639.18	$679.87	$723.18
EG 3 – Aged	1.064	$1204.63	$1281.84	$1364.01	$1451.44	$1544.48
EG 4 – Blind/Disabled	1.072	$1489.42	$1597.11	$1712.58	$1836.40	$1969.17

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
Year 16 through 18	Cumulative budget neutrality limit plus:	0.5 percent
Year 19	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 prior to the expiration of the Demonstration. CMS must provide comments within 60 days 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 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 DELIVERABLE 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	Mediciad 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 DY 14
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 l, 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".

Attachment B
Quarterly Report Format

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)	
Demonstration Eligible Adults Former Foster Children (QUEST)	

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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.

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Quarterly Report Format

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 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)				
Demonstration Eligible Adults Former Foster Children (QUEST)				
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				

Attachment B
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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.

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.

QEIA 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.

Behavior 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

Attachment B
Quarterly Report Format

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, 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 Wider 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 who feel that they are not able to live on their own.
Pediatric Attendant Care	Attendant care is care, 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

Service/Provider Term	Service Definition
	attendant care, are those services that substitute for the absence, loss, diminution, or impairment of function. Attendant care services be self-directed.
Community Care Management Agency (CCMA)	CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. A health plan may, at its option, demonstrate the ability to provide CCMA services by contracting with an entity licensed under HAR subchapters 1 and 2. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, 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 furnishyed to up to three (3) adults who receive these services in conjunction with residieng 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 specifried in the service plan; employer skills updates as necessary to safely maintian the individual at thome; 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, farnilites/caregivers, and professional and paraprofessional caregivers on behalf of the member.
Environmental Accessibility	Environmental are those physical adaptations to the home, required by the individual's care plan, are necessary to ensure the health, welfare and safety of the individual, or which

Attachment C
Home and Community-Based Services (HCBS) and Long-Term Care
Provider Guidelines and Service Definitions

Service/Provider Term	Service Definition
Adaptations	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. Widow air conditioners may be installed when it is necessary for the health and safety of the member. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building code.
Expanded Adult Residential Care Home (E-ARCH) or Residential Care Services0	Residential care services are personal care services, homemaker, chore, attendant care and companion services and medicaiton 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 whome may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, no more than twenty perceint (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 HRS§ 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 nubritionally sound meals delivered to a location where an individual resides (excluding residential or institional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.3., 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 part of personal assistance and include: heavy duty cleaning, which is utilized to 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 determinied, 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 outpaitent setting encompassing both health and social services needed to ensure the optimal function of the individual.

Attachment C
Home and Community-Based Services (HCBS) and Long-Term Care Provider Guidelines and Service Definitions

Service/Provider Term	Service Definition
Moving Assistance	Moving assistance is provided in rare instances when it it determined through an assessment by the care coordinator that the 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 elavator; 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 loger able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.
Non-Medical Transportation	Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation
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.l70(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

Service/Provider Term	Service Definition
	Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. The following activities may be included as a part of personal assistance services Level II: • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing; • Assistance with bowel and bladder care; • Assistance with ambulation and mobility; • Assistance with transfers; • Assistance with medications, which are ordinarily self-administered when ordered by member's physician; • Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician; • Assistance with feeding, nutrition, meal preparation and other dietary activities; • Assistance with exercise, positioning, and range of motion; • Taking and recording vital signs, including blood pressure; • Measuring and recording intake and output, when ordered; • Collecting and testing specimens as directed; • Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter • 16-89, Hawaii Administrative Rules; • Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished; • Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and • Maintaining documentation of observations and services provided. 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

Service/Provider Term	Service Definition
	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. 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 art 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);

Service/Provider Term	Service Definition
	• 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:

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:

Attachment D
Certified Public Expenditure (CPE)/ Government-Owned Hospital Uncompensated Care Cost (UCC) Protocol

[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:

Attachment D
Certified Public Expenditure (CPE)/ Government-Owned Hospital Uncompensated Care Cost (UCC) Protocol

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)/ Government-Owned 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SHO # 09-001

February 6, 2009

Dear State Health Official:

On February 4, 2009, President Barack Obama signed Public Law 111-3, The Children's Health Insurance Program Reauthorization Act of 2009, and issued a Presidential Memorandum directing the Secretary of Health and Human Services to withdraw the August 17, 2007, and May 07, 2008, letters issued to State Health Officials. Therefore, the Centers for Medicare & Medicaid Services is withdrawing the letters and will no longer apply the policies in those letters when reviewing Children's Health Insurance Program State plan amendments or section 1115 demonstration waivers.

If you have any questions regarding this letter, please contact Ms. Dianne Heffron, Acting Director, Family and Children's Health Programs, who may be reached at (410) 786-3247.

Sincerely,

/s/

Jackie Garner
Acting Director, Center for Medicaid and State Operations

cc:

CMS Regional Administrators

CMS Associate Regional Administrators,
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Directory for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Council

Barbara W. Levine
Chief, Government Relations and Legal Affairs
Association of State and Territorial Health Officials

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST
Amended June 11, 2012

NUMBER: **11-W-00001/9**

TITLE: **QUEST Expanded Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project beginning February 1, 2008, through June 30, 2013. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted subject to the STCs for the QUEST Expanded Medicaid Section 1115 Demonstration.

1. Medically Needy	**Section 1902(a)(10)(C); Section 1902(a)(17)**

To enable the State to limit medically needy spend-down eligibility except those enrolled in QUEST Expanded Access (QExA) to those individuals whose gross incomes, before any spend-down calculation, are at or below 300 percent of the Federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which have no gross income limit.

2. Amount, Duration, and Scope	**Section 1902(a)(10)(B)**

To enable the State to offer demonstration benefits that may not be available to all categorically eligible or other individuals.

3. Financial Responsibility/Deeming	**Section 1902(a)(17)(D)**

To allow the State to determine eligibility for QUEST and QUEST-Net Children using the income of household members whose income may be taken into account under the income rules of the related cash assistance program. The State shall determine eligibility for other eligibility components using standard Medicaid financial responsibility and deeming rules.

4. Three-Month Retroactive Eligibility	**Section 1902(a)(34)**

To enable the State to limit retroactive eligibility to a five (5) day period prior to application, or up to three months for individuals requesting long-term care services.

5. Freedom of Choice	Section 1902(a)(23)

To enable Hawaii to restrict the freedom of choice of providers to groups that could not otherwise be mandated into managed care under section 1932.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY
Amended May 1, 2010

NUMBER: **11-W-00001/9**

TITLE: **QUEST Expanded Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration extension be regarded as expenditures under the State's title XIX plan but are further limited by the Special Terms and Conditions for the QUEST Expanded (QEx) Section 1115 Demonstration.

For enrollees in All Components of the Demonstration:

- **Managed Care Payments.** Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m):

  Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.

  Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and Federal regulations at 42 CFR section 438.52, to the extent necessary if a plan exceeds its enrollment cap.

- **Quality Review of Eligibility**. Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings .

- **Demonstration Eligibility**. Expenditures to provide coverage to the following populations:

  - **Demonstration Eligibles Enrolled in QEx Eligibility Components other than Quest Expanded Access (QExA).**

    - TANF cash recipients, whose income is up to 100 percent FPL (using the TANF methodology), but are not otherwise eligible under the Medicaid State plan;

- Adults, including General Assistance (GA) cash recipients, who have lost QUEST, QExA, or Medicaid Fee-for-Service eligibility because they have income or assets in excess of the Medicaid limits, up to 133 percent of the FPL (QUEST-Net)~~; and~~.

- Adults, including General Assistance (GA) cash recipients, with incomes or assets in excess of the Medicaid limits up to 133 percent of the FPL, but who are not otherwise Medicaid eligible. (QUEST-ACE); and~~.~~

- Adults with income up to 300 percent FPL with no asset limit who (i) have aged out of foster care; (ii) were receiving medical assistance under the State plan or a waiver while in foster care; (iii) are under age 26; and (iv) are not described or enrolled in an existing mandatory Medicaid eligibility group, or are described in such a group but have income that exceeds the income level for that group.

- **Demonstration Eligibles Enrolled in the QExA eligibility component.**

  - Persons who would be eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR section 435.217 if the home and community-based services that they are receiving from a QExA plan were provided under a waiver that was granted to the State under section 1915(c) as of the initial approval date of the QExA component of this demonstration. This includes the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

  - Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

  - Individuals who would otherwise be eligible under the State plan or another QExA demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of the QExA capitation payment, subject to an enrollment fee equal to the spend-down liability.

- **Hospital Uncompensated Care Costs**. Expenditures to reimburse certain hospital providers for provider costs of hospital services to the uninsured, and or underinsured, subject to the restrictions placed on hospital uncompensated care costs, as defined in the STCs.

- **QExA Home and Community-Based Services (HCBS) and Personal Care Services.** Expenditures to provide HCBS and personal care services not included in the Medicaid State plan and furnished to QExA enrollees, as follows:

    - Expenditures for the continued provision of services provided to individuals enrolled during the transition from fee-for-service to QExA in the State's Nursing Home Without Walls (NHWW), Residential Alternatives Community Care Program (RAACP), Medically Fragile Community Care Program (MFCCP) and HIV Community Care Program (HCCP) HCBS waiver programs as fee-for-service expenditures for the period beginning with the effective date of these authorities until QExA plan coverage (under the authority of subparagraphs band c below) is operational;

    - Expenditures for the provision of services, through QExA plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

    - Expenditures for the provision of personal care services, through QExA plans, to individuals with less than a need for an institutional level of care, including personal care assistance services provided by a family member;

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration beginning February 1, 2008, through June 30, 2013, except those waived or listed below as not applicable.

Title XIX Requirements Not Applicable to Demonstration Populations

Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable the State to maintain a waiting list, through a QExA plan, for home and community-based services and personal care services. No waiting list is permissible for other services for QExA enrollees.

Cost Sharing **Section 1902(a)(14)**

To enable the State to charge cost sharing up to 5 percent of annual family income. To enable the State to charge an enrollment fee to QExA enrollees whose spend-down liability or cost share obligation is estimated to exceed the QExA capitation rate (Demonstration Population 3.b.iii.), in the amount equal to the estimated spend-down or cost share amount

Expenditures for MCO Contracts **Section 1903(m)(2)(A)(vi)**

To enable the State to restrict an enrollees' right to disenroll without cause within 90 days of enrollment in a new MCO.

Hawaii 1115 QUEST Waiver									7/2012-6/2013	7/2013-12/2013
TOTAL COMPUTABLE		12	13	14	15	16	17	18	19	20
		Std Renewal /Extension			**Renewal**					
WITHOUT WAIVER	**FMAP**	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081	0.5152	0.5186
		58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%	50.48%	51.86%
	MEG Description and Comments	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%	51.86%	51.86%
					67.35%		62.63%			
	TANF (AFDC), Foster Children, GA children									
	SHIP Children									
	TANF (AFDC), Foster Children, GA children, SHIP Children	$261.16	$281.11	$302.59	$322.62	$343.98	$366.75	$391.03	$416.92	$444.52
	TANF Adults	$458.35	$493.37	$531.07	$564.90	$600.88	$639.18	$679.87	$723.18	$7689.25
	Aged				$1,204.63	$1,281.84	$1,364.01	$1,451.44	$1,544.48	$1,643.48
	Blind/Disabled				$1,489.42	$1,597.11	$1,712.58	$1,836.40	$1,969.17	$2,111.54
Mem ber Months										
	TANF (AFDC), Foster Children, GA children									
	SHIP Children									
	TANF (AFDC), Foster Children, GA children, SHIP Children	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583	1,328,320	680,333
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,978	422,741	465,274	238,902
	Aged				98,211	228,008	236,945	234,307	245,940	123,973
	Blind/Disabled				115,266	273,836	288,269	286,344	293,512	147,964
	Total Without Waiver Member Months	**1,282,911**	**1,261,533**	**1,193,278**	**1,540,890**	**1,994,062**	**2,130,996**	**2,166,975**	**2,333,046**	**1,191,172**
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	$402,056,806	$424,960,513	$443,327,661	$837,493,616	$1,343,204,149	$1,520,758,456	$1,631,791,072	$1,848,104,462	$1,002,375,581
DSH		$80,364,047	$81,971,327	$83,856,667	$87,546,360	$89,735,019	$91,350,249	$94,547,507	$97,856,670	$101,281,653
Total Ceiling		**$482,420,853**	**$506,931,840**	**$527,184,328**	**$925,039,976**	**$1,432,939,168**	**$1,612,108,705**	**$1,726,338,579**	**$1,945,961,132**	**$1,103,657,234**
WITH WAIVER	1115	$0	$0	$0	$0	$0	$0	$0		
	1902 R 2	$0	$0	$0	$0	$0	$0	$0		
	1902 R 2X	$0	$0	$0	$0	$0	$0	$0		
	1902R2	$0	$0	$0	$0	$0	$0	$0		
	AFDC	$0	$0	$0	$0	$0	$0	$0		
	Aged w /Mcare	$0	$0	($295)	$121,310,557	$314,957,371	$350,728,888	$330,293,296	$350,348,130	$183,443,708
	Aged w /o Mcare	$0	$0	$0	$2,424,989	$17,555,107	$24,896,097	$19,060,304	$21,444,981	$10,969,774
	B/D w /Mcare	$0	$0	($13,736)	$31,795,707	$74,850,400	$81,249,425	$77,690,468	$79,815,105	$41,730,901
	B/D w /o Mcare	$0	$0	($28,991)	$81,514,842	$211,801,011	$248,768,345	$251,740,251	$269,260,425	$142,154,060
	Breast Cervical Cancer Treatment (BCCT)	$0	$0	$0	$0	$4,051	$545,195	$734,188	$796,710	$428,372
	CURRENT	$0	$0	$0	$0	$0	$0	$0		
	CURRENT POP	$0	$0	$0	$0	$0	$0	$0		
	Current-Haw aii Quest	$0	$0	$0	$0	$0	$0	$0		
	Demo Elig Adults	$127,983,510	$129,458,220	$154,645,707	$177,396,443	$201,629,508	$238,017,265	$245,339,887	$260,923,401	$139,261,655
	FosterCare(19-20)	$0	$0	$91,499	$83,366	$94,158	$137,233	$77,745	$73,698	$40,211
	Haw aiiQuest-1902(R)(2)	$0	$0	$33,061	$26,332	$8,001	$0	$0	$203,088	$203,088
	HCCP	$0	$0	$135,520	$683,159	$0	$0	$0		
	HealthQuest-Current	($2,325,152)	$0	$0	$0	$0	$0	$0		
	HealthQuest-Others	($621,643)	$0	$0	$0	$0	$0	$0		
	Med Needy Adults	$56,504	$120,767	$115,693	$58,345	$117,005	$109,837	$8,305		
	Med Needy Children	$0	$0	$0	$7,715	$3,960	$0	$0		
	MFCP	$0	$0	$122,839	$581,513	$0	$0	$0		
	NH w /o W	$0	$0	$5,100,418	$16,199,737	$0	$0	$0		
	Opt St Pl Children	$76,678	$103,084	$80,075	$257,166	$253,182	$31	$0		
	Others	$0	$0	$0	$0	$0	$0	$0		
	Others-Haw aii Quest	$0	$0	$0	$0	$0	$0	$0		
	OthersX	$0	$0	$0	$0	$0	$0	$0		
	QUEST ACE	($2,751)	$798,681	$5,696,094	$14,353,208	$23,872,001	$30,434,166	$28,884,029	$42,762,105	$24,407,857
	RAACP	$0	$0	$7,862,479	$17,432,949	$0	$0	$0		
	St Pl Adults-Preg Immig/COFAs	$0	$0	$0	$0	$24,990	$2,622,138	$2,718,679	$4,007,371	$2,201,398
	State Plan Adults	$111,983,043	$118,021,622	$109,034,691	$128,225,127	$132,187,409	$123,786,545	$118,966,463	$146,718,138	$78,354,062
	State Plan Children	$181,803,156	$179,673,972	$155,394,295	$168,854,083	$203,903,281	$214,486,295	$199,141,564	$241,379,176	$128,247,304
	Supp. - Private	$0	$0	$0	$0	$0	$0	$0		
	Supp. - State Gov.	$0	$0	$0	$0	$0	$0	$0		
	UCC-Governmental	$15,688,221	$22,546,108	$18,919,184	$16,356,580	$24,507,605	$34,064,491	$40,634,690		$5,000,000
	UCC-Private	$10,056,500	$3,403,710	$7,500,000	$7,500,000	$7,500,000	$7,500,000	$0	$77,000,000	$40,650,000
		$444,698,066	**$454,126,164**	**$464,688,533**	**$785,061,818**	**$1,213,269,040**	**$1,357,345,951**	**$1,315,289,869**	**$1,494,732,327**	**$797,092,391**
		-$1,459,097	-$1,189,919	-$660,309	-$4,962,002	-$38,297,536	-$43,476,661	-$38,375,159	-$38,400,000	-$38,400,000
		$443,238,969	**$452,936,245**	**$464,028,224**	**$780,099,816**	**$1,174,971,504**	**$1,313,869,290**	**$1,276,914,710**	**$1,456,332,327**	**$758,692,391**
		$39,181,885	**$53,995,595**	**$63,156,104**	**$144,940,160**	**$257,967,664**	**$298,239,415**	**$449,423,868**	**$489,628,804**	**$344,964,844**
		$565,691,724	**$619,687,319**	**$682,843,423**	**$827,783,582**	**$1,085,751,247**	**$1,383,990,662**	**$1,833,414,530**	**$2,323,043,334**	**$2,668,008,178**
		-$334,903	-$352,488	-$217,644	-$22,587	-$15,945,497	-$15,835,580	-$10,164,390	-$9,600,000	-$9,600,000
		-$323,973	-$263,058	-$239,466	-$19,777	-$6,517,946	-$9,185,458	-$9,300,862	-$9,600,000	-$9,600,000
		-$347,005	-$279,056	-$147,219	-$22,317	-$9,503,023	-$9,356,037	-$9,335,080	-$9,600,000	-$9,600,000
		-$453,216	-$295,317	-$55,980	-$4,897,321	-$6,331,070	-$9,099,586	-$9,574,826	-$9,600,000	-$9,600,000

Hawaii 1115 QUEST Waiver									7/2012-6/2013	7/2013-12/2013
TOTAL COMPUTABLE		12	13	14	15	16	17	18	19	20
		Std Renewal /Extension					**Renewal**			
WITHOUT WAIVER	**FMAP**	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081	0.5152	0.5186
		58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%	50.48%	51.86%
MEG	**MEG Description and Comments**	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%	51.86%	51.86%
					67.35%		62.63%			
Current	TANF (AFDC), Foster Children, GA children									
1902 R 2	SHIP Children									
Children	**TANF (AFDC), Foster Children, GA children, SHIP Children**	$261.16	$281.11	$302.59	$322.62	$343.98	$366.75	$391.03	$416.92	$444.52
Adults	**TANF Adults**	$458.35	$493.37	$531.07	$564.90	$600.88	$639.18	$679.87	$723.18	$769.25
Aged	**Aged**				$1,204.63	$1,281.84	$1,364.01	$1,451.44	$1,544.48	$1,643.48
Blind/Disabled	**Blind/Disabled**				$1,489.42	$1,597.11	$1,712.58	$1,836.40	$1,969.17	$2,111.54
Member Months										
MEG										
Current	TANF (AFDC), Foster Children, GA children									
1902 R 2	SHIP Children									
Children	**TANF (AFDC), Foster Children, GA children, SHIP Children**	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583	1,296,287	683,404
Adults	**TANF Adults**	339,848	331,334	302,135	348,185	390,404	421,978	422,741	458,263	234,350
Aged	**Aged**				98,211	228,008	236,945	234,307	252,324	127,588
Blind/Disabled	**Blind/Disabled**				115,266	273,836	288,269	286,344	296,413	149,852
	Total Without Waiver Member Months	**1,282,911**	**1,261,533**	**1,193,278**	**1,540,890**	**1,994,062**	**2,130,996**	**2,166,975**	**2,305,287**	**1,175,192**
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	$402,056,806	$424,960,513	$443,327,661	$837,493,616	$1,343,204,149	$1,520,758,456	$1,631,791,072	$1,846,085,411	$1,001,273,177
DSH		$80,364,047	$81,971,327	$83,856,667	$87,546,360	$89,735,019	$91,350,249	$94,547,507	$97,856,670	$101,281,653
Total Ceiling		**$283,301,646.07**	**$293,336,109.06**	**$299,243,003.61**	**$592,279,970.41**	**$965,084,529.78**	**$1,055,326,661.11**	**$877,109,473.31**	**$1,001,421,762.95**	**$571,784,834.78**
WITH WAIVER										
	1115	$0	$0	$0	$0	$0	$0	$0		
	1902 R 2	$0	$0	$0	$0	$0	$0	$0		
	1902 R 2X	$0	$0	$0	$0	$0	$0	$0		
	1902R2	$0	$0	$0	$0	$0	$0	$0		
	AFDC	$0	$0	$0	$0	$0	$0	$0		
	Aged w /Mcare	$0	$0	($199)	$81,150,568	$211,365,921	$229,326,563	$167,847,639	$180,481,839	$95,133,907
	Aged w/o Mcare	$0	$0	$0	$1,622,988	$11,822,762	$16,013,111	$9,683,594	$11,047,382	$5,688,925
	B/D w /Mcare	$0	$0	($9,251)	$21,278,037	$49,918,170	$52,630,292	$39,465,401	$41,116,751	$21,641,645
	B/D w/o Mcare	$0	$0	($19,525)	$54,511,233	$141,689,177	$161,313,096	$127,840,720	$138,709,508	$73,721,095
	Breast Cervical Cancer Treatment (BCCT)	$0	$0	$0	$0	$2,753	$361,192	$481,007	$410,425	$222,154
	CURRENT	$0	$0	$0	$0	$0	$0	$0		
	CURRENT POP	$0	$0	$0	$0	$0	$0	$0		
	Current-Hawaii Quest	$0	$0	$0	$0	$0	$0	$0		
	Demo Elig Adults	$75,196,694	$74,766,897	$87,888,811	$114,381,346	$135,452,855	$238,017,265	$245,339,887	$134,414,690	$72,221,094
	FosterCare(19-20)	$0	$0	$51,916	$53,413	$63,415	$137,233	$77,745	$37,966	$20,853
	FosterCare (up to 25)								$104,621	$105,321
	HawaiiQuest-1902(R)(2)	$0	$0	$18,697	$19,755	$5,389	$0	$0		
	HCCP	$0	$0	$76,578	$438,797	$0	$0	$0		
	HealthQuest-Current	($1,365,848)	$0	$0	$0	$0	$0	$0		
	HealthQuest-Others	($363,962)	$0	$0	$0	$0	$0	$0		
	Med Needy Adults	$32,497	$68,553	$68,082	$38,985	$78,049	$64,590	$4,238		
	Med Needy Children	$0	$0	$0	$5,196	$2,666	$0	$0		
	MFCP	$0	$0	$69,404	$368,050	$0	$0	$0		
	NH w /o W	$0	$0	$2,881,647	$10,235,011	$0	$0	$0		
	Opt St Pl Children	$44,819	$59,404	$45,487	$166,217	$170,408	$21	$0		
	Others	$0	$0	$0	$0	$0	$0	$0		
	Others-Hawaii Quest	$0	$0	$0	$0	$0	$0	$0		
	OthersX	$0	$0	$0	$0	$0	$0	$0		
	QUEST ACE	($1,583)	$454,606	$3,232,556	$9,376,232	$16,053,298	$19,623,482	$14,668,205	$22,028,899	$12,657,915
	RAACP	$0	$0	$4,442,944	$10,922,788	$0	$0	$0		
	St Pl Adults-Preg Immig/COFAs	$0	$0	$0	$0	$16,829	$1,703,701	$1,378,694	$2,064,397	$1,141,645
	State Plan Adults	$65,812,297	$68,288,552	$61,892,816	$82,540,895	$88,970,500	$80,802,462	$60,438,018	$75,581,849	$40,634,417
	State Plan Children	$106,725,650	$103,797,949	$88,087,112	$108,851,430	$137,173,252	$138,386,935	$101,119,769	$124,346,483	$66,509,052
	Supp. - Private	$0	$0	$0	$0	$0	$0	$0		
	Supp. - State Gov.	$0	$0	$0	$0	$0	$0	$0		
	UCC-Governmental	$9,212,484	$13,041,165	$10,762,501	$10,040,250	$16,505,872	$22,280,473	$20,686,860		
	UCC-Private	$5,787,516	$1,958,835	$4,237,500	$4,959,750	$5,051,250	$4,697,250	$0	$39,666,550	$21,081,090
	Total Expenditures Per CMS-64 Waiver	**$261,080,564**	**$262,435,961**	**$263,727,058**	**$510,960,921**	**$614,442,555**	**$861,604,795**	**$668,249,531**	**$770,011,358**	**$410,779,114**
	Premium Share (Not reported on 64 Waiver)	-$1,459,097	-$1,169,919	-$660,309	-$4,962,002	-$38,297,536	-$28,587,255	-$19,574,991	-$38,400,000	-$38,400,000
	Total Expenditures	**$259,621,467**	**$261,246,042**	**$263,066,749**	**$505,998,919**	**$776,145,030**	**$853,017,540**	**$648,674,540**	**$731,611,358**	**$372,379,114**
	DY BN Savings	**$23,680,179**	**$32,090,067**	**$36,176,255**	**$35,281,051**	**$188,939,500**	**$202,309,121**	**$228,434,933**	**$269,810,405**	**$199,405,821**
	Cummulative Savings	**$315,385,083**	**$347,475,150**	**$383,651,405**	**$469,932,457**	**$658,871,956**	**$861,181,077**	**$1,089,615,010**	**$1,359,426,415**	**$1,558,832,236**
		-$334,903	-$352,488	-$217,644	-$22,587	-$15,945,497	-$10,585,264	-$5,334,195	-$9,600,000	-$9,600,000
		-$323,973	-$263,058	-$239,466	-$19,777	-$6,517,946	-$5,166,406	-$4,695,075	-$9,600,000	-$9,600,000
Notes:	**Medicaid Rehab became new benefit during year 11**	-$347,005	-$279,056	-$147,219	-$22,317	-$9,503,023	-$6,036,515	-$4,712,348	-$9,600,000	-$9,600,000
	Childrens outreach lead to more adults, including adults below the line (Adults-expansion) during	-$453,216	-$295,317	-$55,980	-$4,897,321	-$6,331,070	-$5,699,070	-$4,833,372	-$9,600,000	-$9,600,000

Department of Human Services
Med-QUEST Division
Member months

7/2012-6/2013 7/2013-12/2013

	12	13	14	15	16	17	18	19	20
	Std Renewal/Extension			*Renewal*					
1115									
1902 R 2									
1902 R 2X									
1902R2									
AFDC									
Aged w/Mcare				94,425	216,958	221,800	220,161	229,875	115,897
Aged w/o Mcare				3,786	11,050	15,145	14,147	16,066	8,076
B/D w/Mcare				45,420	102,922	113,020	115,224	120,092	60,540
B/D w/o Mcare				69,711	170,497	174,811	170,721	173,058	87,241
Breast Cervical Cancer Treatment (BCCT)				136	417	438	379	363	183
CURRENT									
CURRENT POP									
Current-Hawaii Quest									
Demo Elig Adults	325,926	311,986	326,890	358,603	416,953	488,259	524,992	566,138	289,259
FosterCare(19-20)	456	442	594	496	538	689	407	355	179
FosterCare (up to 25)								1,188	2,376
HawaiiQuest-1902(R)(2)									
HCCP									
HealthQuest-Current									
HealthQuest-Others									
Med Needy Adults									
Med Needy Children									
MFCP									
NH w/o W									
Opt St Pl Children									
Others									
Others-Hawaii Quest									

OthersX									
QUEST ACE		1,132	22,587	70,038	115,481	135,427	150,098	183,420	99,283
RAACP									
St Pl Adults-Preg Immig/COFAs								8,431	4,375
State Plan Adults	339,848	331,334	302,135	348,185	390,404	421,978	423,855	465,275	238,902
State Plan Children	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583	1,327,965	680,154
Supp. - Private									
Supp. - State Gov.									
UCC-Governmental									
UCC-Private							2,843,567		
							236963.9167		

Department of Human Services
Med-QUEST Division
Member months

7/2012-6/2013 7/2013-12/2013

	12	13	14	15	16	17	18	19	20
	Std Renewal/Extension			*Renewal*					
1115									
1902 R 2									
1902 R 2X									
1902R2									
AFDC									
Aged w/Mcare				$1,284.73	$1,451.70	$1,581.28	$1,500.24	$1,524.08	$1,582.82
Aged w/o Mcare				$640.51	$1,588.70	$1,643.85	$1,347.30	$1,334.81	$1,358.32
B/D w/Mcare				$700.04	$727.25	$718.89	$674.26	$664.62	$689.31
B/D w/o Mcare				$1,169.33	$1,242.26	$1,423.07	$1,474.57	$1,555.90	$1,629.44
Breast Cervical Cancer Treatment (BCCT)					$9.71	$1,244.74	$1,937.17	$2,194.79	$2,340.83
CURRENT									
CURRENT POP									
Current-Hawaii Quest									
Demo Elig Adults	$392.68	$414.95	$473.08	$494.69	$483.58	$487.48	$467.32	$460.88	$481.44
FosterCare(19-20)			$154.04	$168.08	$175.01	$199.18	$191.02	$207.60	$224.64
FosterCare (up to 25)								$170.95	$85.47
HawaiiQuest-1902(R)(2)									
HCCP									
HealthQuest-Current									
HealthQuest-Others									
Med Needy Adults									
Med Needy Children									
MFCP									
NH w/o W									
Opt St Pl Children									
Others									
Others-Hawaii Quest									

OthersX									
QUEST ACE	$0.00	$705.55	$252.18	$204.93	$206.72	$224.73	$192.43	$233.14	$245.84
RAACP									
St Pl Adults-Preg Immig/COFAs								$475.31	$503.18
State Plan Adults	$329.51	$356.20	$360.88	$368.27	$338.59	$293.35	$280.68	$315.34	$327.98
State Plan Children	$192.78	$193.16	$174.38	$172.44	$185.06	$181.18	$162.75	$181.77	$188.56
Supp. - Private									
Supp. - State Gov.									
UCC-Governmental						$0.82		$0.86	
UCC-Private								$1.05	

Department of Human Services
Med-QUEST Division
FFS Claims
FY2012

	Dental Total	Catastrophic	Behavioral Health	FQHC Wrap	CAMHD	EIS	AMHD	Total FFS
Aged with Medicare	$376,664.77							$376,664.77
Aged without Medicare	$28,329.56							$28,329.56
Blind/Disabled with Medicare	$383,035.52							$383,035.52
Blind/Disabled without Medicare	$1,170,829.43							$1,170,829.43
Demo Adults	$2,810,805.45	$803,018.89	$68,584.56	$3,989,723.62				$7,672,132.52
Federal Breast & Cervical	$346.20							$346.20
FFS Base	$1,914.91							$1,914.91
Foster Care 19-20	$2,133.84			$1,037.52				$3,171.36
No Match	$7,831.36							$7,831.36
Opt St. Pl Children	$985.46							$985.46
QUEST ACE	$558,187.45		$474.68	$548,642.22				$1,107,304.35
SCHIP HI01	$6,078,032.80							$6,078,032.80
SCHIP HI02	$835,914.05							$835,914.05
St. Pl. Adults-Preg. Imm/COFA	$22,462.43			$186,625.84				$209,088.27
State	$641,442.77							$641,442.77
State Plan Adults	$1,734,197.50	$2,296,848.60	$6,927.14	$2,685,151.49			$7,531,118.00	$14,254,242.73
State Plan Children	$21,614,766.78	$6,965,386.92		$3,938,911.76	$11,858,679.00	$1,200,000.00		$45,577,744.46
	$36,267,880.28	**$10,065,254.41**	**$75,986.38**	**$11,350,092.45**	**$11,858,679.00**	**$1,200,000.00**	**$7,531,118.00**	**$78,349,010.52**

Notice of Amendment to Hawaii's Section 1115 Demonstration (11-W-00001/9) to Cover Young Adults Who Have Aged Out of Foster Care

The State of Hawaii, Department of Human Services (DHS), hereby notifies the public that it intends to seek approval from the Centers for Medicare & Medicaid Services (CMS) for an amendment to its Section 1115 demonstration to provide Medicaid coverage for certain young adults who have aged out of foster care.

The QUEST Expanded Program

Section 1115 of the Social Security Act enables States to implement experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. These demonstrations give States additional flexibility to design and improve their programs. QUEST Expanded is the current version of Hawaii's Section 1115 demonstration to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. Further detail on the program is available at http://www.med-quest.us/. CMS also offers online resources regarding the QUEST Expanded demonstration, which can be viewed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=hawaii.

The Amendment

As part of the State's ongoing efforts to ease the transition for young adults leaving foster care, the State seeks to extend Medicaid coverage to this group of individuals. The Affordable Care Act added Section 1902(a)(10)(A)(i)(IX) to the Social Security Act, which makes the former foster children covered by this amendment eligible for Medicaid effective January 1, 2014. The State would like cover these individuals effective January 1, 2013, subject to CMS approval. Specifically, the State will provide full State plan Medicaid benefits to individuals who: aged out of the foster care program; were enrolled in Medicaid while in the program; are under age 26; have household income up to 300 percent of the federal poverty level (FPL); and are not eligible or enrolled under existing Medicaid eligibility groups (or would be eligible but have income that exceeds the upper income eligibility limit for any such group).

The State expects that this amendment will provide coverage to approximately 200 additional individuals, at an approximate annual cost of $406,000. This amendment will require the State to seek additional expenditure authority, pursuant to Section 1115, to use Medicaid matching funds to cover these young adults. As of January 1, 2014, the State will no longer need that authority.

Public Input and Comments

We invite comments on this proposal. Please submit any comments or questions to Noreen Moon-Ng by mail to PO Box 700190, Kapolei, HI, 96709-0190 or by email at nmoon-ng@ medicaid.dhs.state.hi.us. Comments will be accepted for consideration for a period of thirty days following publication of this notice, from September 14, 2012 through October 14, 2012.

A copy of the proposed amendment is available at http://www.med-quest.us/ and http://hawaii.gov/dhs/. A copy is also available for public viewing from the first working day that this public notice appears in the Honolulu Star-Advertiser, Hawaii Tribune Herald, West Hawaii Today, The Maui News, and The Garden Island, for a period of thirty days after the publication of this notice, from Monday - Friday, exclusive of State holidays, between the hours of 9:00 a.m. to 2:00 p.m. at the appropriate Med-QUEST Division offices on their respective islands listed below. On Oahu, the proposed changes will be available at 601 Kamokila Boulevard, Room 518, Kapolei, Hawaii 96707, between the hours of 7:45 a.m. to 4:30 p.m., from Monday - Friday, exclusive of State holidays.

On Oahu:

Department of Human Services
Med-QUEST Division
Policy & Program Development Office
601 Kamokila Blvd., Room 518
Kapolei, Hawaii 96707-2021
Phone: 692-8058

Mailing Address:
Med-QUEST Division
Policy & Program Development Office
PO Box 700190
Kapolei, Hawaii 96709-0190

On Maui:

Med-QUEST Division
Maui Section
210 Imi Kala Street, Suite 101
Wailuku, Hawaii 96793
Phone: 243-5780

On Kauai:

Med-QUEST Division
Kauai Section
4473 Pahee Street, Suite A
Lihue, Hawaii 96766
Phone: 241-3575

On Hawaii:

Med-QUEST Division
East Hawaii Section
88 Kanoelehua Ave., Room 107
Hilo, Hawaii 96720
Phone: 933-0339

Med-QUEST Division
West Hawaii Section
Lanihau Professional Center
75-5591 Palani Road, Suite 3004
Kailua-Kona, Hawaii 96740

Phone: 327-4970

Special accommodations (*e.g.*, large print, taped materials, or accessible parking) can be made by calling 692-8132. Neighbor island residents needing special accommodations should contact the Med-QUEST Division sections on the respective islands with their requests.

The State will hold two public hearings to seek public input on this amendment:

Date:	Wednesday, September 19, 2012
Time:	9:00 a.m.
Location:	Kalanimoku State Office Building 1151 Punchbowl Street, Basement Honolulu, Hawaii

Date:	Friday, September 21, 2012
Time:	9:00 a.m.
Location:	Kakuhihewa State Office Building 601 Kamokila Blvd, Suite 577 A&B Kapolei, Hawaii

Interested parties may participate by teleconference in the September 21, 2012 meeting. Should you be interested in participating in the teleconference, please call 808-692-8139 by close of business on September 20, 2012.

If you require special assistance or auxiliary aids or services to participate in the public hearings (*e.g.*, sign or foreign language or wheelchair accessibility), please contact:

Oahu - Renee Konen (808) 692-8132
Hawaii - Calvin Unoki (808) 933-0339
Kauai - Iris Venzon (808) 241-3582
Maui - Gail Omura (808) 243-5787

at least 72 hours prior to the hearing for arrangements.

PATRICIA MCMANAMAN, DIRECTOR
DEPARTMENT OF HUMAN SERVICES

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Policy and Program Development Office
P.O. Box 700190
Kapolei, Hawaii 96709-0190

September 21, 2012

Ms. Joelene K. Lono, Executive Director
Ke Ola Mamo
Native Hawaiian
Health Care System-Oahu
1505 Dillingham Boulevard, Room 205
Honolulu, Hawaii 96817

Dear Ms. Lono:

RE: AMENDMENT TO HAWAII MEDICAID STATE PLAN

Pursuant to Section 5006(e)(2) of the American Recovery and Reinvestment Act of 2009, the Department of Human Services, Med-QUEST Division (MQD) is soliciting your expedited consultation on the proposed amendment to the Hawaii Medicaid State Plan.

The amendment proposes to ease the transition for young adults leaving foster homes through the extension of Medicaid coverage for former foster children who have aged out of foster care who are under age 26 years old; have household income up to 300 percent of the federal poverty level; were enrolled in Medicaid; and are not eligible or enrolled under existing Medicaid eligibility groups.

Please provide your written comments by October 8, 2012 to the:

Department of Human Services
Med-QUEST Division
P.O. Box 700190
Kapolei, Hawaii 96709-0190
Attn: Policy and Program Development Office

Should you have any questions or desire a meeting, please call Ms. Aileen Befitel at 692-8074 or email her at abefitel@medicaid.dhs.state.hi.us.

Thank you for your efforts, support and advocacy for the American Indian and Alaska Native communities and your continuing support of our Medicaid programs.

Sincerely,

Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

Children and Adults Health Programs Group

December 18, 2012

Ms. Patricia McManaman
Director
Hawaii Department of Human Services
P.O. Box 339
Honolulu, Hawaii 96809-0339

Dear Ms. McManaman:

This letter is to inform you that the extension request of the QUEST Expanded section 1115 demonstration (project number 11-W-00001/9) has been approved in accordance with section 1115(e) of the Social Security Act (the Act). Under this demonstration, the state will continue to provide health care coverage for families, children, and pregnant women eligible under the state plan. The extended demonstration will also continue to provide health care coverage to adults age 19 or older with incomes up to 133 percent of the Federal poverty level (FPL), as well as institutional and home and community-based long-term-care services to aged, blind, or disabled individuals eligible under the Medicaid state plan and the demonstration. Your section 1115(e) demonstration is authorized through December 31, 2013, upon which date, unless reauthorized, all waiver and expenditure authorities granted to operate this demonstration will expire.

The state requested this extension under section 1115(e) of the Act. An 1115(e) extension requires action by CMS within 6 months and does not permit any changes to be made to the demonstration, other than minor technical changes and updates to the budget neutrality agreement in order to reflect new trend rates. Because the extension only allows 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 in order to permit the state to mandate managed care, and updates to reflect revised budget neutrality trend rates.

Our approval of this demonstration project is subject to the limitations specified in the enclosed waiver and expenditure authorities. The state may deviate from Medicaid state plan requirements to the extent those requirements have been specifically waived or, with respect to expenditure authorities, listed as not applicable to expenditures for demonstration expansion populations and other services not covered under the state plan.

The approval is also conditioned upon compliance with the enclosed Special Terms and Conditions (STCs), defining the nature, character, and extent of anticipated Federal involvement in the project. All previously granted waiver and expenditure authorities are superseded by this approval, the enclosed STCs, and waiver and expenditure authority lists.

The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs, waiver and expenditure authorities within 30 days of the date of this letter.

As this approval extends your demonstration through December 31, 2013, we also wanted to clarify the timeframes in which the state may submit a request to extend its demonstration. We will consider an initial extension request that simply indicates the state's interest in extending the demonstration to fulfill the requirement for submission 12 months in advance of the demonstration's expiration. This request must be submitted in time to meet the December 31, 2012 submission deadline. As we explain below, that initial extension request can then be supplemented or supplanted by a revised extension request that includes all the required information for a complete extension request. This process will allow more time for the state to consider its options and engage in preliminary discussions with CMS as well as to hold preliminary discussions with CMS regarding any extension requests

The initial extension request need not include all of the elements outlined in section 431.412(c) of the transparency regulation in order for the request to fulfill the advance submission requirement. The submission of a subsequent revised extension request that identifies the specific authorities the state seeks to extend along with the elements outlined in section 431.412(c), including a completed state-level public notice process, will be considered to supplant the original request without affecting compliance with the advance submission requirement. CMS will consider the application complete and further process the extension request, however, once your state has conducted the required public notice and consultation process and submitted a revised request reflecting those activities.

In order to give CMS and the state sufficient time for review and consideration of the demonstration extension, as well as an opportunity for the federal comment period, we ask for submission of all revised extension requests completing or supplanting the initial submission no later than June 30, 2013. You are welcome to submit your complete extension request at any earlier point if you are ready to do so.

Your project officer is Ms. Alexis E. Gibson. She is available to answer any questions concerning your section 1115 demonstration. Ms. Gibson's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard, Mail Stop S2-02-26
Baltimore, MD 21244-1850
Telephone: (410) 786-2813
Facsimile: (410) 786-8534
E-mail: alexis.gibson@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Gibson and to Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Division of Medicaid and Children Health Operations Program
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103
(415) 744-3568
(415) 744-2933 (fax)
E-mail: gloria.nagle@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Victoria Wachino, CMCS
Gloria Nagle, Associate Regional Administrator, Region IX
Alexis E. Gibson, CMCS

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00001/9**

TITLE: **QUEST Expanded Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration extension be regarded as expenditures under the State's title XIX plan but are further limited by the Special Terms and Conditions for the QUEST Expanded (QEx) Section 1115 Demonstration.

For enrollees in All Components of the Demonstration:

1. **Managed Care Payments.** Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m):

   Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.

   Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and Federal regulations at 42 CFR section 438.52, to the extent necessary if a plan exceeds its enrollment cap.

2. **Quality Review of Eligibility.** Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

3. **Demonstration Eligibility.** Expenditures to provide coverage to the following populations:

a) **Demonstration Eligibles Enrolled in QEx Eligibility Components other than Quest Expanded Access (QExA).**

i. TANF cash recipients, whose income is up to 100 percent FPL (using the TANF methodology), but are not otherwise eligible under the Medicaid State plan or enrolled in QUEST;

ii. Adults who have lost QUEST or Medicaid Fee-for-Service eligibility because they have income or assets in excess of the Medicaid limits (QUEST-Net Adults):

1. Effective through June 30, 2012: With income up to 200 percent of the FPL or, for individuals continuously enrolled since January 1, 2008, incomes up to 300 percent FPL;
2. Effective July 1, 2012 through December 31, 2013: With income up to 133 percent of the FPL; and

iii. Adults with incomes or assets in excess of the Medicaid limits, but who are not otherwise Medicaid eligible (QUEST-ACE):

1. Effective through June 30, 2012: With income up to 200 percent of the FPL;
2. Effective July 1, 2012 through December 31, 2013: With income up to 133 percent of the FPL.

b) **Demonstration Eligibles Enrolled in the QExA eligibility component.**

i. Persons who would be eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR section 435.217 if the home and community-based services that they are receiving from a QExA plan were provided under a waiver that was granted to the State under section 1915(c) as of the initial approval date of the QExA component of this demonstration. This includes the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

ii. Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

iii. Individuals who would otherwise be eligible under the State plan or another QExA demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of

the QExA capitation payment, subject to an enrollment fee equal to the spend-down liability.

4. **Hospital Uncompensated Care Costs.** Expenditures to reimburse certain hospital providers for provider costs of hospital services to the uninsured, and or underinsured, subject to the restrictions placed on hospital uncompensated care costs, as defined in the STCs.

5. **QExA Home and Community-Based Services (HCBS) and Personal Care Services**. Expenditures to provide HCBS and personal care services not included in the Medicaid State plan and furnished to QExA enrollees, as follows:

   a) Expenditures for the continued provision of services provided to individuals enrolled during the transition from fee-for-service to QExA in the State's Nursing Home Without Walls (NHWW), Residential Alternatives Community Care Program (RAACP), Medically Fragile Community Care Program (MFCCP) and HIV Community Care Program (HCCP) HCBS waiver programs as fee-for-service expenditures for the period beginning with the effective date of these authorities until QExA plan coverage (under the authority of subparagraphs b and c below) is operational;

   b) Expenditures for the provision of services, through QExA plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

   c) Expenditures for the provision of personal care services, through QExA plans, to individuals with less than a need for an institutional level of care, including personal care assistance services provided by a family member.

6. **Additional Primary and Acute Care Services for the Aged, Blind, and Disabled Population.** Expenditures to provide the following additional Primary and Acute Care Services for all individuals eligible for Medicaid or QExA who are aged, blind, or disabled when medically necessary. These services are detailed in STC 27(b)(i)

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration beginning February 1, 2008, through December 31, 2013, except those waived or listed below as not applicable.

<u>Title XIX Requirements Not Applicable to Demonstration Populations</u>

Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable the State to maintain a waiting list, through a QExA plan, for home and community-based services and personal care services. No waiting list is permissible for

other services for QExA enrollees.

Cost Sharing **Section 1902(a)(14) and1916**

To the extent necessary to enable the State to impose cost-sharing that is above the limits that would apply under the State Plan. A qualifying Hawaii Prepaid Health Care Act employer must limit the employee's premium costs to no more than 1.5 percent of the employee's salary for employer sponsored insurance coverage. Co-payments and other cost-sharing will be consistent with the enrollee's specific health plan.

Cost Sharing **Section 1902(a)(14)**

To enable the State to charge cost sharing up to 5 percent of annual family income.

To enable the State to charge an enrollment fee to QExA enrollees whose spend-down liability or cost share obligation is estimated to exceed the QExA capitation rate (Demonstration Population 3.b.iii.), in the amount equal to the estimated spend-down or cost share amount.

Expenditures for MCO Contracts **Section 1903(m)(2)(A)(vi)**

To enable the State to restrict an enrollees' right to disenroll without cause within 90 days of enrollment in a new MCO.

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

Attachment B
Quarterly Report Format

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.

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.

Attachment B
Quarterly Report Format

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.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SHO # 09-001

February 6, 2009

Dear State Health Official:

On February 4, 2009, President Barack Obama signed Public Law 111-3, The Children's Health Insurance Program Reauthorization Act of 2009, and issued a Presidential Memorandum directing the Secretary of Health and Human Services to withdraw the August 17, 2007, and May 07, 2008, letters issued to State Health Officials. Therefore, the Centers for Medicare & Medicaid Services is withdrawing these letters and will no longer apply the policies in those letters when reviewing Children's Health Insurance Program State plan amendments or section 1115 demonstration waivers.

If you have any questions regarding this letter, please contact Ms. Dianne Heffron, Acting Director, Family and Children's Health Programs, who may be reached at (410) 786-3247.

Sincerely,

/s/

Jackie Garner
Acting Director, Center for Medicaid and State Operations

cc:

CMS Regional Administrators

CMS Associate Regional Administrators,
Division of Medicaid and Children's Health

Ann C. Kohler
NASMD Executive Director
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Debra Miller
Directory for Health Policy
Council of State Governments

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Council

Barbara W. Levine
Chief, Government Relations and Legal Affairs
Association of State and Territorial Health Officials

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

January 15, 2013

Ms. Patricia McManaman
Director
Hawaii Department of Human Services
P.O. Box 339
Honolulu, Hawaii 96809-0339

Dear Ms. McManaman:

Thank you for your recent request to extend the state's QUEST Expanded section 1115 demonstration (project number 11-W-00001/9). The Centers for Medicare & Medicaid Services (CMS) received your extension request on December 28, 2012. We have completed a preliminary review of the extension request, and have determined that the state's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's extension request. The 30-day federal comment period, as required under 42 CFR 431.416(b), begins on Wednesday, January 16, 2013, and ends on Friday, February 15, 2013. The state's extension request is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=1115#waivers.

We look forward to working with you and your staff to extend the state's demonstration. If you have additional questions or concerns, please contact Jessica Schubel, Technical Director, Division of State Demonstrations and Waivers, at (410) 786-3032, or at Jessica.Schubel@cms.hhs.gov.

Sincerely,

/s/

Angela D. Garner
Acting Director
Division of State Demonstrations and Waivers

cc: Jennifer Ryan, CMCS
Gloria Nagle, ARA, CMS San Francisco Regional Office

EXECUTIVE CHAMBERS

HONOLULU

NEIL ABERCROMBIE
GOVERNOR

June 29, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

RE: QUEST Expanded Section 1115 Demonstration (11-W-00001/9) Extension Application

Enclosed is the State of Hawaii's application for an extension of the QUEST Expanded Section 1115 Demonstration. Hawaii seeks a three-year extension of the Demonstration, under the same terms and conditions as the current waiver and any pending amendments. The State requests this extension under Section 1115(e) of the Social Security Act.

Hawaii recognizes that it will need to amend the Demonstration to reflect the new requirements in the Affordable Care Act that take effect January 1, 2014. The State plans to develop, in the fall of 2012, a separate proposed demonstration amendment to address those requirements, and will offer a separate notice and opportunity for public comment on that proposal.

Should you have any questions about this application, please feel free to contact me, or Dr. Kenneth S. Fink, Administrator of the Med-QUEST Division at (808) 692-8050 or KFink@medicaid.dhs.state.hi.us.

Thank you for your prompt consideration of this application.

Sincerely,

/Neil Abercrombie/

NEIL ABERCROMBIE
Governor, State of Hawaii

Enclosure
c: Marilyn Tavenner, Acting Administrator, Centers for Medicare and Medicaid Services
Cindy Mann, Director, Center for Medicaid and CHIP Services

STATE OF HAWAII
"QUEST EXPANDED" SECTION 1115 DEMONSTRATION
(11-W-00001/9)

SECTION 1115(e) EXTENSION APPLICATION
June 29, 2012

Pursuant to Section 1115(e) of the Social Security Act, the State of Hawaii, Department of Human Services (DHS), is seeking a three-year extension of the QUEST Expanded Section 1115 demonstration project (the Demonstration) from the Centers for Medicare & Medicaid Services (CMS). Absent an extension, the Demonstration will expire on June 30, 2013.

I. Historical Narrative Summary of the QUEST Expanded Program

Originally implemented as the QUEST program in 1994, QUEST Expanded is the current version of Hawaii's demonstration project to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. The 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 Medical Assistance Program and its State Children's Health Insurance Program. Low-income women, 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 contributed substantially to closing the coverage gap in the State for low-income individuals.

QUEST includes three primary programs: QUEST, QUEST-Net, and QUEST-ACE. In 2009, the State added QUEST Expanded Access (QExA) for Medicaid clients who are 65 years or older or disabled of all ages, who were previously receiving services through a fee-for-service (FFS) system. Together, the four components are known as QUEST Expanded.

The goals of QUEST Expanded are to:

- Improve the health care status of the member population;
- Maintain a managed care delivery system that assures access to high quality, cost-effective care;
- Establish a "provider home" for members through the use of assigned primary care providers (PCPs);
- Establish contractual accountability among the state health plans and health care providers;
- Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility that leads to more appropriate utilization of the health care system.

For the Aged, Blind and Disabled (ABD) population, the goals of the QExA program are to:

- Maintain a managed care delivery system for the ABD population that assures access to high quality, cost-effective care;
- Coordinate care for the ABD population across the care continuum (from primary care through long-term care);
- Expand access to home- and community-based (HCBS) services, and allow beneficiaries meeting the institutional level of care to have a choice between institutional services and HCBS.

Since its implementation, the State has made several changes to the current QUEST Expanded program.

1) The first amendment, approved July 11, 1995, allowed the State to deem parental income for tax dependents up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing for expansion populations, impose a premium for self-employed individuals, and change the FFS window from the date of coverage to the date of enrollment.

2) The second amendment, approved on September 14, 1995, allowed the State to cap QUEST enrollment at 125,000 expansion eligibles.

3) The third amendment, approved on May 10, 1996, allowed the State to reinstate the asset test, establish the QUEST-Net program, and require participants to pay a premium.

4) The fourth amendment, approved on March 14, 1997, lowered the income thresholds to the mandatory coverage groups and allowed the State to implement its medically needy option for the AFDC-related coverage groups for individuals who become ineligible for QUEST and QUEST-Net.

5) The fifth amendment, approved on July 29, 2001, allowed the State to expand the QUEST-Net program to children who were previously enrolled in SCHIP when their family income exceeds the Title XXI income eligibility limit of 200% FPL.

6) In January 2006 (with a retroactive start date of July 1, 2005), the federal government approved an extension of the Section 1115 waiver for Hawaii QUEST programs, which incorporated the existing QUEST program with some significant changes including:

   - Extension of coverage to all Medicaid-eligible children in the child welfare system;
   - Extension of coverage to adults up to 100% of the FPL who meet Medicaid asset limits through QUEST-ACE;
   - Elimination of premium contributions for children with income at or below 250% of the FPL;
   - Elimination of the requirement that children have prior QUEST coverage as a condition to qualifying for QUEST-Net; and

- Increased SCHIP eligibility from 200% of the FPL to 300% of the FPL.

7) In February 2008, the waiver was amended to implement the QExA program and to increase the eligibility level for QUEST-ACE from 100% to 200% of the FPL.

8) In April 2012, CMS approved the State's request to cap eligibility for non-pregnant, non-disabled adults not otherwise Medicaid eligible at 133% of the FPL.

9) In June 2012, CMS approved an amendment to align the QUEST-Net and QUEST-ACE benefits with the QUEST benefit package, and to add certain benefits to the QExA benefit package.

II. Description of the QUEST Expanded Demonstration

Delivery System

The State seeks an extension of the Demonstration in order to continue to provide most benefits through capitated managed care programs. The State will continue to use a FFS system for long-term care services for individuals with developmental disabilities, applicants eligible for retroactive coverage only, and medical services under the State of Hawaii Organ and Tissue Transplant (SHOTT) program, as well as for certain other benefits.

Eligibility Requirements

QUEST. The QUEST program provides Medicaid State plan benefits through comprehensive managed care plans to the following children and adults:

- Families with dependent children covered by the State plan up to 300% of the FPL for children and 100% for adults;
- Pregnant women with a family income not exceeding 185% of the FPL;
- Adults who are Temporary Assistance for Needy Families (TANF) cash recipients but are otherwise not eligible for Medicaid;
- Low-income adults covered under Section 1931 of the Social Security Act;
- Individuals qualifying for transitional medical assistance under Section 1925 of the Social Security Act;
- Participants in the State General Assistance Program; and
- Childless adults with income up to 100% of the FPL, subject to an enrollment cap.

QUEST-Net. Pursuant to the amendment approved in June 2012 (June 2012 Amendment), QUEST-Net will provide State plan benefits to adults with income up to 133% of the FPL who were previously enrolled in QUEST, QExA or Medicaid Fee-For-Service but who have income in excess of the Medicaid limits or assets exceeding QUEST limits. QUEST-Net currently provides State plan benefits to children between 200% and 300% of the FPL, but under the June 2012 Amendment all of these children will be moved to the QUEST program, as staffing resources permit.

QUEST-ACE. The QUEST-ACE program provides the same asset limits and benefits as QUEST-Net—which under the June 2012 Amendment will be State plan benefits—for the childless adult applicants with income up to 133% OF THE FPL.

QExA. QExA provides State plan benefits, plus long-term care services, including nursing facility and HCBS, for the following individuals:

- ABD individuals who meet the SSI standards.
- Individuals with breast or cervical cancer with income at or below 250% of the FPL.
- Aged or disabled adults whose SSI-related net income is at or below 100% of the FPL.
- Medically needy aged, blind, or disabled individuals who meet the medically needy household income standard using SSI income methodology.
- Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules.
- Individuals who would otherwise be eligible under the State plan or another QExA demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of the QExA capitation payment, subject to an enrollment fee equal to the spend-down liability.

Eligibility for all four programs will continue as described above, until January 1, 2014, when the Medicaid changes enacted in the Affordable Care Act (ACA) take effect. In this extension application, the State is not currently proposing any amendments related to the January 1, 2014 changes. That will be done by separate amendment, subject to a separate notice and comment process.

Benefit Coverage

Prior to implementation of the June 2012 Amendment, the Demonstration offered three benefit packages:

1) Full Medicaid State plan benefits for QUEST children and adults and for QUEST-Net children.
2) The QExA benefit package through which ABD individuals may receive State plan primary, acute, and long-term (*i.e.*, nursing facility) care services in addition to the waiver HCBS.
3) A limited benefit plan for adults in QUEST-Net and QUEST-ACE, which includes: emergency visits; 10 inpatient hospital days (no benefit for maternity, nursery, rehabilitation, or skilled nursing level of care); 12 outpatient medical visits; 6 mental health outpatient visits; 3 ambulatory surgery procedures; diagnostic tests associated with the outpatient medical visits; certain immunizations; family planning services; limited prescription drugs; language interpretation services; and preventive and restorative dental.

Under the June 2012 Amendment, the Demonstration will now offer two benefit packages:

1) Full Medicaid State plan benefits for QUEST, QUEST-Net, and QUEST-ACE beneficiaries.
2) The QExA benefit package through which aged, blind, and disabled individuals may receive State plan primary, acute, and long-term care services in addition to the waiver HCBS. The QExA benefit package will include primary and acute care beyond that which is offered in the State plan, including inpatient services without limitation, optometry services (glasses and contact lenses), prosthetic devices, hospice services for children without limitation, and rehabilitation services.

Cost Sharing
The State will continue to allow copayments as set forth in the Medicaid State plan, and will continue to have the authority to charge up to 5% in annual family income for cost sharing. Additionally, medically-needy individuals with a spend-down will be required to pay 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.

III. Recently Approved Amendments Included in the Extension Application

Hawaii requests an extension of the Demonstration under the same terms and conditions as the current waiver, including the amendments approved in the June 2012 Amendment. DHS is aware that it will need to amend the Demonstration to reflect new requirements in ACA that take effect January 1, 2014, and it plans to submit a separate proposed amendment, with a separate notice and opportunity for comment, to do so.

The recently-approved amendments include the following:

- Align benefits for non-ABD adults. Currently, the Demonstration offers three different benefit packages: QUEST (State plan benefits); QExA (State plan benefits plus additional long-term care services); and QUEST-ACE/QUEST-Net benefits (less comprehensive benefits package). The June 2012 Amendment changes the QUEST-ACE/QUEST-NET benefit package to mirror State plan benefits. These changes will facilitate preparation for expansion under ACA and a future program merger.

- Consolidate all non-categorically needy recipient adults—*i.e.*, non-pregnant childless adults age 19 and older—under QUEST-Net or, for applicants, QUEST-ACE. The consolidation of all non-Medicaid eligibles, who will eventually be the new ACA mandatory group, under QUEST-ACE/QUEST-Net promotes efficiency and streamlines operations without any negative impact on recipients. This will distinguish the QUEST program as the program that serves the categorically needy populations, thereby effectively eliminating the need for the QUEST enrollment cap.

- Consolidate all eligible CHIP children under QUEST, or QExA for those who are blind or disabled. Currently, CHIP children with income up to and including 200% of the FPL are placed in QUEST, or QExA if they are blind or disabled, and those with income

above 200% of the FPL but not exceeding 300% of the FPL are placed in QUEST-Net. Despite enrollment in different programs, all children below 19 years of age receive identical benefits. Consolidating CHIP children under one program is more efficient with no negative impact on recipients.

- Allow retroactive enrollment in QUEST, QUEST-Net, and QUEST-ACE health plans as already exists in QExA plans.

- Expand QExA benefits. The QExA benefit package currently includes State plan primary and acute care. Pursuant to the June 2012 Amendment, QExA plans will include primary and acute care beyond that which is offered in the State plan. These expanded services will include inpatient services without limitation, optometry services (glasses and contact lenses), prosthetic devices, hospice services for children without limitation, and rehabilitation services.

- Enroll medically needy individuals who are expected to prospectively incur expenses from the date of eligibility sufficient to satisfy their spend-down obligation in a QExA plan.

- Make the QUEST-ACE assets limit the same as the assets limit in QUEST-Net.

- Repeal the Hawaii Premium Plus Program due to absence of legislative appropriation.

- Allow uncompensated cost of care (UCC) payments to be made to nursing facilities.

- Make technical changes, as detailed in the State's amendment application.

IV. Waivers and Expenditure Authorities

The State requests the same waiver and expenditure authorities as those approved in the current demonstration, as recently amended. This waiver and expenditure authority is described below.

Waiver Authority

1. Medically Needy Section - 1902(a)(10)(C); Section 1902(a)(17)

To enable the State to limit medically needy spend-down eligibility **except for** those enrolled in QExA to those individuals whose gross incomes, before any spend-down calculation, are at or below 300% of the FPL. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which have no gross income limit.

2. Amount, Duration, and Scope - Section 1902(a)(10)(B)

To enable the State to offer demonstration benefits that may not be available to all categorically eligible or other individuals.

3. Financial Responsibility/Deeming - Section 1902(a)(17)(D)

To allow the State to determine eligibility for QUEST, and QUEST-Net children using the income of household members whose income may be taken into account under the income rules of the related cash assistance program. If the household income exceeds the program's limits, the State shall determine eligibility using standard Medicaid financial responsibility and deeming rules.

4. Three-Month Retroactive Eligibility - Section 1902(a)(34)

To enable the State to limit retroactive eligibility to a five (5) day period prior to application, or up to three months for individuals requesting long-term care services.

5. Freedom of Choice Section 1902(a)(23)

To enable Hawaii to restrict the freedom of choice of providers to groups that could not otherwise be mandated into managed care under Section 1932.

Expenditure Authority

1. Managed Care Payments.

Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of Section 1903(m):

Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under Section 1903(m)(2)(A)(vi) and Section 1932(a)(4)(A)(ii)(l). Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at Section 1932(a)(4)(A)(ii)(II), except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.

Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under Section 1903(m)(2)(A)(xii), Section 1932(a)(3) and Federal regulations at 42 C.F.R. § 438.52, to the extent necessary if a plan exceeds its enrollment cap.

2. Quality Review of Eligibility.

Expenditures for Medicaid services that would have been disallowed under Section 1903(u) based on Medicaid Eligibility Quality Control findings.

3. Demonstration Eligibility. Expenditures to provide coverage to the following populations:

    a. Demonstration Eligibles Enrolled in QEx Eligibility Components other than QExA.
        i. TANF cash recipients, whose income is up to 100% of the FPL (using the TANF methodology), but are not otherwise eligible under the Medicaid State plan or enrolled in QUEST;
        ii. Adults, including General Assistance (GA) cash recipients, whose income is up to 100% of the FPL (using the GA methodology), but are not otherwise eligible under the Medicaid State plan or enrolled in QUEST, subject to an enrollment cap;
        iii. Adults who have lost QUEST or Medicaid Fee-for-Service eligibility because they have income or assets in excess of the Medicaid limits (QUEST-Net Adults):
            1. Effective through June 30, 2012: With income up to 200% of the FPL or, for individuals continuously enrolled since January 1, 2008, incomes up to 300% of the FPL;
            2. Effective July 1, 2012 through June 30, 2013: With income up to 133% of the FPL; and
        iv. Adults with incomes or assets in excess of the Medicaid limits, but who are not otherwise Medicaid eligible (QUEST-ACE):
            1. Effective through June 30, 2012: With income up to 200% of the FPL;
            2. Effective July 1 through June 30, 2013: With income up to 133% of the FPL.

    b. Demonstration Eligibles Enrolled in the QExA eligibility component.
        i. Persons who would be eligible under Section 1902(a)(10)(A)(ii)(VI) of the Act and 42 C.F.R. § 435.217 if the HCBS that they are receiving from a QExA plan were provided under a waiver that was granted to the State under Section 1915(c) as of the initial approval date of the QExA component of this demonstration. This includes the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.
        ii. Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited

to those consistent with the regular post eligibility rules and spousal impoverishment rules.

iii. Individuals who would otherwise be eligible under the State plan or another QExA demonstration population only upon incurring medical expenses (spend-down liability) that are estimated to exceed the amount of the QExA capitation payment, subject to an enrollment fee equal to the spend-down liability.

4. Hospital Uncompensated Care Costs.

Expenditures to reimburse certain hospital providers for provider costs of hospital services to the uninsured, and/or underinsured, subject to the restrictions placed on hospital uncompensated care costs, as defined in the STCs.

5. QExA Home- and Community-Based Services (HCBS) and Personal Care Services.

Expenditures to provide HCBS and personal care services not included in the Medicaid State plan and furnished to QExA enrollees, as follows:

a. Expenditures for the continued provision of services provided to individuals enrolled during the transition from fee-for-service to QExA in the State's Nursing Home Without Walls (NHWW), Residential Alternatives Community Care Program (RAACP), Medically Fragile Community Care Program (MFCCP) and HIV Community Care Program (HCCP) HCBS waiver programs as fee-for-service expenditures for the period beginning with the effective date of these authorities until QExA plan coverage (under the authority of subparagraphs band c below) is operational;
b. Expenditures for the provision of services, through QExA plans, that could be provided under the authority of Section 1915(c) waivers, to individuals who meet an institutional level of care requirement;
c. Expenditures for the provision of personal care services, through QExA plans, to individuals with less than a need for an institutional level of care, including personal care assistance services provided by a family member.

6. Hawaii Premium Plus (HPP) Subsidy Program.

Expenditures to provide of a premium subsidy to eligible HPP employers, as defined within the May 1, 2010 amended special terms and conditions, Section XI, in the provision of employer sponsored health insurance (ESI) coverage.

Title XIX Requirements Not Applicable to Demonstration Populations

1. Amount, Duration, and Scope - Section 1902(a)(10)(B)

To enable the State to modify the Medicaid benefit package to provide a more limited package to eligible QUEST-Net Adult and QUEST ACE beneficiaries.

To enable the State to maintain a waiting list, through a QExA plan, for HCBS and personal care services. No waiting list is permissible for other services for QExA enrollees.

2. Cost Sharing - Section 1902(a)(14) and 1916

To the extent necessary to enable the State to impose cost-sharing that is above the limits that would apply under the State Plan. A qualifying Hawaii Prepaid Health Care Act employer must limit the employee's premium costs to no more than 1.5 percent of the employee's salary for employer sponsored insurance coverage. Co-payments and other cost-sharing will be consistent with the enrollee's specific health plan.

3. Cost Sharing - Section 1902(a)(14)

To enable the State to charge cost sharing up to 5% of annual family income.

To enable the State to charge an enrollment fee to QExA enrollees whose spend-down liability or cost share obligation is estimated to exceed the QExA capitation rate (Demonstration Population 3.b.iii.), in the amount equal to the estimated spend-down or cost share amount.

4. Expenditures for MCO Contracts - Section 1903(m)(2)(A)(vi)

To enable the State to restrict an enrollees' right to disenroll without cause within 90 days of enrollment in a new MCO.

V. Summaries of EQRO Reports, MCO and State Quality Assurance Monitoring, and Other Information About the Quality of and Access to Care Provided Under the Demonstration

DHS hired the Health Services Advisory Group, Inc. (HSAG) as its external quality review organization (EQRO) to monitor the Demonstration's managed care health plans. The 2011 External Quality Review Report of Results for the QUEST and QExA Health Plans (hereafter "2011 EQR Report"), which provides more detail about the EQRO's activities, is available at http://www.med-quest.us/PDFs/Consumer%20Guides/2011%20External%20Quality%20Review%20Report.pdf

In 2011, HSAG performed the three federally mandated activities set forth in 42 C.F.R. § 438.358: a review and evaluation of compliance with the federal managed care standards and associated State contract requirements; validation of performance measures/Healthcare Effectiveness Data and Information Set (HEDIS®) compliance audits; and validation of performance improvement projects. HSAG also performed two optional external quality review activities: a survey of child members (*i.e.*, parents/caregivers) using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and a survey of health care providers (primary care providers and specialists) contracted with QUEST Expanded health plans. The chart below summarizes these external quality review activities:

External Quality Review Activity	Description	Findings, Conclusions, and/or Recommendations
Review and Evaluation of Compliance with Federal Managed Care Standards and State Contract Requirements	HSAG developed a monitoring tool to document pertinent findings and calculate performance scores in five areas or standards—delegation, member information, grievance system, provider selection, and credentialing—related to the health plans' structure and operations, as described in the managed care regulations at 42 C.F.R. §§ 438.214-230. This review included approximately half of the managed care regulations and associated State standards to be reviewed within a three-year period, as the other half had been reviewed in 2010.	The plans received individual scores for each of the five areas reviewed for compliance. These scores can be viewed in the 2011 EQR Report linked to above. Two areas of strong health plan performance statewide emerged: member information and provider selection. Following issuance of the final reports, the health plans were required by the Med-QUEST Division to submit corrective action plans for any standards scored "Partially Met" or "Not Met". HSAG collaborated with the Med-QUEST Division to review and approve the health plans' corrective action plans. The results of the corrective activity and reevaluation of compliance will be reported in next year's EQR Report.
Validation of Performance Measures/HEDIS®	HSAG performed independent audits of the HEDIS data. Each HEDIS Compliance Audit incorporated a detailed assessment of the health plans' information systems capabilities for collecting, analyzing, and reporting HEDIS information. During the HEDIS audits, HSAG reviewed the performance of the health plans on six State-selected HEDIS performance measures: Childhood Immunization Status, Comprehensive Diabetes Care, Ambulatory Care, Cholesterol Management for Patients With Cardiovascular Conditions, Breast Cancer Screening, and Chlamydia Screening in Women.	All plans were compliant with the National Committee for Quality Assurance's (NCQA) information systems standards. Plans varied in how they compared to the national Medicaid HEDIS 2010 averages. Those comparisons can be viewed in the 2011 EQR Report linked to above. Recommendations varied across the indicators. HSAG recommended that each plan target the lower-performing measures for improvement.

Validation of Performance Improvement Projects	The QUEST plans were required to conduct performance improvement projects on "Access to Care" and "Assessing the Documentation of Body Mass Index or Height and Weight Using the EPSDT Form." The QExA plans were required to conduct one project on improving the results of a HEDIS measure, and a second on a topic of the plan's choice, approved by the Med-QUEST Division. Both QExA plans conducted performance improvement projects related to the HEDIS measure on diabetes care. For their second project, both QExA plans focused on an aspect of obesity care.	HSAG validated each plan's performance improvement project by following standardized validation procedures to assess the degree to which the projects were designed, conducted, and reported in a methodologically sound manner. Following the review and validation of the plans' 2011 projects, HSAG arrived at a handful of specific conclusions, which can be viewed in the 2011 EQR Report linked to above. All plans' projects achieved a "Met" validation status, with one exception. The health plans received various recommendations.
CAHPS®	The CAHPS health plan surveys are standardized survey instruments that measure members' satisfaction levels with their health care. For 2011, HSAG administered a CAHPS survey for plan enrollees under 18 years of age.	The results of nine measures of satisfaction were reported. These measures included four global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and five composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making). The QUEST plans' aggregate score was above the NCQA national child Medicaid average on five measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, How Well Doctors Communicate, and Shared Decision Making. The QExA plan aggregate score was above the NCQA national child Medicaid average on one measure: Shared Decision Making. More details about the CAHPS findings can be found in the 2011 EQR Report linked to above.
Provider Survey	HSAG administered a survey to health care providers serving Demonstration enrollees. The goal of the provider survey was to supply feedback as it relates to providers' perceptions of the Demonstration health plans and the QUEST Expanded program. The survey covered topics for primary care and specialty providers, including the impact of the plans' utilization management on the providers' abilities to provide quality care, satisfaction with reimbursement, and adequacy of the formulary.	The provider survey revealed that there was an opportunity to improve provider satisfaction with the Demonstration plans, and HSAG provided recommendations for improving provider satisfaction within the domains evaluated. Recommendations for the Med-QUEST Division related to the survey results were also offered. More details about the survey's results can be found in the 2011 EQR Report linked to above.

In addition to the EQRO activities, in 2010, the Med-QUEST Division finalized a new Quality Strategy in compliance with 42 C.F.R. § 438.202. The Quality Strategy was developed in part by following the CMS toolkit and checklist for State Quality Strategies, and by using the CMS-approved Delaware Quality Strategy as a template. A copy of the Quality Strategy is available at http://www.med-quest.us/ManagedCare/qualitystrategy.html.

Under the Quality Strategy, the Health Care Services Branch in the Med-Quest Division receives and reviews all monitoring and quality reports from the MCOs, the DD/ID waiver, the SHOTT program, and the EQRO. Findings from the reports are presented to various Quality Strategy Committees on a monthly rotation. The Committees are composed of representatives from the Quality Strategy Leadership Team, technical experts from the programs being reviewed, and Health Care Services Branch reviewers. The Committee meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The Committees recommend feedback to the MCOs and programs, and corrective action is requested if needed.

The Med-QUEST Division also began implementing CMS's Quality Framework for HCBS in state fiscal year 2011. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. The State will use this template for HCBS monitoring.

Like all States, Hawaii compiles data for the CMS-Form 416, Annual EPSDT Participation Report. Form 416 includes, among other things, the number of individuals eligible for EPSDT, the number receiving screening, the number referred for medical treatment, and the number provided dental services. Hawaii's 2011 Form 416 shows a screening ratio of .98, and a participation ratio of .78. The Form 416 from 2010 and from 2011 are included as Attachment A.

VI. Waiver-Related Financial Data

In the last full demonstration year, July 1, 2010 to June 30, 2011, state and federal expenditures totaled approximately $1.35 billion. During the requested extension period, aggregate expenditures for each year are anticipated to total approximately $1.42 billion (DY 20), $1.50 billion (DY 21), and $1.60 billion (DY 22), with a federal share of $717 million (DY 20), $762 million (DY 21), and $810 million (DY 22). Neither these figures nor the State's budget neutrality analysis referenced below account for the changes to the Demonstration that will be required by ACA starting on January 1, 2014. When the State submits its separate proposed amendment to address those requirements, it will also include financial data and projections, and a budget neutrality analysis, to account for the ACA-mandated changes.

The State's budget neutrality calculations are included as Attachment B, and include detailed data about the Demonstration's historic, cumulative, and projected expenditures. No changes are being requested to the State's current demonstration.

VII. Evaluation Report of the QUEST Expanded Waiver

Hawaii is testing the following research hypotheses through the current Demonstration:

1) The Demonstration will improve health outcomes and reduce inappropriate utilization.

2) The Demonstration will improve the overall health of Hawaii's most vulnerable citizens under a coordinated care management environment.

3) The Demonstration will decrease the percentage of uninsured individuals in the State.

4) The Demonstration will expand access to HCBS.

The Med-QUEST Division (MQD), Health Care Services Branch (HCSB) is in the process of developing its Demonstration Evaluation for the current 1115(a) waiver. The previous evaluation was submitted in April 2007 prior to renewal of the current waiver on February 1, 2008. In completing the previous evaluation, MQD/HCSB utilized a document from CMS that was produced in August 2006 called "Evaluating Demonstrations: A Technical Assistance Guide for States."

MQD/HCSB requested technical assistance (TA) to ensure that it is developing the Demonstration Evaluation report consistent with any new requirements that CMS may have imposed since August 2006. MQD's Medical Director, Dr. Curtis Toma, contacted Mr. Gary Jackson from CMS about TA on Demonstration Evaluations. Mr. Jackson referred MQD to a CMS project officer, Ms. Alexis Gibson. On April 12, 2012, MQD/HCSB requested TA from Ms. Alexis Gibson on development of the Demonstration Evaluation report. As of the date of this application, MQD/HCSB has not yet received TA.

Once TA is received, MQD/HCSB will complete development of the Demonstration Evaluation report for submission to CMS. The State will use the same evaluation parameters during the three-year extension period.

VIII. Documentation of the State's Compliance with the Public Notice Process

A. The State's Public Notice and Input Efforts

The State has taken multiple steps to inform the public and solicit public input about its Demonstration extension application. These public notice and public input procedures comply with 42 C.F.R. § 431.408.

The State's public notice and comment period began on May 29, 2012 and ran for 30 days, until June 28, 2012. During that time, the State accepted public comments sent to Noreen Moon-Ng by mail to P.O. Box 700190, Kapolei, HI 96709-0190 or by email to nmoon-ng@medicaid.dhs.state.hi.us.

On May 23, 2012, the State issued a public notice document with a comprehensive description of the proposed Demonstration extension. Consistent with 42 C.F.R. § 431.408, the notice included the location and internet address where copies of the Demonstration extension application were available for review and comment; the dates of the public comment period; postal and e-mail addresses where written comments could be sent; and the locations, dates, and times of the two public hearings convened by the State to seek public input about the extension application. This public notice document described the public notice and input processes, included a link to the relevant Medicaid demonstration page on the CMS web site, and was maintained for the entire public comment period in a prominent location at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules?.

On May 25, 2012, the State published an abbreviated public notice in the newspapers of widest circulation in each city with a population of 100,000 or more, which included a description of the demonstration extension; the locations, dates, and times of two public hearings convened to seek public input about the extension application; and an active link to the full public notice document on the State's web page.

On May 29, 2012, the State notified, via e-mail, a list of potentially interested parties. This e-mail list was gathered from individuals who attended one of two community forums or provided comments as part of the public input process for the recently-approved amendment.

Copies of the public notice, the abbreviated public notice, and the e-mail notification are included as Attachment C, Attachment D, and Attachment E, respectively. Copies of proof of publication of the abbreviated notice are included as Attachment F.

The State held two public hearings to solicit public input and comment about the Demonstration extension application:

1. **May 31, 2012: 9:00 a.m.**:

Oahu	Keoni Ana Videoconference Center Keoni Ana Building 1177 Alakea Street, Room 302 Honolulu, Hawaii
Hawaii	Hilo Videoconference Center Hilo State Office Building 75 Aupuni Street, Basement Hilo, Hawaii
Kauai	Lihue Videoconference Center Lihue State Office Building 3060 Eiwa Street, Basement Lihue, Hawaii

Maui Wailuky Videoconference Center
Wailuku Judiciary Building
2145 Main Street, First Floor
Wailuky, Hawaii

2. **June 6, 2012: 9:00 a.m.**:

Med-QUEST Division
Kakuhihewa State Office Building
601 Kamokila Blvd., Room 577 A & B
Kapolei, Hawaii

In its public notice, the State provided contact information for State staff to assist individuals who require special assistance or auxiliary aids and/or services to participate in the public hearings (*e.g.*, sign or foreign language or wheelchair accessibility).

Below is a chart detailing the State's public notice and input procedures:

Date	Public Notice and/or Public Input Opportunity
May 17, 2012	Tribal notice issued
May 23, 2012	Public notice issued and available on websites
May 25, 2012	Abbreviated public notice published in newspapers
May 29, 2012	E-mail to potentially interested parties
May 29, 2012	1115(e) Extension Application posted on the Department of Human Services and the Med-QUEST Division websites and available for public distribution
May 29, 2012	Public comment period begins
May 31, 2012	Public meeting via videoconference
June 6, 2012	Public meeting at the Med-QUEST Division
June 13, 2012	Additional tribal notice issued

In addition to steps taken specific to this extension request, Med-QUEST recently solicited public input regarding its recently-approved and pending Demonstration amendments, which afforded the public the opportunity to comment on proposed changes to the Demonstration. As part of this public input process, Dr. Kenneth Fink, Administrator of the Med-QUEST Division, held six public forums to discuss the changes to QUEST Expanded.

B. Issues Raised by the Public and the State's Consideration of Those Issues

Six public comments were received (three in person, two through teleconference and one via email). Of the six public comments:

1. Three individuals sought clarifications to assure the maximization of CHIP federal reimbursement for children, confirmation of the continuation of a State-only funded program for individuals under the Compact of Free Association, and clarification that the extension did not include the ACA mandates.
2. Two individuals advocated for the value and continuation of substance abuse treatment services.
3. One individual questioned the effectiveness of managed care as a health care delivery system.

The State reviewed the comments received and determined the comments did not affect the content of the extension submission because:

1. CHIP federal reimbursement would continue as currently maximized.
2. The Compact of Free Association health program was outside the parameters of the 1115 Demonstration Waiver.
3. The application for extension did not include forthcoming ACA requirements.
4. The discussion of the health care delivery system (managed care, PCCM, FFS, etc.) for Medicaid will be addressed through the State's amendment to the 1115 extension to align with Medicaid provisions under ACA, which will be subject to another public comment period sometime later this year.

C. Tribal Consultation

Consistent with 42 C.F.R. § 431.408(b) and Hawaii's State plan, the State notified its sole urban Indian Organization, Ke Ola Mamo, to seek its consultation, feedback and recommendation on behalf of designees of its health organization through written correspondence on May 17, 2012 and June 13, 2012. This correspondence summarized the intended submission of the proposed extension application. The first notification of May 17, 2012 provided the required 30-day comment period until June 18, 2012. Ke Ola Mamo emailed the State to confirm receipt and express appreciation of the request for consultation, and informed the State that it would contact the State if necessary. No further communications has been received to date.

The second notification of June 13, 2012 expressly invoked the expedited process for situations that require immediate submission with a comment period of 14 days until June 27, 2012. Ke Ola Mamo has made no contact since receiving the second notification.

The State continues to have an amicable and productive relationship with Ke Ola Mamo through written correspondence, email, and face-to-face meetings, as requested.

Copies of the tribal notice are included as Attachment G.

D. The Post-Award Public Input Process

The State will comply with the post-award public notice and input procedures in 42 C.F.R. § 431.420(c). Within six months of implementation of the Demonstration extension, and

annually thereafter, it will hold a public forum to solicit public comments on the progress of the Demonstration, at which the public will have an opportunity to comment. The State will publish the date, time, and location of the public forum in a prominent location on its web site at least 30 days prior to the date of the public forum. The State will hold the forum at such time as to enable it to include a summary of the forum in the quarterly report associated with the quarter in which the forum will be held, as well as in its annual report to CMS.

IX. Affordable Care Act Amendment

DHS recognizes that it will need to amend the Demonstration to reflect the new requirements in ACA that take effect January 1, 2014, but has been awaiting CMS approval of the recently-approved amendment before undertaking that process. The State plans to develop, in the fall of 2012, a separate proposed amendment to address those requirements, and will offer a separate notice and opportunity for comment on that proposal. The State expects to submit the proposed amendment to CMS no later than February 1, 2013.

Table of Contents - Attachments

A. Form 416 - 2011 & 2010

B. Budget Neutrality Chart

C. Public Notice Document

D. Abbreviated Public Notice

E. E-mail Notification to Interested Parties

F. Proof of Publication of the Abbreviated Public Notice

G. Tribal Notice

Attachment A

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code	**Fiscal Year**								
HI	**2010**	Totals	**Age Group <1**	**Age Group 1-2**	**Age Group 3-5**	**Age Group 6-9**	**Age Group 10-14**	**Age Group 15-18**	**Age Group 19-20**
1a. Total individuals eligible for EPSDT	CN:	152,233	8,813	19,198	25,773	29,783	32,126	24,700	11,840
	MN:	2	1	0	1	0	0	0	0
	Total:	152,235	8,814	19,198	25,774	29,783	32,126	24,700	11,840
1b. Total Individuals eligible for EPSDT for 90 Continous Days	CN:	135,927	5,919	17,663	23,746	27,340	29,548	22,429	9,282
	MN:	0	0	0	0	0	0	0	0
	Total:	135,927	5,919	17,663	23,746	27,340	29,548	22,429	9,282
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	26,659	168	1,621	3,280	6,079	7,722	6,407	1,382
	MN:	0	0	0	0	0	0	0	0
	Total:	26,659	168	1,621	3,280	6,079	7,722	6,407	1,382
2a. State Periodicity Schedule			5	4	3	2	3	2	1
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule			5.00	2.00	1.00	0.50	0.60	0.50	0.50
3a. Total Months of Eligibility	CN:	1,555,614	46,391	203,621	276,806	321,026	348,529	263,892	95,350
	MN:	1	0	0	1	0	0	0	0
	Total:	1,555,615	46,391	203,621	276,807	321,026	348,529	263,892	95,350
3b. Average Period of Eligibility	CN:	0.95	0.65	0.96	0.97	0.98	0.98	0.98	0.86
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.95	0.65	0.96	0.97	0.98	0.98	0.98	0.86
4. Expected Number of Screenings per Eligible	CN:		3.25	1.92	0.97	0.49	0.59	0.49	0.43
	MN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:		3.25	1.92	0.97	0.49	0.59	0.49	0.43
5. Expected Number of Screenings	CN:	121,995	19,237	33,913	23,034	13,397	17,433	10,990	3,991
	MN:	0	0	0	0	0	0	0	0
	Total:	121,995	19,237	33,913	23,034	13,397	17,433	10,990	3,991
6. Total Screens Received	CN:	117,218	27,540	37,902	17,816	11,199	12,488	8,880	1,393
	MN:	0	0	0	0	0	0	0	0
	Total:	117,218	27,540	37,902	17,816	11,199	12,488	8,880	1,393
7. SCREENING RATIO	CN:	0.96	1.00	1.00	0.77	0.84	0.72	0.81	0.35
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.96	1.00	1.00	0.77	0.84	0.72	0.81	0.35
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	92,427	5,919	17,663	23,034	13,397	17,433	10,990	3,991
	MN:	0	0	0	0	0	0	0	0
	Total:	92,427	5,919	17,663	23,034	13,397	17,433	10,990	3,991

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code	Fiscal Year								
HI	2010	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	70,061	7,099	15,320	16,136	10,497	11,703	8,061	1,245
	MN:	0	0	0	0	0	0	0	0
	Total:	70,061	7,099	15,320	16,136	10,497	11,703	8,061	1,245
10. PARTICIPANT RATIO	CN:	0.76	1.00	0.87	0.70	0.78	0.67	0.73	0.31
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.76	1.00	0.87	0.70	0.78	0.67	0.73	0.31
11. Total Eligibles Referred for Corrective Treatment	CN:	34,045	4,627	8,375	6,682	4,423	5,028	3,932	978
	MN:	0	0	0	0	0	0	0	0
	Total:	34,045	4,627	8,375	6,682	4,423	5,028	3,932	978
12a. Total Eligibles Receiving Any Dental Services	CN:	68,884	157	9,975	17,218	16,225	15,277	8,519	1,513
	MN:	0							
	Total:	68,884	157	9,975	17,218	16,225	15,277	8,519	1,513
12b. Total Eligibles Receiving Preventive Dental Services	CN:	53,514	101	7,302	13,579	13,404	12,229	6,088	811
	MN:	0							
	Total:	53,514	101	7,302	13,579	13,404	12,229	6,088	811
12c. Total Eligibles Receiving Dental Treatment Services	CN:	32,522	43	2,848	8,406	8,068	7,433	4,815	909
	MN:	0							
	Total:	32,522	43	2,848	8,406	8,068	7,433	4,815	909
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	4,693				2609	2084		
	MN:	0							
	Total:	4,693				2,609	2,084		
12e. Total Eligibles Reciving Dental Diagnostic Services	CN:	56,536	113	8,149	14,130	13,597	12,637	6,773	1,137
	MN:	0							
	Total:	56,536	113	8,149	14,130	13,597	12,637	6,773	1,137
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	0	0	0	0	0	0	0	0
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12g. Total Eligibles Reciving Any Dental Or Oral Health Service	CN:	68,884	157	9,975	17,218	16,225	15,277	8,519	1,513
	MN:	0							
	Total:	68,884	157	9,975	17,218	16,225	15,277	8,519	1,513
13. Total Eligibles Enrolled in Managed Care	CN:	149,281	8,753	18,981	25,445	29,219	31,417	24,049	11,417
	MN:	0	0	0	0	0	0	0	0
	Total:	149,281	8,753	18,981	25,445	29,219	31,417	24,049	11,417
14. Total Number of Screening Blood Lead Tests	CN:	8,943	674	6,821	1,448				
	MN:	0							
	Total:	8,943	674	6,821	1,448				

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code	Fiscal Year								
HI	2011	Totals	Age Group <1	Age Group 1-2	Age Group 3-5	Age Group 6-9	Age Group 10-14	Age Group 15-18	Age Group 19-20
1a. Total individuals eligible for EPSDT	CN:	158,910	9,032	19,489	27,616	31,697	34,075	25,494	11,507
	MN:	0	0	0	0	0	0	0	0
	Total:	158,910	9,032	19,489	27,616	31,697	34,075	25,494	11,507
1b. Total Individuals eligible for EPSDT for 90 Continous Days	CN:	144,843	5,894	18,091	25,780	29,855	32,084	23,875	9,264
	MN:	0	0	0	0	0	0	0	0
	Total:	144,843	5,894	18,091	25,780	29,855	32,084	23,875	9,264
1c. Total Individuals Eligible under a CHIP Medicaid Expansion	CN:	26,234	175	1,546	3,304	6,119	7,714	6,174	1,202
	MN:	0	0	0	0	0	0	0	0
	Total:	26,234	175	1,546	3,304	6,119	7,714	6,174	1,202
2a. State Periodicity Schedule			5	4	3	2	3	2	1
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule			5.00	2.00	1.00	0.50	0.60	0.50	0.50
3a. Total Months of Eligibility	CN:	1,594,086	46,768	202,980	289,167	335,878	360,982	268,298	90,013
	MN:	0	0	0	0	0	0	0	0
	Total:	1,594,086	46,768	202,980	289,167	335,878	360,982	268,298	90,013
3b. Average Period of Eligibility	CN:	0.92	0.66	0.93	0.93	0.94	0.94	0.94	0.81
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.92	0.66	0.93	0.93	0.94	0.94	0.94	0.81
4. Expected Number of Screenings per Eligible	CN:		3.30	1.86	0.93	0.47	0.56	0.47	0.41
	MN:		0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:		3.30	1.86	0.93	0.47	0.56	0.47	0.41
5. Expected Number of Screenings	CN:	124,092	19,450	33,649	23,975	14,032	17,967	11,221	3,798
	MN:	0	0	0	0	0	0	0	0
	Total:	124,092	19,450	33,649	23,975	14,032	17,967	11,221	3,798
6. Total Screens Received	CN:	121,192	28,205	37,766	18,865	12,147	13,488	9,431	1,290
	MN:	0	0	0	0	0	0	0	0
	Total:	121,192	28,205	37,766	18,865	12,147	13,488	9,431	1,290
7. SCREENING RATIO	CN:	0.98	1.00	1.00	0.79	0.87	0.75	0.84	0.34
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.98	1.00	1.00	0.79	0.87	0.75	0.84	0.34
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN:	94,978	5,894	18,091	23,975	14,032	17,967	11,221	3,798
	MN:	0	0	0	0	0	0	0	0
	Total:	94,978	5,894	18,091	23,975	14,032	17,967	11,221	3,798

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT

State Code	**Fiscal Year**								
HI	**2010**	Totals	**Age Group <1**	**Age Group 1-2**	**Age Group 3-5**	**Age Group 6-9**	**Age Group 10-14**	**Age Group 15-18**	**Age Group 19-20**
9. Total Eligibles Receiving at least One Initial or Periodic Screen	CN:	73,900	7,294	15,605	17,227	11,420	12,612	8,585	1,157
	MN:	0	0	0	0	0	0	0	0
	Total:	73,900	7,294	15,605	17,227	11,420	12,612	8,585	1,157
10. PARTICIPANT RATIO	CN:	0.78	1.00	0.86	0.72	0.81	0.70	0.77	0.30
	MN:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total:	0.78	1.00	0.86	0.72	0.81	0.70	0.77	0.30
11. Total Eligibles Referred for Corrective Treatment	CN:	33,890	4,331	8,344	6,518	4,369	5,271	4,152	905
	MN:	0	0	0	0	0	0	0	0
	Total:	33,890	4,331	8,344	6,518	4,369	5,271	4,152	905
12a. Total Eligibles Receiving Any Dental Services	CN:	73,868	129	6,005	15,981	19,062	18,212	11,561	2,918
	MN:	0							
	Total:	73,868	129	6,005	15,981	19,062	18,212	11,561	2,918
12b. Total Eligibles Receiving Preventive Dental Services	CN:	57,337	26	3,682	12,350	15,566	14,920	8,854	1,939
	MN:	0							
	Total:	57,337	26	3,682	12,350	15,566	14,920	8,854	1,939
12c. Total Eligibles Receiving Dental Treatment Services	CN:	45,208	84	2,374	9,775	12,642	10,638	7,605	2,090
	MN:	0							
	Total:	45,208	84	2,374	9,775	12,642	10,638	7,605	2,090
12d. Total Eligibles Receiving a Sealant on a Permanent Molar Tooth	CN:	6,075				3461	2614		
	MN:	0							
	Total:	6,075				3,461	2,614		
12e. Total Eligibles Reciving Dental Diagnostic Services	CN:	60,822	46	4,520	13,000	15,772	15,308	9,759	2,417
	MN:	0							
	Total:	60,822	46	4,520	13,000	15,772	15,308	9,759	2,417
12f. Total Eligibles Receiving Oral Health Services provided by a Non-Dentist Provider	CN:	0	0	0	0	0	0	0	0
	MN:	0							
	Total:	0	0	0	0	0	0	0	0
12g. Total Eligibles Reciving Any Dental Or Oral Health Service	CN:	73,868	129	6,005	15,981	19,062	18,212	11,561	2,918
	MN:	0							
	Total:	73,868	129	6,005	15,981	19,062	18,212	11,561	2,918
13. Total Eligibles Enrolled in Managed Care	CN:	154,597	9,027	19,372	26,765	30,683	32,880	24,651	11,219
	MN:	0	0	0	0	0	0	0	0
	Total:	154,597	9,027	19,372	26,765	30,683	32,880	24,651	11,219
14. Total Number of Screening Blood Lead Tests	CN:	8,949	647	6,900	1,402				
	MN:	0	0	0	0				
	Total:	8,949	647	6,900	1,402				

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN"= Medically Needy

Attachment B

Hawaii 1115 QUEST Waiver		7/1/05-6/30/06	7/1/06-6/30/06	7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10	7/1/10-6/30/11	7/1/11-6/30/12	7/1/12-6/30/13	7/1/13-6/30/14	7/1/14-6/30/15	7/1/15-6/30/16
TOTAL COMPUTABLE		**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**
		Std Renewal/Extension			***Renewal***					***Extension***		
WITHOUT WAIVER	**FMAP**	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081	0.5152	0.5186	0.5186	0.5186
		58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%	50.48%	51.86%	51.86%	51.86%
	MEG Description and Comments	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%	51.86%	51.86%	51.86%	51.86%
					67.35%		62.63%					
	Trend											
	TANF (AFDC), Foster Children, GA children	$261.16	$281.11	$302.59	$322.62	$343.98	$366.75	$391.03	$416.92	$444.52	$473.95	$505.32
	TANF Adults	$458.35	$493.37	$531.07	$564.90	$600.88	$639.18	$679.87	$723.18	$769.25	$818.25	$870.37
	Aged				$1,204.63	$1,281.84	$1,364.01	$1,451.44	$1,544.48	$1,643.48	$1,748.83	$1,860.93
	Blind/Disabled				$1,489.42	$1,597.11	$1,712.58	$1,836.40	$1,969.17	$2,111.54	$2,264.21	$2,427.91
Member Months												
	TANF (AFDC), Foster Children, GA children	943,063	930,199	891,143	979,228	1,101,814	1,183,785	1,215,239	1,282,187	1,336,039	1,392,152	1,450,623
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,975	418,663	435,385	453,671	472,726	492,580
	Aged				98,211	228,003	236,960	231,562	231,562	233,878	236,216	238,579
	Blind/Disabled				115,130	273,418	287,789	284,071	284,071	286,912	289,781	292,679
	Total Without Waiver Member Months	**1,282,911**	**1,261,533**	**1,193,278**	**1,540,754**	**1,993,639**	**2,130,509**	**2,149,535**	**2,233,205**	**2,310,500**	**2,390,875**	**2,474,460**
	Total Without Waiver Expenditures including HCBS	$402,056,806	$424,960,513	$443,327,661	$837,291,055	$1,342,530,074	$1,519,948,220	$1,617,597,917	$1,766,458,748	$1,933,081,124	$2,115,839,336	$2,316,334,311
	DSH/UCC	$80,364,047	$81,971,327	$83,856,667	$87,546,360	$89,735,019	$91,350,249	$94,547,507	$96,911,195	$99,818,531	$102,813,086	$105,897,479
	Total Ceiling	**$482,420,853**	**$506,931,840**	**$527,184,328**	**$924,837,415**	**$1,432,265,093**	**$1,611,298,469**	**$1,712,145,424**	**$1,863,369,942**	**$2,032,899,655**	**$2,218,652,422**	**$2,422,231,790**
WITH WAIVER	Aged w/Mcare	$0	$0	($295)	$121,311,117	$312,827,995	$350,715,326	$329,572,924	$338,746,689	$359,240,864	$380,974,936	$404,023,919
	Aged w/o Mcare	$0	$0	$0	$2,424,989	$17,428,507	$24,929,013	$18,419,325	$18,893,546	$20,036,606	$21,248,821	$22,534,374
	B/D w/Mcare	$0	$0	($13,736)	$31,795,878	$73,773,354	$81,195,371	$77,201,971	$76,135,822	$80,742,039	$85,626,932	$90,807,362
	B/D w/o Mcare	$0	$0	($28,991)	$81,514,842	$210,159,329	$246,381,749	$250,949,188	$251,809,465	$267,043,938	$283,200,096	$300,333,702
	Breast Cervical Cancer Treatment (BCCT)	$0	$0	$0	$0	$0	$545,195	$726,823	$746,923	$792,112	$840,035	$890,857
	Demo Elig Adults	$127,983,558	$129,458,220	$154,645,824	$177,396,443	$201,627,226	$237,833,752	$244,076,136	$247,680,156	$262,664,806	$278,556,027	$295,408,666
	FosterCare(19-20)	$0	$0	$91,499	$83,366	$94,158	$137,091	$77,404	$76,094	$80,698	$85,580	$90,758
	HawaiiQuest-1902(R)(2)	$0	$0	$33,061	$26,332	$8,001	$0	$0				
	HCCP	$0	$0	$135,520	$683,159	$0	$0	$0				
	HealthQuest-Current	($2,325,152)	$0	$0	$0	$0	$0	$0				
	HealthQuest-Others	($621,643)	$0	$0	$0	$0	$0	$0				
	Med Needy Adults	$56,504	$120,767	$115,693	$58,345	$117,005	$109,837	$11,073	$0			
	Med Needy Children	$0	$0	$0	$7,715	$3,960	$0	$0				
	MFCP	$0	$0	$122,839	$581,513	$0	$0	$0				
	NH w/o W	$0	$0	$5,100,418	$16,199,737	$0	$0	$0				
	Opt St Pl Children	$76,678	$103,084	$80,075	$257,166	$253,182	$31	$0				
	QUEST ACE	($2,751)	$798,681	$5,696,094	$14,353,208	$23,870,964	$30,371,619	$28,458,020	$21,182,144	$22,463,664	$23,822,716	$25,263,990
	RAACP	$0	$0	$7,862,479	$17,432,949	$0	$0	$0				
	St Pl Adults-Preg Immig/COFAs	$0	$0	$0	$0	$24,990	$2,620,387	$2,582,863	$2,777,644	$2,945,691	$3,123,905	$3,312,902
	State Plan Adults	$111,983,043	$118,021,979	$109,034,691	$128,225,127	$132,188,623	$123,678,397	$119,023,911	$127,508,086	$135,222,325	$143,403,276	$152,079,174
	State Plan Children	$181,803,156	$179,673,972	$155,394,307	$168,854,125	$203,927,324	$213,641,071	$199,685,237	$212,795,772	$225,669,916	$239,322,946	$253,801,984
	UCC	$25,744,721	$25,949,818	$26,419,184	$23,856,580	$32,007,605	$41,564,491	$61,679,587	$75,500,000	$78,900,000	$82,470,000	$86,218,500
Total Expenditures Per CMS-64 Waiver		**$444,698,114**	**$454,126,521**	**$464,688,662**	**$785,062,591**	**$1,208,312,223**	**$1,353,723,330**	**$1,332,464,461**	**$1,373,852,342**	**$1,455,802,659**	**$1,542,675,270**	**$1,634,766,189**
Premium Share (Not reported on 64 Waiver)		-$1,459,097	-$1,189,919	-$660,309	-$4,962,002	-$38,297,536	-$43,476,661	-$38,300,332	-$38,000,000	-$38,000,000	-$38,000,000	-$38,000,000
Total Expenditures		**$443,239,017**	**$452,936,602**	**$464,028,353**	**$780,100,589**	**$1,170,014,687**	**$1,310,246,669**	**$1,294,164,129**	**$1,335,852,342**	**$1,417,802,659**	**$1,504,675,270**	**$1,596,766,189**
DY BN Savings		**$39,181,837**	**$53,995,238**	**$63,155,975**	**$144,736,826**	**$262,250,406**	**$301,051,800**	**$417,981,295**	**$527,517,600**	**$615,096,996**	**$713,977,152**	**$825,465,602**
Cummulative Savings		**$565,691,629**	**$619,686,866**	**$682,842,841**	**$827,579,666**	**$1,089,830,073**	**$1,390,881,873**	**$1,808,863,168**	**$2,336,380,768**	**$2,951,477,764**	**$3,665,454,916**	**$4,490,920,517**
		-$334,903	-$352,488	-$217,644	-$22,587	-$15,945,497	-$15,835,580	-$10,164,390	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000
		-$323,973	-$263,058	-$239,466	-$19,777	-$6,517,946	-$9,185,458	-$9,300,862	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000
		-$347,005	-$279,056	-$147,219	-$22,317	-$9,503,023	-$9,356,037	-$9,335,080	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000
		-$453,216	-$295,317	-$55,980	-$4,897,321	-$6,331,070	-$9,099,586	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000

Hawaii 1115 QUEST Waiver		7/1/05-6/30/06	7/1/06-6/30/06	7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10	7/1/10-6/30/11	7/1/11-6/30/12	7/1/12-6/30/13	7/1/13-6/30/14	7/1/14-6/30/15	7/1/15-6/30/16
FEDERAL SHARE		**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**
		Std Renewal/Extension			***Renewal***					***Extension***		
WITHOUT WAIVER	**FMAP**	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081	0.5152	0.5186	0.5186	0.5186
		58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%	50.48%	51.86%	51.86%	51.86%
	MEG Description and Comments	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%	51.86%	51.86%	51.86%	51.86%
					67.35%		62.63%					
	Trend											
	TANF (AFDC), Foster Children, GA children	$261.16	$281.11	$302.59	$322.62	$343.98	$366.75	$391.03	$416.92	$444.52	$473.95	$505.32
	TANF Adults	$458.35	$493.37	$531.07	$564.90	$600.88	$639.18	$679.87	$723.18	$769.25	$818.25	$870.37
	Aged				$1,204.63	$1,281.84	$1,364.01	$1,451.44	$1,544.48	$1,643.48	$1,748.83	$1,860.93
	Blind/Disabled				$1,489.42	$1,597.11	$1,712.58	$1,836.40	$1,969.17	$2,111.54	$2,264.21	$2,427.91
Member Months												
	TANF (AFDC), Foster Children, GA children	943,063	930,199	891,143	979,228	1,101,814	1,183,785	1,215,239	1,282,187	1,336,039	1,392,152	1,450,623
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,975	418,663	435,385	453,671	472,726	492,580
	Aged				98,211	228,003	236,960	231,562	231,562	233,878	236,216	238,579
	Blind/Disabled				115,130	273,418	287,789	284,071	284,071	286,912	289,781	292,679
	Total Without Waiver Member Months	**1,282,911**	**1,261,533**	**1,193,278**	**1,540,754**	**1,993,639**	**2,130,509**	**2,149,535**	**2,233,205**	**2,310,500**	**2,390,875**	**2,474,460**
	Total Without Waiver Expenditures including HCBS	$402,056,806	$424,960,513	$437,576,978	$824,358,323	$1,342,530,074	$1,519,948,220	$1,617,597,917	$1,766,458,748	$1,933,081,124	$2,115,839,336	$2,316,334,311
	DSH/UCC	$80,364,047	$81,971,327	$83,856,667	$87,546,360	$89,735,019	$91,350,249	$94,547,507	$96,911,195	$99,818,531	$102,813,086	$105,897,479
	Total Ceiling	**$283,301,646**	**$293,336,109**	**$295,978,772**	**$583,869,771**	**$964,630,540**	**$1,054,796,261**	**$869,898,286**	**$959,915,026**	**$1,054,261,761**	**$1,150,593,146**	**$1,256,169,406**
WITH WAIVER	Aged w/Mcare	$0	$0	($199)	$81,151,489	$209,915,839	$229,255,014	$167,447,763	$174,505,357	$186,302,312	$197,573,602	$209,526,805
	Aged w/o Mcare	$0	$0	$0	$1,622,988	$11,738,142	$16,033,955	$9,358,399	$9,733,010	$10,390,984	$11,019,638	$11,686,327
	B/D w/Mcare	$0	$0	($9,251)	$21,278,908	$49,170,284	$52,539,409	$39,224,391	$39,221,369	$41,872,821	$44,406,127	$47,092,698
	B/D w/o Mcare	$0	$0	($19,525)	$54,511,233	$140,732,652	$159,989,699	$127,501,009	$129,719,646	$138,488,986	$146,867,570	$155,753,058
	Breast Cervical Cancer Treatment (BCCT)	$0	$0	$0	$0	$0	$354,549	$369,280	$384,778	$410,789	$435,642	$461,999
	Demo Elig Adults	$75,196,722	$74,767,026	$87,888,968	$114,381,788	$135,413,710	$153,979,539	$124,008,983	$127,592,433	$136,217,968	$144,459,155	$153,198,934
	FosterCare(19-20)	$0	$0	$51,916	$53,413	$63,415	$88,815	$39,327	$39,200	$41,850	$44,382	$47,067
	HawaiiQuest-1902(R)(2)	$0	$0	$18,679	$19,755	$5,389	$0	$0	$0			
	HCCP	$0	$0	$76,578	$438,797	$0	$0	$0	$0			
	HealthQuest-Current	($1,365,848)	$0	$0	$0	$0	$0	$0	$0			
	HealthQuest-Others	($363,962)	$0	$0	$0	$0	$0	$0	$0			
	Med Needy Adults	$32,497	$68,553	$68,082	$38,985	$78,049	$63,796	$5,626	$0			
	Med Needy Children	$0	$0	$0	$5,196	$2,666	$0	$0	$0			
	MFCP	$0	$0	$69,404	$368,050	$0	$0	$0	$0			
	NH w/o W	$0	$0	$2,881,647	$10,235,011	$0	$0	$0	$0			
	Opt St Pl Children	$44,819	$59,404	$45,487	$166,217	$170,408	$21	$0	$0			
	QUEST ACE	($1,583)	$454,606	$3,232,556	$9,387,314	$16,051,434	$19,539,165	$14,458,809	$10,911,982	$11,649,656	$12,354,460	$13,101,905
	RAACP	$0	$0	$4,442,944	$10,922,768	$0	$0	$0	$0			
	St Pl Adults-Preg Immig/COFAs	$0	$0	$0	$0	$16,829	$1,702,522	$1,312,288	$1,430,903	$1,527,635	$1,620,057	$1,718,071
	State Plan Adults	$65,812,297	$68,288,754	$61,892,816	$82,540,925	$88,871,618	$80,703,835	$60,473,073	$65,685,790	$70,126,298	$74,368,939	$78,868,260
	State Plan Children	$106,725,650	$103,797,949	$88,087,123	$108,852,207	$137,121,675	$137,873,161	$101,455,077	$109,621,742	$117,032,419	$124,112,880	$131,621,709
	UCC	$15,000,000	$15,000,000	$15,000,001	$15,000,000	$21,557,122	$26,977,723	$31,337,856	$38,893,825	$40,917,540	$42,768,942	$44,712,914
		$261,080,592	**$262,436,292**	**$263,727,226**	**$510,975,044**	**$810,909,232**	**$879,101,203**	**$676,991,881**	**$707,740,034**	**$754,979,259**	**$800,031,395**	**$847,789,746**
		-$1,459,097	-$1,189,919	-$660,309	-$4,962,002	-$38,297,536	-$43,476,661	-$38,300,332	-$38,000,000	-$38,000,000	-$38,000,000	-$38,000,000
		$259,621,495	**$261,246,373**	**$263,066,917**	**$506,013,042**	**$772,611,696**	**$835,624,542**	**$638,691,549**	**$669,740,034**	**$716,979,259**	**$762,031,395**	**$809,789,746**
		$23,680,151	**$32,089,736**	**$32,911,855**	**$77,856,729**	**$192,018,844**	**$219,171,718**	**$231,206,737**	**$290,174,992**	**$337,282,502**	**$388,561,751**	**$446,379,661**
		$315,385,027	**$347,474,764**	**$380,386,619**	**$458,243,348**	**$650,262,192**	**$869,433,910**	**$1,100,640,648**	**$1,390,815,639**	**$1,728,098,141**	**$2,116,659,892**	**$2,563,039,553**
		-$334,903	-$352,488	-$217,644	-$22,587	-$15,945,497	-$15,835,580	-$10,164,390	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000
		-$323,973	-$263,058	-$239,466	-$19,777	-$6,517,946	-$9,185,458	-$9,300,862	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000
		-$347,005	-$279,056	-$147,219	-$22,317	-$9,503,023	-$9,356,037	-$9,335,080	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000
		-$453,216	-$295,317	-$55,980	-$4,897,321	-$6,331,070	-$9,099,586	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000	-$9,500,000

Attachment C

Notice of Request for an Extension of Hawaii's
QUEST Expanded Section 1115 Demonstration (11-W-00001/9)

The State of Hawaii, Department of Human Services (DHS), hereby notifies the public that it intends to seek a three-year extension of the QUEST Expanded Section 1115 demonstration project (the Demonstration) from the Centers for Medicare & Medicaid Services (CMS). By May 29, 2012, a copy of the proposed demonstration extension application will be available at the Department of Human Services, Med-QUEST, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707, or at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/. We are providing this notice pursuant to CMS requirements in 42 C.F.R. § 431.408.

QUEST Expanded Waiver Extension Request

The Demonstration is set to expire on June 30, 2013. Hawaii intends to request an extension of the Demonstration under the same terms and conditions as the current waiver and any pending amendments. DHS will submit a separate proposal, with a separate notice and opportunity for comment, to amend the Demonstration to reflect new requirements in the Affordable Care Act that take effect January 1, 2014.

Program Description, Goals, and Historical Context

Originally implemented as the QUEST program in 1994, QUEST Expanded is the current version of Hawaii's demonstration project to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. The provision of benefits through managed care has saved tens of millions of dollars in state and federal funds and has enabled the State to use some of the savings to provide coverage to individuals not otherwise eligible for Medicaid.

The program has been amended and renewed several times since 1994. One of the more recent changes included the 2007 renewal that provided for new QUEST Expanded Access (QExA) plans to serve individuals enrolled in Medicaid as aged, blind, or disabled, and the addition of long-term care benefits to the benefit package in those plans.

The Hawaii Medicaid program covers adults in certain categories and up to certain income levels, as well as all children up to 300% of the federal poverty level (FPL). In addition, through the years, the State has provided coverage to non-Medicaid eligible adults through a variety of programs known as QUEST, QUEST-Net, and QUEST-ACE. In April 2012, CMS approved the State's request to cap eligibility for non-pregnant, non-disabled adults not otherwise Medicaid eligible at 133% of the FPL.

The State currently has an amendment pending that seeks to align the QUEST-Net and QUEST-ACE benefits with the QUEST benefit package, and to add certain benefits to the QExA benefit package.

Further detail on the existing program and pending amendments is available here: http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/. CMS also offers online resources regarding the QUEST Expanded Demonstration, which can be viewed at

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=hawaii

Delivery System
The State seeks an extension of the Demonstration in order to continue to provide most benefits through capitated managed care programs. Fee-for-service shall continue to be provided for long-term care service for individuals with developmental disabilities, applicants eligible for retroactive coverage only, and medical services under the State of Hawaii Organ and Tissue Transplant (SHOTT) program.

Eligibility Requirements
Eligibility will continue to be determined by the Medicaid State plan and the CHIP State plan. The extension of the Demonstration will enable Hawaii to continue to provide coverage to non-Medicaid individuals with income up to 133% of the FPL. A chart of eligibility groups is on pages 9 to 13 in the current Demonstration's Special Terms and Conditions, which can be found at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/. A similar chart detailing how the State's pending amendments would modify these eligibility groups is on pages 8 to 12 of the amendment application's redlined proposed Special Terms of Conditions, which can also be found at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/.

Benefit Coverage
The Demonstration currently offers three benefit packages:

1) Full Medicaid State plan benefits for QUEST children and adults and for QUEST-Net children.
2) The QExA benefit package through which aged, blind, and disabled individuals may receive State plan primary and acute care, State plan long-term care, and home- and community-based services.
3) A limited benefit plan for adults in QUEST-Net and QUEST-ACE, which includes: emergency visits; 10 in-patient hospital days (no benefit for maternity, nursery, rehabilitation, or skilled nursing level of care); 12 out-patient medical visits; 6 mental health outpatient visits; 3 ambulatory surgery procedures; diagnostic tests associated with the outpatient medical visits; certain immunizations; family planning services; limited prescription drugs; language interpretation services; and preventive and restorative dental.

Once CMS approves the pending amendments, the Demonstration will offer two benefit packages:

1) Full Medicaid State plan benefits for QUEST, QUEST-Net, and QUEST-ACE beneficiaries.
2) The QExA benefit package through which aged, blind, and disabled individuals may receive primary and acute care, State plan long-term care, and home- and community-based services. The QExA benefit package will include primary and acute care beyond that which is offered in the State plan. These expanded services will include in-patient services without limitation, optometry services, hospice services without limitation, durable medical equipment and medical supplies, and rehabilitation services.

Cost Sharing
The State will continue to allow copayments as set forth in the Medicaid State plan, and will continue to have the authority to charge up to 5% in annual family income for cost sharing. Additionally, medically-needy individuals with a spend-down will be required to pay 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.

Annual Enrollment and Annual Expenditures
From July 1, 2010 to June 30, 2011, state and federal expenditures in the Demonstration totaled approximately $1.2 billion In June 2011, 263,848 individuals were enrolled in the Demonstration (and covered in part by a federal match).

During the extension period, the annual increase in enrollment is expected to be 4.2% per year, or approximately 10,000 recipients per year. Total aggregate expenditures for each year are anticipated to be $1.7 billion in both State and federal funding.

Hypotheses and Evaluation Parameters
Hawaii is testing the following research hypotheses through the current Demonstration:

1) The Demonstration will improve health outcomes and reduce inappropriate utilization.
2) The Demonstration will improve the overall health of Hawaii's most vulnerable citizens under a coordinated care management environment.
3) The Demonstration will decrease the percentage of uninsured individuals in the State.
4) The Demonstration will expand access to home- and community-based services.

During the three-year extension period, the State will use the same evaluation parameters that it currently uses under the Demonstration.

Waiver and Expenditure Authorities
The extension will require the same waiver and expenditure authorities that are employed in the current demonstration, including any additional authorities the State has requested in its pending amendment.

Specifically, consistent with the current Demonstration, the State will request waivers and expenditure authority related to the following requirements:

1. Medically Needy - Section 1902(a)(10)(C); Section 1902(a)(17)

To enable the State to limit medically needy spend-down eligibility, except for those enrolled in QExA, to individuals whose gross income, before any spend-down calculation, is at or below 300% of the FPL. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which have no gross income limit.

2. Amount, Duration, and Scope - Section 1902(a)(10)(B)

To enable the State to offer benefits that may not be available to all categorically eligible or other individuals, and to provide more limited benefits to adults in QUEST-Net and QUEST-ACE. The pending amendments would, however, eliminate this limited benefit package for QUEST-Net and QUEST-ACE.

To enable the State to maintain a waiting list, through a QExA plan, for home- and community-based services and personal care services. No waiting list is permissible for other services for QExA enrollees.

3. Financial Responsibility/Deeming - Section 1902(a)(17)(D)

To allow the State to determine the eligibility for certain children using the income of household members whose income may be taken into account under the income rules of the related cash assistance program. The State shall determine eligibility for other eligibility components using standard Medicaid financial responsibility and deeming rules. The State's pending amendments would also allow the State to consider financial support from parents or legal guardians of individuals ages 18 to 20 if the parent/legal guardian claims the individual as a tax dependent.

4. Three-Month Retroactive Eligibility - Section 1902(a)(34)

To enable the State to limit retroactive eligibility to a five (5) day period prior to application, or ninety (90) days for transitional home- and community-based services. The pending amendments would modify these retroactivity rules to allow for retroactive coverage for up to three months prior to application for all individuals requesting long-term care services.

5. Freedom of Choice - Section 1902(a)(23)

To enable the State to restrict the freedom of choice of providers for groups of individuals that could not otherwise be mandated into managed care under section 1932.

6. Cost Sharing - Section 1902(a)(14)

To enable the State to charge an enrollment fee to QExA enrollees whose spend-down liability or cost share obligation is estimated to exceed the QExA capitation rate, in the amount equal to the estimated spend-down or cost-share amount.

To enable the State to charge up to 5% in annual family income in cost sharing.

7. Managed Care Organization Contracts - Section 1903(m)(2)(A)(vi)

To enable the State to restrict an enrollees' right to disenroll without cause within 90 days of enrollment in a new MCO.

Consistent with the current demonstration, the extension will request continued authority for the following expenditures:

- to provide coverage to certain individuals not otherwise eligible for Medicaid, up to 133% of the FPL

- to reimburse hospitals for certain uncompensated costs of providing services to QUEST Expanded enrollees and the uninsured

- to enable QExA plans to provide home- and community-based services

Further detail on these authorities is set forth in Hawaii's current demonstration documents.

Comments

We invite comments on this proposal. Please submit any comments or questions to Noreen Moon-Ng by mail to P. O. Box 700190, Kapolei, HI, 96709-0190 or by email at nmoon-ng@medicaid.dhs.state.hi.us. Comments will be accepted for consideration between May 29, 2012, and June 28, 2012 (30 days from the date of this notice).

Please note that we will have a separate notice and opportunity for comment to amend the Demonstration to reflect new requirements in the Affordable Care Act that take effect January 1, 2014.

Public Hearings

The State will hold two public hearings to seek public input on this Demonstration extension application from interested parties on the proposed extension on:

Date:	Thursday, May 31, 2012	
Time:	9:00 a.m.	
Location:	Oahu	Keoni Ana Videoconference Center Keoni Ana Building 1177 Alakea Street, Room 302 Honolulu, Hawaii
	Hawaii	Hilo Videoconference Center Hilo State Office Building 75 Aupuni Street, Basement Hilo, Hawaii
	Kauai	Lihue Videoconference Center Lihue State Office Building 3060 Eiwa Street, Basement Lihue, Hawaii
	Maui	Wailuku Videoconference Center Wailuku Judiciary Building 2145 Main Street, First Floor Wailuku, Hawaii
Date:	June 6, 2012	

Time:	9:00 a.m.
Location:	Med-QUEST Division Kakuhihewa State Office Building 601 Kamokila Blvd, Room 577 A & B Kapolei, Hawaii

Interested parties may alternatively participate by teleconference. Should you be interested in participating in the teleconference, please call 808-692-8139 by close of business on Monday, June 4, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (i.e. sign or foreign language or wheelchair accessibility), please contact:

Oahu	Renee Konen	(808) 692-8132
Hawaii	Ann Stephenson	(808) 933-0046
Kauai	Iris Venzon	(808) 241-3582
Maui	Gail Omura	(808) 243-5787

at least 72 hours prior to the hearing for arrangements. Prompt requests submitted help to ensure the availability of qualified individuals and appropriate

Attachment D

Statement of Public Notice
Extension of Hawaii's QUEST Expanded Section 1115 Demonstration

The State of Hawaii, Department of Human Services (DHS), hereby notifies the public that it intends to seek a three-year extension of the QUEST Expanded Section 1115 demonstration project (the Demonstration) from the Centers for Medicare & Medicaid Services (CMS). DHS is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. § 431.408(a)(2)(ii).

The Demonstration is set to expire on June 30, 2013. Hawaii intends to request an extension of the Demonstration under the same terms and conditions as the current waiver and any pending amendments. DHS will submit a separate proposal, with a separate notice and opportunity for comment, to amend the Demonstration to reflect new requirements in the Affordable Care Act that take effect January 1, 2014.

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DHS will hold two public hearings to solicit comments from interested parties on: the proposed extension on:

Date:	Thursday, May 31, 2012	
Time:	9:00 a.m.	
Location:	Oahu	Keoni Ana Videoconference Center Keoni Ana Building 1177 Alakea Street, Room 302 Honolulu, Hawaii
	Hawaii	Hilo Videoconference Center Hilo State Office Building 75 Aupuni Street, Basement Hilo, Hawaii
	Kauai	Lihue Videoconference Center

		Lihue State Office Building 3060 Eiwa Street, Basement Lihue, Hawaii
	Maui	Wailuku Videoconference Center Wailuku Judiciary Building 2145 Main Street, First Floor Wailuku, Hawaii

Date:	June 6, 2012
Time:	9:00 a.m.
Location:	Med-QUEST Division Kakuhihewa State Office Building 601 Kamokila Blvd, Room 577 A & B Kapolei, Hawaii

Interested parties may alternatively participate by teleconference. Should you be interested in participating in the teleconference, please call 808-692-8139 by close of business on Monday, June 4, 2012.

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (i.e. sign or foreign language or wheelchair accessibility), please contact:

Oahu	Renee Konen	(808) 692-8132
Hawaii	Ann Stephenson	(808) 933-0046
Kauai	Iris Venzon	(808) 241-3582
Maui	Gail Omura	(808) 243-5787

at least 72 hours prior to the hearing for arrangements. Prompt requests submitted help to ensure the availability of qualified individuals and appropriate accommodations.

Attachment E

The Department of Human Services intends to seek a three-year extension of the QUEST Expanded Section 1115 demonstration project (the Demonstration) from the Centers for Medicare & Medicaid Services (CMS). The Demonstration is set to expire on June 30, 2013. Hawaii intends to request an extension of the Demonstration under the same terms and conditions as the current waiver and any pending amendments. DHS will submit a separate proposal, with a separate notice and opportunity for comment, to amend the Demonstration to reflect new requirements in the Affordable Care Act that take effect January 1, 2014.

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Additional information about the Demonstration and the proposed extension can be found at http://www.med-quest.us/ and http://hawaii.gov/dhs/main/har/proposed_rules/. For your convenience, attached is the demonstration extension application.

(See attached file: Draft Waiver Extension Application.PDF) *(See attached file: BN Projected 1115 Extension 20120524 without ACA.PDF)*

Attachment F

Statement of Public Notice
Extension of Hawaii's QUEST Expanded Section 1115 Demonstration

The State of Hawaii, Department of Human Services (DHS), hereby notifies the public that it intends to seek a three-year extension of the QUEST Expanded Section 1115 demonstration project (the Demonstration) from the Centers for Medicare & Medicaid Services (CMS). DHS is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. § 431.408(a)(2)(ii).

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Hawaii	Ann Stephenson	(808) 933-0046
Kauai	Iris Venzon	(808) 241-3582
Maui	Gail Omura	(808) 243-5787

at least 72 hours prior to the hearing for arrangements. Prompt requests submitted help to ensure the availability of qualified individuals and appropriate accommodations.

(45869r1 Hawaii Tribune-Herald: May 25, 2012)

AFFIDAVIT OF PUBLICATION

IN THE MATTER OF
Public Notice

STATE OF HAWAII }
} SS.
City and County of Honolulu }

Doc. Date: MAY 2 5 2012 **# Pages:** 1
Notary Name: Patricia K. Reese First Judicial **Circuit**
Doc. Description: Affidavit of Publication

[redacted] MAY 2 5 2012
Notary Signature Date

PATRICIA K. REESE NOTARY PUBLIC (Stamp or Seal) Comm. No. 06-467 STATE OF HAWAII

Rose Rosales being duly sworn, deposes and says that she is a clerk, duly authorized to execute this affidavit of Oahu Publications, Inc. publisher of The Honolulu Star-Advertiser and MidWeek, that said newspapers are newspapers of general circulation in the State of Hawaii, and that the attached notice is true notice as was published in the aforementioned newspapers as follows:

Honolulu Star-Advertiser 1 times on:
05/25/2012

Midweek Wed. 0 times on:

_____ times on:

And that affiant is not a party to or in any way interested in the above entitled matter.

Rose Rosales

Subscribed to and sworn before me this 25th day
of May, A.D. 20 12

[redacted]

Patricia K. Reese, Notary Public of the First Judicial Circuit, State of Hawaii
My commission expires: Oct 07 2014

Ad # 0000419133

PATRICIA K. REESE NOTARY PUBLIC Comm. No. 06-467 STATE OF HAWAII

Statement of Public Notice
Extension of Hawaii's QUEST Expanded Section 1115 Demonstration

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Maui — Wailuku Videoconference Center, Wailuku Judiciary Building, 2145 Main Street, First Floor, Wailuku, Hawaii

Date: June 6, 2012
Time: 9:00 a.m.
Location: Med-QUEST Division, Kakuhihewa State Office Building, 601 Kamokila Blvd., Room 577 A & B, Kapolei, Hawaii

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Kauai	Iris Venzon	(808) 241-3582
Maui	Gail Omura	(808) 243-5787

at least 72 hours prior to the hearing for arrangements. Prompt requests submitted help to ensure the availability of qualified individuals and appropriate accommodations.
(SA419133 5/25/12)

STATE OF HAWAII
COUNTY OF KAUAI
AFFIDAVIT OF PUBLICATION

THE GARDEN ISLAND

DHS/MED-QUEST DIV/FINANCE OFFI
601 KAMOKILA BLVD RM 518
KAPOLEI HI 96707

REFERENCE: 113004 00449034
744777 QUEST EXPANDED SECTI

Sherri Cole, being duly sworn, deposes and says, that she is an employee of "The Garden Island," a newspaper published in Lihue, County of Kauai, State of Hawaii; that the NOTICE in the above entitled matter of which the annexed is a true and correct copy, was published 1 time(s) in "The Garden Island" aforesaid and that this affiant is not a party to or in any way interested in the above entitled matter.

[redacted]

Subscribed and sworn to me this 1st day of [redacted], 2012.

CATHERINE VALENCIA
Notary Public, Fifth Judicial Ciruit
State of Hawaii
My Commission Expires: 10-3-2012

Document Description: Affidavit of Publication
No. of pages: 1 Document Date: 6-1-12

PUBLISHED ON: 05/25/2012

FILED ON: ~~05/25/12~~ SLC

No. 04-530
STATE OF HAWAII

Extension of Hawaii's QUEST Expanded Section 1115 Demonstration

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at least 72 hours prior to the hearing for arrangements. Prompt requests submitted help to ensure the availability of qualified individuals and appropriate accommodations.

(May 25, 2012)

Maui

Statement of Public Notice
Extension of Hawaii's QUEST Expanded Section
1115 Demonstration

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(MN: May 25, 2012)

Statement of Public Notice
Extension of Hawaii's QUEST Expanded Section 1115 Demonstration

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at least 72 hours prior to the hearing for arrangements. Prompt requests submitted help to ensure the availability of qualified individuals and appropriate accommodations.

(No. 60000-West Hawaii Today: ay 25, 2012)

Attachment G

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Policy and Program Development Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

May 17, 2012

Ms. Joelene K. Lono, Executive Director
Ke Ola Mamo
Native Hawaiian
Health Care System-Oahu
1505 Dillingham Boulevard, Room 205
Honolulu, Hawaii 96817

Dear Ms. Lono:

RE: QUEST EXPANDED SECTION 1115 DEMONSTRATION PROJECT

Pursuant to Section 5006(e)(2) of the American Recovery and Reinvestment Act of 2009, the Department of Human Services, Med-QUEST Division (MQD) is soliciting your consultation of the State of Hawaii's intent to seek a three-year extension of the QUEST Expanded Section 1115 demonstration project from the Centers for Medicare and Medicaid Services.

The Demonstration is set to expire on June 30, 2013. MQD intends to request an extension of the Demonstration under the same terms and conditions as the current waiver and any pending amendments. MQD will submit a separate proposal, with a separate notice and opportunity for comment, to amend the Demonstration to reflect new requirements in the Affordable Care Act that take effect January 1, 2014.

Please provide your written comments by June 18, 2012 to the:

Department of Human Services
Med-QUEST Division
P. O. Box 700190
Kapolei, Hawaii 96709-0190
Attn: Policy and Program Development Office

Should you have any questions or desire a meeting, please call Ms. Aileen Befitel at 692-8074 or email her at abefitel@medicaid.dhs.state.hi.us

Thank you for your efforts, support and advocacy for the American Indian and Alaska Native communities and your continuing support of our Medicaid programs.

Sincerely,

/S/ for

Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

NEIL ABERCROMBIE
GOVERNOR

PATRICIA MCMANAMAN
DIRECTOR

BARBARA A. YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Administration
P. O. Box 700190
Kapolei, Hawaii 96709-0190

June 13, 2012

Ms. Joelene K. Lono, Executive Director
Ke Ola Mamo
Native Hawaiian
Health Care System-Oahu
1505 Dillingham Boulevard, Room 205
Honolulu, Hawaii 96817

Dear Ms. Lono:

RE: AMENDMENT TO HAWAII MEDICAID STATE PLAN

Pursuant to Section 5006(e)(2) of the American Recovery and Reinvestment Act of 2009, the Department of Human Services, Med-QUEST Division (MQD) is soliciting your expedited consultation on the proposed extension of the Medicaid section 1115 Demonstration Waiver (Demonstration).

The Demonstration is set to expire on June 30, 2013. MQD intends to request an extension of the Demonstration under the same terms and conditions as the current waiver and any pending amendments. MQD will submit a separate proposal, with a separate notice and opportunity for comments, to amend the Demonstration to reflect new requirements in the Affordable Care Act that take effect January 1, 2014.

Please provide your written comments by June 27, 2012 to the:

Department of Human Services
Med-QUEST Division
P.O. Box 700190
Kapolei, Hawaii 96709-0190
Attention: Policy and Program Development Office

Should you have any questions or desire a meeting, please feel free to call
Ms. Aileen Joy C. Befitel at 692-8074 or email her at abefitel@medicaid.dhs.state.hi.us.

Thank you for your efforts, support and advocacy for the American Indian and Alaska Native communities and your continuing support of our Medicaid programs.

Sincerely,

/S/ for

Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

Hawaii QUEST Expanded
Section 1115 Demonstration Waiver

Interim Demonstration Evaluation Report

September 5, 2012

Demonstration Year Ending: June 30, 2012

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Executive Summary

The demonstration evaluation period for this report is from January 1, 2008 to June 30, 2012. This concludes the 18th demonstration year for the QUEST Expanded Medicaid section 1115 demonstration waiver. The demonstration evaluation period has seen several significant initiatives for the QUEST Expanded program:

- **Development and implementation of the QUEST Expanded Access (QExA) program on February 1, 2009.**

  Effective February 1, 2009, the majority of the fee-for-service (FFS) population was transitioned into managed care in the QUEST Expanded Access (QExA) program. The Medicaid population in QExA consists of beneficiaries 65 years or older or with a disability of any age. The QExA program has two health plans: 'Ohana Health Plan and UnitedHealthcare Community Plan. As of June 30, 2012, the QExA program has approximately 45,000 beneficiaries. The QExA health plans provide a continuum of services to include primary, acute care, standard behavioral health, and long-term care services. The goals of the QExA program are:
  - Improve the health status of the member population;
  - Establish a "provider home" for members through the use of assigned primary care providers (PCPs);
  - Establish contractual accountability among the State, the health plan and healthcare providers;
  - Expand and strengthen a sense of member responsibility and promote independence and choice among members;
  - Assure access to high quality, cost-effective care that is provided, whenever possible, in a member's home and/or community;
  - Coordinate care for the members across the benefit continuum, including primary, acute and long-term care benefits;
  - Provide home and community based services (HCBS) to persons with neurotrauma;
  - Develop a program that is fiscally predictable, stable and sustainable over time; and
  - Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals.

- **Reprocurement of the QUEST program.**

  The QUEST program is for Medicaid beneficiaries under the age of 65 without a disability. As of June 30, 2012, the QUEST program has approximately 239,000 beneficiaries. Through the demonstration evaluation period, the QUEST program had three health plans: AlohaCare, Hawaii Medical Services Association (HMSA), and Kaiser Permanente. In August 2011, the Med-QUEST Division (MQD) reprocured the QUEST program and added two additional health plans: 'Ohana Health Plan and UnitedHealthcare Community Plan. The new QUEST procurement went into effect on July 1, 2012.

  In the new procurement, MQD added or expanded on several new initiatives. These include:
  - Value-based purchasing (e.g., patient centered medical homes and accountable care organizations);
  - Financial incentives for improving quality to their members;

- Integration of medical and behavioral health services;
- Auto-assign algorithm based upon quality instead of cost; and
- Standardization of capitation payments amongst health plans.

MQD will report on the progress of these initiatives in the upcoming reports to CMS.

- **Implementation of the QUEST Adult Coverage Expansion (QUEST-ACE) program.**
  In April 2007, the MQD implemented a new program called QUEST-ACE that provides medical assistance to a childless adult who is unable to enroll in the QUEST program due to the limitations of the statewide enrollment cap of QUEST as indicated in HAR §17-1727-26. The QUEST-ACE benefit package will encompass the same limited package of benefits currently provided under the QUEST-Net program. This program continues to reducing the number of uninsured and underinsured adults in our community.

- **Implementation of revised Quality Strategy.**
  MQD implemented a new Quality Strategy in 2010 after receiving approval from CMS. As part of the implementation of the Quality Strategy, MQD has:
  - Increased health plan monitoring;
  - Standardized health plan reporting; and
  - Implemented public reporting of health plan quality results.

- **Implementation of Pay for Performance through financial incentives in the QUEST program.**
  MQD implemented a Pay for Performance program that provides financial incentives to QUEST health plans based upon improved quality results. Results of the implementation of this program during the demonstration year are provided below:

	AlohaCare	HMSA	Kaiser
Childhood Immunization (HEDIS 2010)	No	No	Yes
Clamydia Screening (HEDIS 2010)	No	Yes	Yes
LDL Control- Comprehensive Diabetes Care (HEDIS 2010)	No	No	Yes
Getting Needed Care- Child CAHPS (CAHPS 2011)	No	No	No
Getting Needed Care- Adult CAHPS (CAHPS 2010)	Yes	No	No
ED Visits/1000 (HEDIS 2010)	Yes	Yes	Yes
Total PMPM	$0.40	$0.40	$0.80

The implementation of these initiatives has occurred to decrease the uninsured population in Hawaii and improve the quality of services to Hawaii's Medicaid beneficiaries. Though results have not consistently met the benchmarks, MQD has identified several recommendations to improve future results. These recommendations include improved data gathering, collaborative partnership with health plans, and financial incentives to improve quality of services.

Information about the Demonstration

Overview and Brief History of the Demonstration

Hawaii's QUEST Expanded is a Med-QUEST Division (MQD) wide comprehensive section 1115 (a) demonstration that expands Medicaid coverage to children and adults. The demonstration creates a public purchasing pool that arranges for health care through capitated-managed care plans. The State of Hawaii implemented QUEST on August 1, 1994. The current extension period is from February 1, 2008 to June 30, 2013.

QUEST is a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Assistance Program and its innovative State Health Insurance Program and offered benefits to citizens up to 300 percent FPL. Low-income women and children and adults who had been covered by the two State-only programs were enrolled into fully capitated managed care plans throughout the State. This program virtually closed the coverage gap in the State.

The QUEST program covered adults with incomes at or below 100 percent of the federal poverty level (FPL) and uninsured children with family incomes at or below 200 percent FPL. In addition, the QUEST-Net program provided a full Medicaid benefit for children with family incomes above 200, but not exceeding 300 percent FPL and a limited benefit package for adults with incomes at or below 300 percent FPL. In order to be eligible for QUEST-Net, individuals must first have been enrolled in QUEST or Medicaid fee-for-service and may enroll in QUEST-Net when their income or assets rise above the QUEST or Medicaid fee-for-service eligibility limits. QUEST eligibles who are self-employed were previously assessed a premium. These individuals were allowed to opt for QUEST-Net as a source of insurance coverage.

In February 2007, the State requested to renew the QUEST demonstration, and the State reaffirmed its 2005 request to CMS to amend the Demonstration to advance the State's goals to develop a managed care delivery system for the Aged, Blind, and Disabled (ABD) population.

As a condition of the 2007 renewal the State was required to achieve compliance with the August 17, 2007, CMS State Health Official (SHO) letter that mandated by August 16, 2008, the State must meet the specific crowd-out prevention strategies for new title XXI eligibles above 250 percent of the Federal poverty level (FPL) for which the State seeks Federal Financial Participation (FFP). On March 30, 2009 the State requested that this provision be removed from the STCs. The State's request was a result of Public Law 111-3 The Children's Health Insurance Reauthorization Act of 2009 (CHIPRA), and the issuance of a Presidential memorandum t to the Secretary of Health and Human services to withdraw the August 17, 2007 SHO letter. On February 6, 2009 the letter was withdrawn through SHO #09-001.

On February 18, 2010 the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment. The proposed amendment would provide a 12 month subsidy to eligible employers for approximately half of the employer's share for eligible employees newly hired between May 1, 2010 and April 30, 2011.

On July 28, 2010, the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment to eliminate the unemployment insurance eligibility requirement for the Hawaii Premium Plus (HPP) program. The HPP program was recently created to encourage employment growth and employer sponsored health insurance coverage in the State.

On August 11, 2010, Hawaii submitted an amendment proposal to add the pneumonia vaccine as a covered immunization. In addition to the July 28 and August 11, 2010 proposed amendments, several technical corrections were made regarding expenditure reporting for both Title XIX and XXI Demonstration populations.

On July 7, 2011, Hawaii submitted an amendment proposal to reduce QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL, including the elimination of the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. On July 8, 2011, Hawaii filed a coordinating budget deficit certification, in accordance with CMS' February 25, 2011, State Medicaid Director's Letter. This certification was approved by CMS on September 22, 2011. This certification grants the State a time-limited non-application of the maintenance of effort provisions in section 1902(gg) of the Act and provides the foundation for CMS to approve the State's amendment to reduce eligibility for non-pregnant, non-disabled adults with income above 133 percent of the FPL in both QUEST-Net and QUEST-ACE. On April 5, 2012, CMS approved an amendment which reduced the QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL and eliminated the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL.

In the July 7, 2011 amendment, Hawaii also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the Demonstration; eliminate the QUEST enrollment limit for childless adults; provide QUEST Expanded Access (QExA) individuals with expanded primary and acute care benefits; remove the Hawaii Premium Plus program, a premium assistance program, due to a lack of Legislative appropriation to continue the program, and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

Population Groups Impacted

Based on the goals and objectives of this demonstration, the targeted populations groups to be impacted are the most vulnerable and needy who do not have access to any other form of healthcare coverage. Individuals and family members who are sixty-five years old or older, or are blind, or are disabled are generally disqualified from the eligible groups. The scope of the population groups impacted by the demonstration has consistently and regularly been expanding from its initial focus. In its current form, the following populations are expected to benefit from this demonstration:

- Pregnant women in families whose income is up to 185 percent of the FPL.
- Infants and children in families whose income is up to 300 percent of the FPL.
- Adults and families with dependent children whose income is up to 100 percent of the FPL.
- Childless adults whose income is up to 100 percent of the FPL.
- Uninsured individuals in general.

Summary of the requirements for the evaluation in the special terms and conditions

The State must provide an update on evaluation status monthly to the Centers for Medicare & Medicaid Services (CMS) during State/CMS calls.

The State must submit a draft evaluation design at the start of the waiver. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period when submitting a request for Demonstration extension. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

Purpose, aims, objectives, and goals of the demonstration

Goals and Objectives of the Demonstration

The goals and objectives of the demonstration include:

- Developing a managed care delivery system for the Aged, Blind, and Disabled (ABD) population that would assure access to high quality, cost-effective care.
- Coordinating care for the ABD population across the care continuum (from primary care through long-term care).
- Increasing access to a health care benefit for low-income children.
- Developing a program design that is fiscally sustainable over time.
- Developing a program that places emphasis on the efficacy of services and performance.

Hypotheses on the Outcomes of the Demonstration

The state's hypotheses about the outcomes of the demonstration are based on State Quality Improvement Strategy targets. The following outcomes are expected in this demonstration:

- Childhood Immunizations (CIS): Increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the Medicaid 75th percentile.

- Chlamydia Screening (CHL): Increase performance on the state aggregate HEDIS Chlamydia Screening measure to meet/exceed the Medicaid 75th percentile.

- Breast Cancer Screening (BCS): Increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the Medicaid 75th percentile.

- Comprehensive Diabetes Care (CDC):

  - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the HEDIS 75th percentile.

  - Improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c poor control (>9) to meet/fall below the HEDIS 25th percentile.

  - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<7) to meet/exceed below the HEDIS 75th percentile.

  - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL screening to meet/exceed the HEDIS 75th percentile.

  - Increase performance on the state aggregate HEDIS Diabetes Care Measure for LDL control (<100) to meet/exceed the HEDIS 75th percentile.

  - Increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<130/80) to meet/exceed the 2010 HEDIS 75th percentile.

  - Increase performance on the state aggregate HEDIS Diabetes Care Measure for eye exams to meet/exceed the HEDIS 75th percentile.

- Cholesterol Management in Patients with Cardiovascular Conditions (CMC): Increase performance on the state aggregate HEDIS Cholesterol Screening measure to meet/exceed the HEDIS 75th percentile.

- Controlling High Blood Pressure (CBP): Increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the HEDIS 75th percentile.

- Use of Appropriate Medications for People with Asthma (ASM): Increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the HEDIS 75th percentile.

- Emergency Department Visits (AMB): Improve performance on the state aggregate HEDIS 2010 Emergency Department Visits/1000 rate to meet/fall below the HEDIS 10th percentile.

- Getting Needed Care: Increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Rating of Health Plan: Increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- How well doctors communicate: Increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS Adult Medicaid 75th percentile.

- Home and Community Based Service (HCBS) clients: Increase by 5% the proportion of clients receiving HCBS instead of institutional-based long-term care services over the next year.

Key Interventions Planned

The key interventions planned in for the evaluation of the demonstration include:

- Monitoring of annual Healthcare Effectiveness Data and Information Set (HEDIS) measures gathered from health plans from both the QUEST and QExA programs
- Monitoring of utilization of home and community based services in the long term supports and services population
- Monitoring of enrollment numbers monthly
- Conducting CAHPS surveys annually
- Conducting provider surveys biennially

Evaluation Design

Management and Coordination of Evaluation

Organization Conducting the Evaluation

The evaluation will be conducted internally within Med-QUEST Division (MQD), primarily by the Health Care Services Branch (HCSB). The MQD works in concert with its External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), on collection of information from the health plans. This includes validation of several HEDIS measures, performing annual CAPHS survey and biennial provider surveys.

The HCSB receives the raw data from HSAG and analyzes it against demonstration goals. The MQD team that conducts the evaluation includes:

- Jon Fujii, Research Officer- primary lead
- Lily Ota, RN, Nurse Consultant
- Dr. Curtis Toma, MQD Medical Director
- Madi Silverman, Home & Family Access Program Manager
- Christian Butt, Contract and Compliance Section Administrator
- Patricia M. Bazin, Health Care Services Branch Administrator
- Brian Pang, Finance Officer

Timeline for Implementation of the Evaluation and for Deliverables

Summary of Timeline for Annual Quality Activities

Time Frame	Activity
March	Mail CAHPS surveys to Medicaid beneficiaries
April/May	Health plan site visit by MQD and EQRO to gather HEDIS data from previous year
May	Close CAHPS surveys to Medicaid beneficiaries
June	Preliminary HEDIS results due to EQRO
July	Final HEDIS results released by EQRO to MQD
July	EQRO releases preliminary CAHPS star report to MQD
September	EQRO releases final CAHPS star report to MQD
October	Analysis of health plan HEDIS results to NCQA quality compass (i.e., compare to 75th and 90th results for Medicaid populations)
November	Develop consumer guides for QUEST and QExA health plans Note: the consumer guide is a summary of several HEDIS measures and CAHPS survey results for health plans in both the QUEST and QExA programs that is provided to the public
December	Release of the following items for public reporting: • EQRO annual report • QUEST Consumer Guide • QExA Consumer Guide

Summary of Timeline for Biennial Quality Activities

Time Frame	Activity
April	Mail survey to Medicaid health plan providers
June	Close survey to Medicaid health plan providers
October	EQRO releases final provider survey results to MQD

Summary of Timeline for Annual Deliverables

Time Frame	Activity
February	Submit quarterly report for September to December
March	Submit annual report for State Fiscal Year (July to June) of previous year
May	Submit quarterly report for January to March
August	Submit quarterly report for April to June
November	Submit quarterly report for July to August

Summary of Timeline for Compilation of Demonstration Evaluation Report

July	Analyze data from previous demonstration years
August	Compile information into report
September	Submit report

Performance Metrics

Summary of Performance Metrics

When observing the various measures below, and unless stated otherwise, remember that a higher numeric score is considered positive and a lower numeric score is considered negative.

Measures	Reported Years	Latest Score	Target Score
HEDIS Measures:			
Use of Appropriate Medications for People With Asthma, Total (ASM)	HEDIS 2008-2012	75.6%	90.5%
Eye Exam (CDC)	HEDIS 2008-2012	59.4%	63.7%
HbA1c Testing (CDC)	HEDIS 2008-2012	81.2%	87.1%
HbA1c Control <7.0% (CDC)	HEDIS 2008-2012	24.2%	41.3%
Poor HbA1c Control >9% (CDC) #	HEDIS 2008-2012	52.8%	34.9%
LDL-C Screening (CDC)	HEDIS 2008-2012	77.2%	80.3%
LDL-C Level <100 mg/dL (CDC)	HEDIS 2008-2012	34.0%	41.4%
Medical Attention for Nephropathy (CDC)	HEDIS 2008-2012	79.0%	82.5%
Blood Pressure Controlled <140/80 mm Hg (CDC) *	HEDIS 2008-2012	36.2%	44.2%
LDL-C Screening (CMC)	HEDIS 2008-2012	81.0%	85.9%
LDL-C level <100 mg/dL (CMC)	HEDIS 2008-2012	41.7%	50.0%
Controlling High Blood Pressure (CBP)	HEDIS 2008-2012	47.1%	63.7%
Child Immunizations Status, Combination 2 (CIS)	HEDIS 2008-2012	61.9%	80.7%
Breast Cancer Screening (BCS)	HEDIS 2008-2012	49.7%	57.4%
Cervical Cancer Testing (CCS)	HEDIS 2008-2012	63.7%	74.2%
Chlamydia Screening (CHL)	HEDIS 2008-2012	58.2%	63.4%
Emergency Department Visits, per 1,000 member months, Total (AMB) @	HEDIS 2008-2012	43.0	44.4
EPSDT Measures:			
Screening Ratio	FFYE 2007-2011	0.98	0.82
Participant Ratio	FFYE 2007-2011	0.78	0.64
CAHPS Measures:			
Rating of Health Plan	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.51 QExA: 2.25	2.61
Rating of Personal Doctor	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.53 QExA: 2.54	2.65
Rating of Specialist Seen Most Often	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.48 QExA: 2.43	2.60
How Well Doctors Communicate	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.65 QExA: 2.57	2.70
Getting Needed Care	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.26 QExA: 2.23	2.43
Getting Care Quickly	QUEST: 2008-2012 QExA: 2010-2012	QUEST: 2.29 QExA: 2.30	2.65
Physicians' Assessment Measures			
Attitude toward Hawaii Med-QUEST	2009, 2011	34.7%	N/A
Satisfaction with reimbursement from the Med-QUEST health plan	2009, 2011	26.4%	N/A
Does the health plan personnel have the necessary professional knowledge	2009, 2011	24.8%	N/A
Impact of the health plan's UM (prior authorizations) on quality care	2009, 2011	19.1%	N/A
Med-QUEST Internal Measures			
HCBS % of Nursing Home Population	2008 - 2012	68.5%	N/A
Cumulative Savings from Increase in HCBS Population	2008 - 2012	$80,123,000	N/A
Medicaid Enrollment	2008 - 2012	287,902	N/A
Budget Neutrality Savings	DY 18	$1,833,414,530	> 0

(#) Unlike the other measures, for this measure higher numeric scores are considered negative and lower numeric scores are considered positive. Accordingly, the targets for the HEDIS measures represent the score for the national Medicaid 25th %ile, NOT the score for the 75th %ile.

(@) Unlike the other measures, for this measure higher numeric scores are considered negative and lower numeric scores are considered positive. Accordingly, the targets for the HEDIS measures represent the score for the national Medicaid 10th %ile, NOT the score for the 75th %ile.
(*) This numerator changed from BP <130/80 to BP < 140/80 in HEDIS 2011.

Population Groups of Enrollees for which Data will be Analyzed

- Individuals with a diagnosis of Asthma.
- Individuals with a diagnosis of Diabetes Mellitus.
- Individuals with a diagnosis of Cardiovascular disease.
- Children up to 21 years old.
- Women ages 21 years and older.

Methods by which the data collected will be analyzed, including the statistical methodologies to be used

The results of the data collection and calculation will be various values for the given period. These results will be displayed in graphical format. For most measures, a longitudinal comparison will be made among the various years' Hawaii statewide QUEST scores. Where applicable, comparison to State Quality Improvement Strategy targets will also be reviewed.

A determination will be made if unexpected or expected factors are influencing the calculated values. These factors could be internal to DHS, specific to a plan's operations, or external at a state or national level. Either way, there will be a discussion on how we believe these factors are exerting influence on the values.

Initiatives related to each measure will be discussed. These may be conducted by the health plan or by the MQD, and in each case was implemented to improve the quality of care or collection of data related to the measure calculation.

Integration of the State Quality Improvement Strategy

The MQD started working with CMS, with Gary Jackson as the contact, in January 2010 on the revision of the Quality Strategy. MQD followed the CMS toolkit and checklist for State Quality Strategies as well as the Delaware Quality Strategy as a template. In May 2010, MQD submitted the revised Quality Strategy to CMS. The public comment period ended on September 9, 2010 and MQD received approval of its Quality Strategy. A copy of the Quality Strategy is posted at the MQD website (www.med-quest.us).

MQD's continuing goal is to ensure that our clients receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. MQD has adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. An initial set of ambulatory care measures based on this framework was identified. HEDIS measures that the health plans report

to us are reviewed and updated each year. As MQD evaluates the demonstration, the Quality Strategy is used as the framework for the evaluation.

The Health Services Advisory Group (HSAG) is the MQD's External Quality Review Organization (EQRO). Many of the MQD's quality activities are completed in partnership with HSAG. HSAG compiles and validates both QUEST and QExA HEDIS measures annually. In addition, HSAG administers both the CAHPS and provider surveys for MQD.

HSAG provides this data to us in the timeframe established in the *Timeline for Implementation of the Evaluation and for Deliverables* section. MQD analyzes this data as part of the annual parts of the evaluation of the demonstration.

Finally, HSAG submits an annual report to MQD in November of each year. MQD posts this report on our website (www. med-quest.us) under the Managed Care/Consumer Guides section for public awareness.

Steps were taken to ensure that measures in the State Quality Improvement Strategy were reported here. These measures included comparisons to the targets from the State Quality Improvement Strategy. There are also measures that are not a part of the State Quality Improvement Strategy in this report.

Measures

The graphs used to illustrate the various measures are, unless otherwise noted, scaled from 0% to 100%. This was done to facilitate comparisons between graphs and to present a consistent scale of measurement.

Initiatives related to these measures are reported separately in a subsequent section of this report.

HEDIS Measures

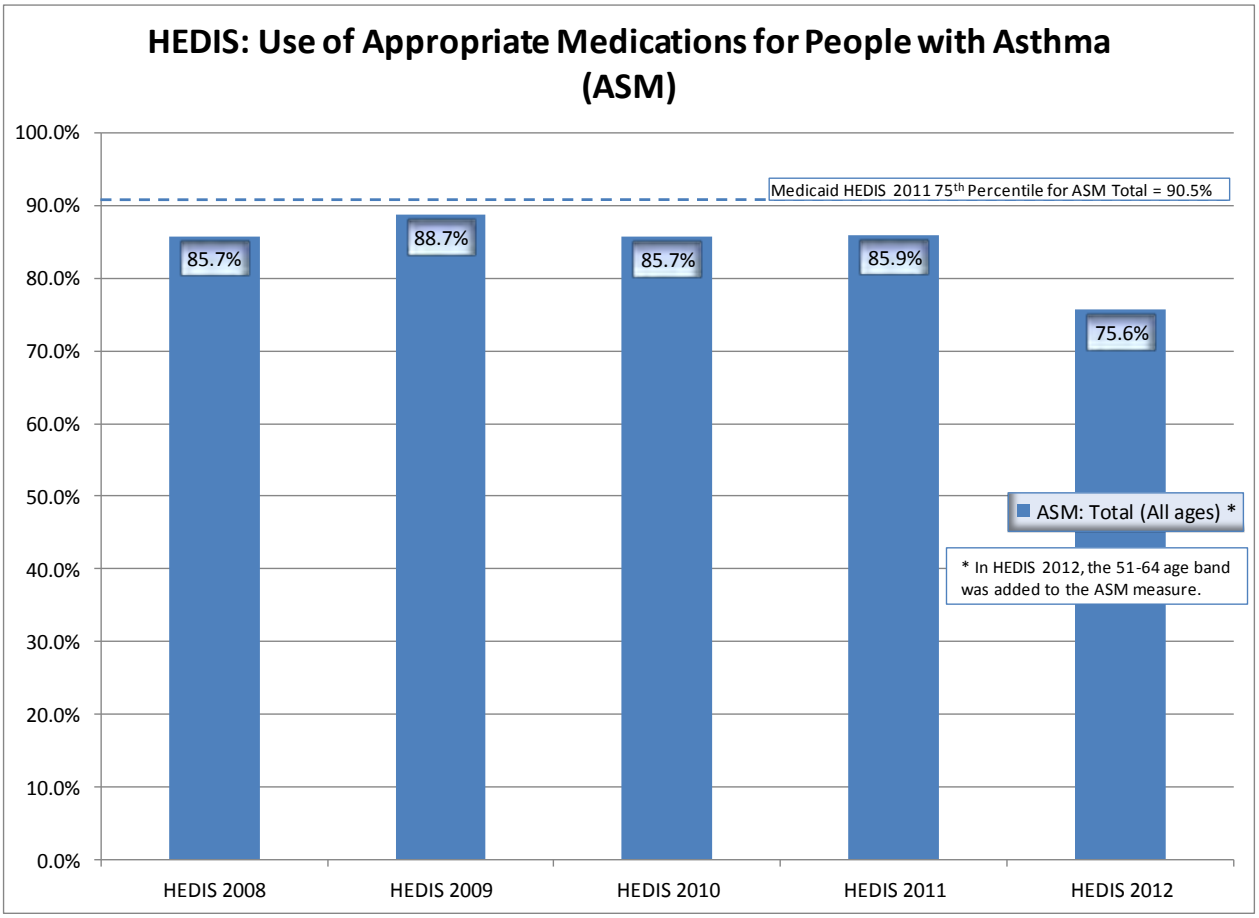
The Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure both the quality of healthcare delivered to, as well as the overall healthcare utilization levels of, the Hawaii QUEST and QExA recipients.

The HEDIS measures mostly involve ratios of a target behavior over the entire population that is eligible for that behavior. Occasionally ratios are reported on a sample of the population instead of the entire population, but on these occasions there are intensive internal claim audits applied to a sample of the claims. The HEDIS measures are based on self-reported HEDIS reports received from the five individual QUEST and QExA plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan, and UnitedHealth Community Plan. It should be noted that prior to HEDIS 2011, only the QUEST recipients are reflected in the HEDIS scores. HEDIS reports from the plans are based on a calendar year period, a twelve-month period beginning in January 1 and ending on December 31 of the report year, and are due to Med-QUEST on approximately June 30 of the following year. These are sent via standard NCQA electronic file (IDSS) to Med-QUEST, and are then weight-averaged to create composite HEDIS measures for the entire Med-QUEST population for a single year. The plans are required to report on most of the HEDIS measures in each year. The definitions of the various HEDIS measures reported by the plans are no different from the national standard HEDIS definitions – we do not have any HEDIS-like measures. All five plans are concurrently audited by our External Quality Review Organization (EQRO).

Annual audits on how the plans calculate and report their HEDIS scores are conducted by the HEDIS-certified External Quality Review Organization (EQRO) entity under contract with, and under the direction of, Med-QUEST. Typically, these audits involve a sample of three to six HEDIS measures. The measures presented below are a small sample of the complete set of HEDIS measures that are reported each year,

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. For most measures scores are reported for each year from 2008 to 2012. A comparison is made to the 2011 National Medicaid Median 75th Percentile score to bring perspective to where we score on a national level. Our Quality Strategy sets the National Medicaid 75th Percentile score as the target score for most of the HEDIS measures.

For all of the HEDIS measures except for the CDC: Poor HbA1c Control >9% and AMB: Emergency Department Visits, higher numeric scores are considered positive and lower numeric scores are considered negative; for these measures lower numeric scores are considered positive and higher numeric scores are considered negative.



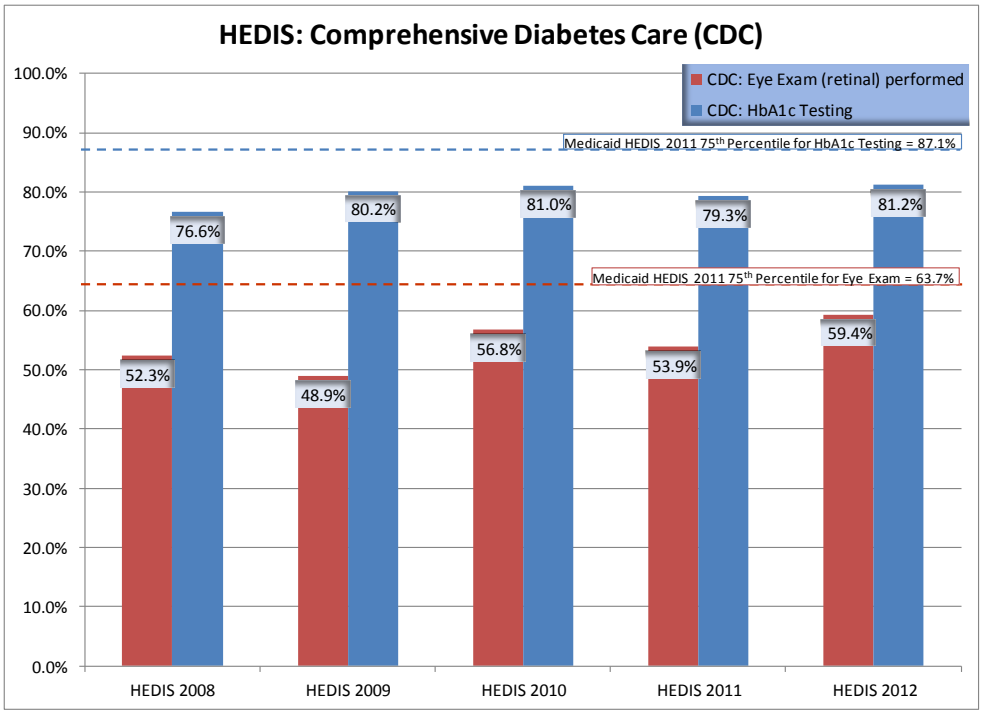
ASM:

- The statewide Medicaid percentage of members 5-64 years of age identified as having persistent asthma and who appropriately prescribed medication has varied between 75% and 89% from 2008 to 2012, with the highest rate of 88.7% occurring in 2009 and the lowest rate of 75.6% occurring in 2012. Note that although the 51-64 year of age group was added in 2012, removing this age group would not have increased the 2012 score past 76.0%.

- The 2012 year's score fell significantly from the previous four-year range between 85% and 88%, clearly falling out of the historical trend for this measure on the negative side.

- The HI Quality Strategy target percentage for the ASM measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 90.5%, which was better than all of the years reported.

CDC – Eye Exam:



- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had a retinal eye exam performed varied between 48% and 60% from 2008 to 2012, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.

- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.

- The HI Quality Strategy target percentage for the CDC – Eye Exam measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 63.7%, which was better than all of the years reported.

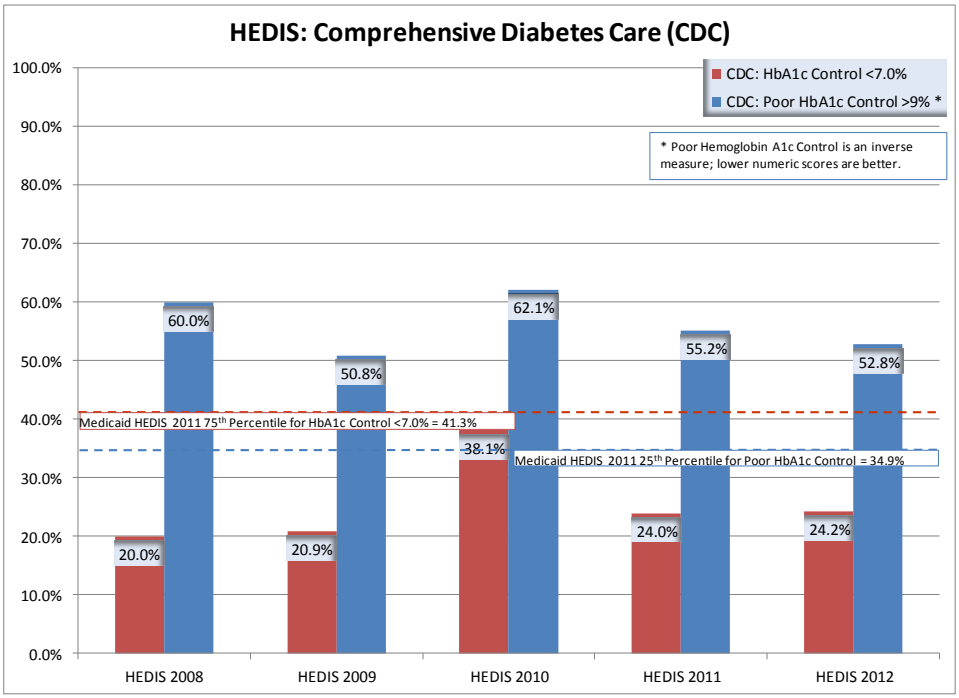
CDC – HbA1c Testing:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an HbA1c test performed varied between 76% and 82% from 2008 to 2012, with the highest rate of 59.4% occurring in 2012 and the lowest rate of 48.9% occurring in 2009.

- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the first two years (2008 and 2009) reported the lowest rates.

- The HI Quality Strategy target percentage for the CDC – HbA1c Testing measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 87.1%, which is above all of the years reported.

CDC – HbA1c Control <7.0%:



- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under good control varied between 20% and 39% from 2008 to 2012, with the highest rate of 38.1% occurring in 2010 and the lowest rate of 20.0% occurring in 2008.

- There is a moderate uptrend in the rates of the five years reported. The latest year (2012) reported the highest rate, and the earliest year (2008) reported the lowest rate. There is what seems like an outlier score in 2010 of 38.1%, especially when considering the four other years' scores were bunched between 20.0% and 24.2%

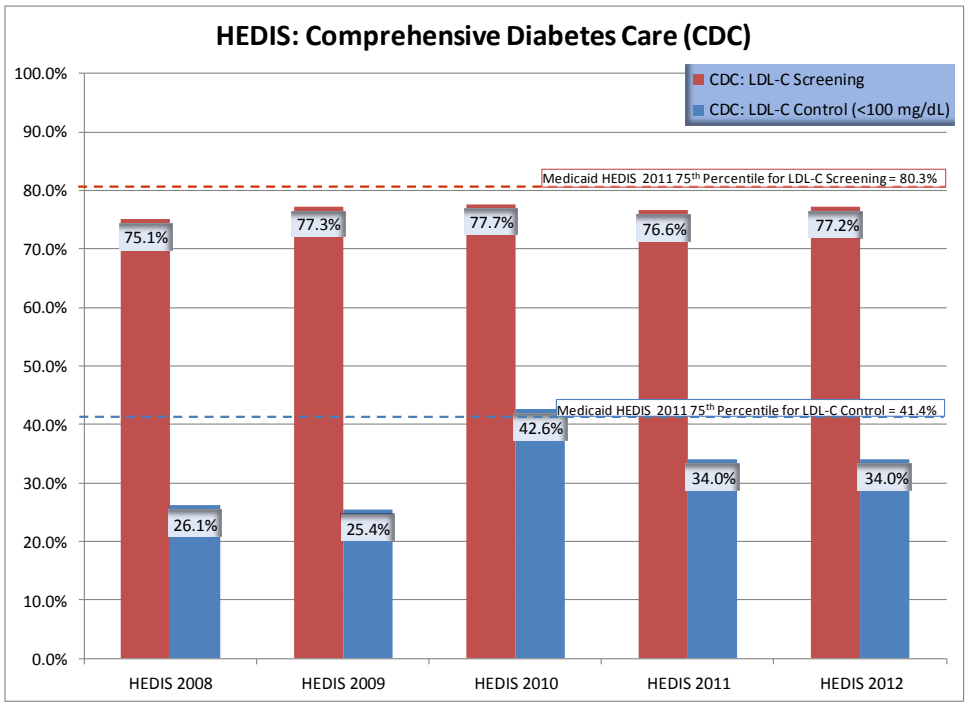
- The HI Quality Strategy target percentage for the CDC – HbA1c Control <7.0% measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 41.3%, which is above all of the years reported.

CDC – HbA1c Poor Control >9.0%:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had HbA1c under poor control varied between 63% and 50% from 2008 to 2012, with the highest rate of 62.1% occurring in 2010 and the lowest rate of 50.8% occurring in 2009. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.

- There is a slight downtrend (good) to flat trend in the rates of the five years reported. The last three years' score went from 62.1% to 55.2% to 52.8%, yet the lowest score occurred in 2009 (50.8%).

- The HI Quality Strategy target percentage for the CDC – HbA1c Poor Control >9.0% measure is the 25th percentile of the national Medicaid population. For the 2011 this target was 34.9%, which is below (not good) all of the years reported.



CDC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) who had an LDL-C screening performed varied between 75% and 78% from 2008 to 2012, with the highest rate of 77.7% occurring in 2010 and the lowest rate of 75.1% occurring in 2008.

- There is a flat trend (no trend) in the rates of the five years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).

- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 80.3%, which is higher than all of the years reported.

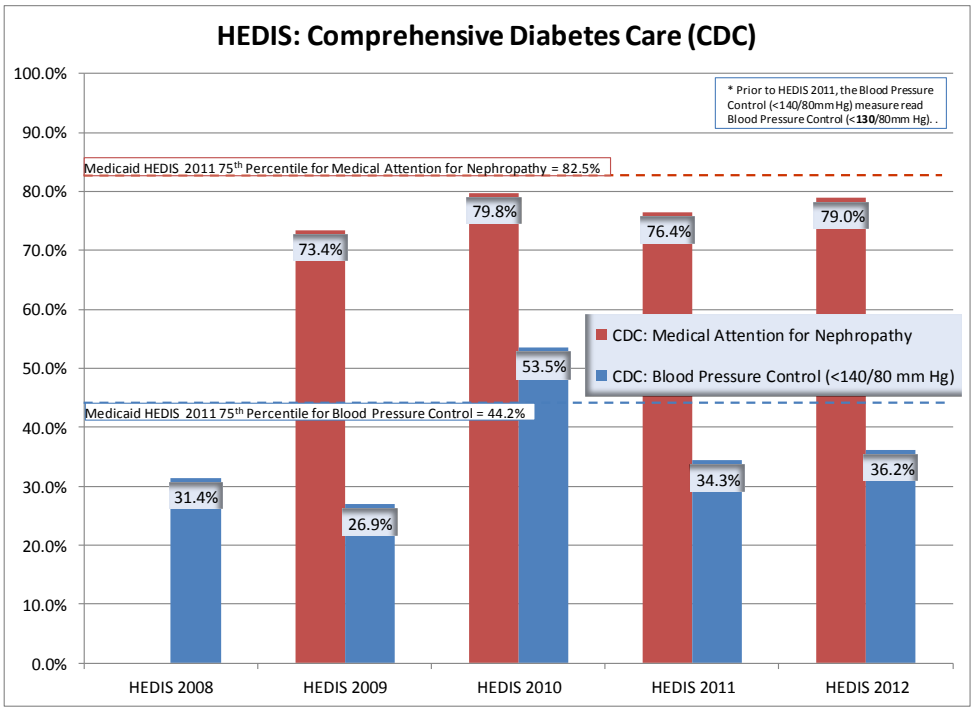
CDC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had LDL-C under control varied between 25% and 43% from 2008 to 2012, with the highest rate of 42.6% occurring in 2010 and the lowest rate of 25.4% occurring in 2009.

- There is a flat trend (no trend) in the rates of the five years reported. All years' scores were tightly bunched within three percentage points. The lowest rate was reported in the first year (2008).

- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 80.3%, which is higher than all of the years reported.

CDC – Medical Attention for Nephropathy:



- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had medical attention for nephropathy varied between 73% and 80% from 2009 to 2012, with the highest rate of 79.8% occurring in 2010 and the lowest rate of 73.4% occurring in 2009. Note that this was a new measure in 2009.

- There is a slight up trend in the rates of the four years reported. The lowest rate was reported in the first year (2009), and the latest year reported (2012) had a rate (79.0%) not much lower than the 79.8% in 2010.

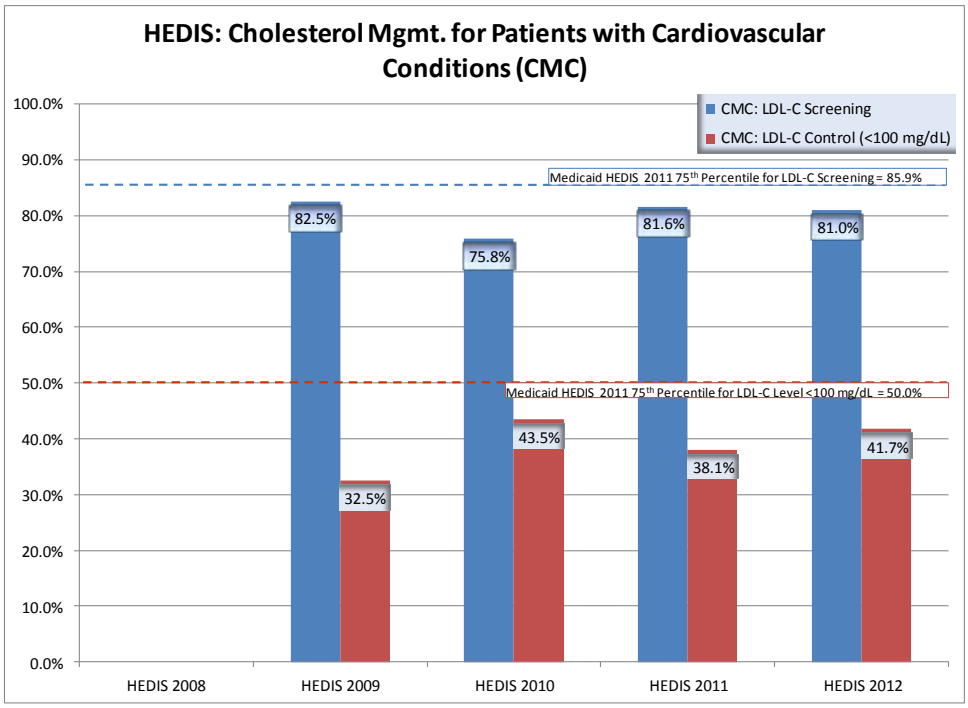
- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 this target was 82.5%, which is higher than all of the years reported.

CDC – Blood Pressure Control (<140/80 mm Hg):

- The statewide Medicaid percentage of members 18-75 years of age identified with diabetes (type 1 and type 2) that had blood pressure under control below <140/80 mm Hg varied between 26% and 54% from 2008 to 2012, with the highest rate of 53.5% occurring in 2010 and the lowest rate of 26.9% occurring in 2009.

- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010 (which looks like an outlier), the highest two scores were in 2011 (34.3%) and 2012 (36.2%).

- The HI Quality Strategy target percentage for the CDC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with a national averages -- this target was 44.2%, which is higher than all of the years reported except for in 2010.



CMC – LDL-C Screening:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had an LDL-C screening performed varied between 75% and 82% from 2009 to 2012, with the highest rate of 82.5% occurring in 2009 and the lowest rate of 75.8% occurring in 2010. Note that the first year for this measure is 2009.

- There is a flat trend (no trend) in the rates of the four years reported. The highest rate was reported in the first year (2009), the lowest rate occurred in the second year (2010), and the remaining two years' scores fell between these.

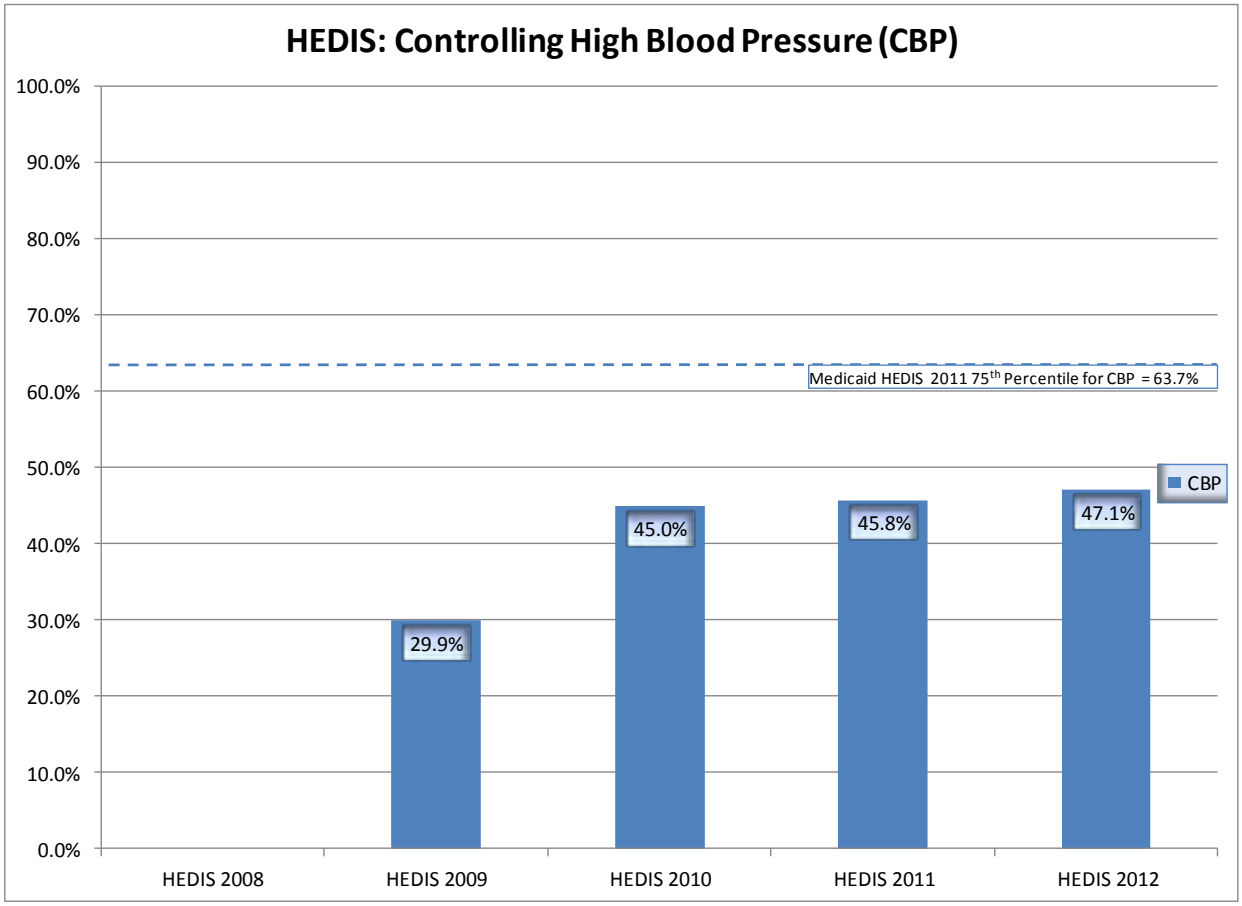
- The HI Quality Strategy target percentage for the CMC – LDL-C Screening measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 85.9%, which is higher than all of the years reported.

CMC – LDL-C Control:

- The statewide Medicaid percentage of members 18-75 years of age identified with a cardiac condition that had LDL-C under control varied between 32% and 43% from 2009 to 2012, with the highest rate of 43.5% occurring in 2010 and the lowest rate of 32.5% occurring in 2009. Note that the first year for this measure is 2009.

- There is a slight up trend in the rates of the five years reported. Leaving out the high score for 2010, the highest two scores were in 2011 (38.1%) and 2012 (41.7%).

- The HI Quality Strategy target percentage for the CMC – LDL-C Control measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 50.0%, which is higher than all of the years reported.

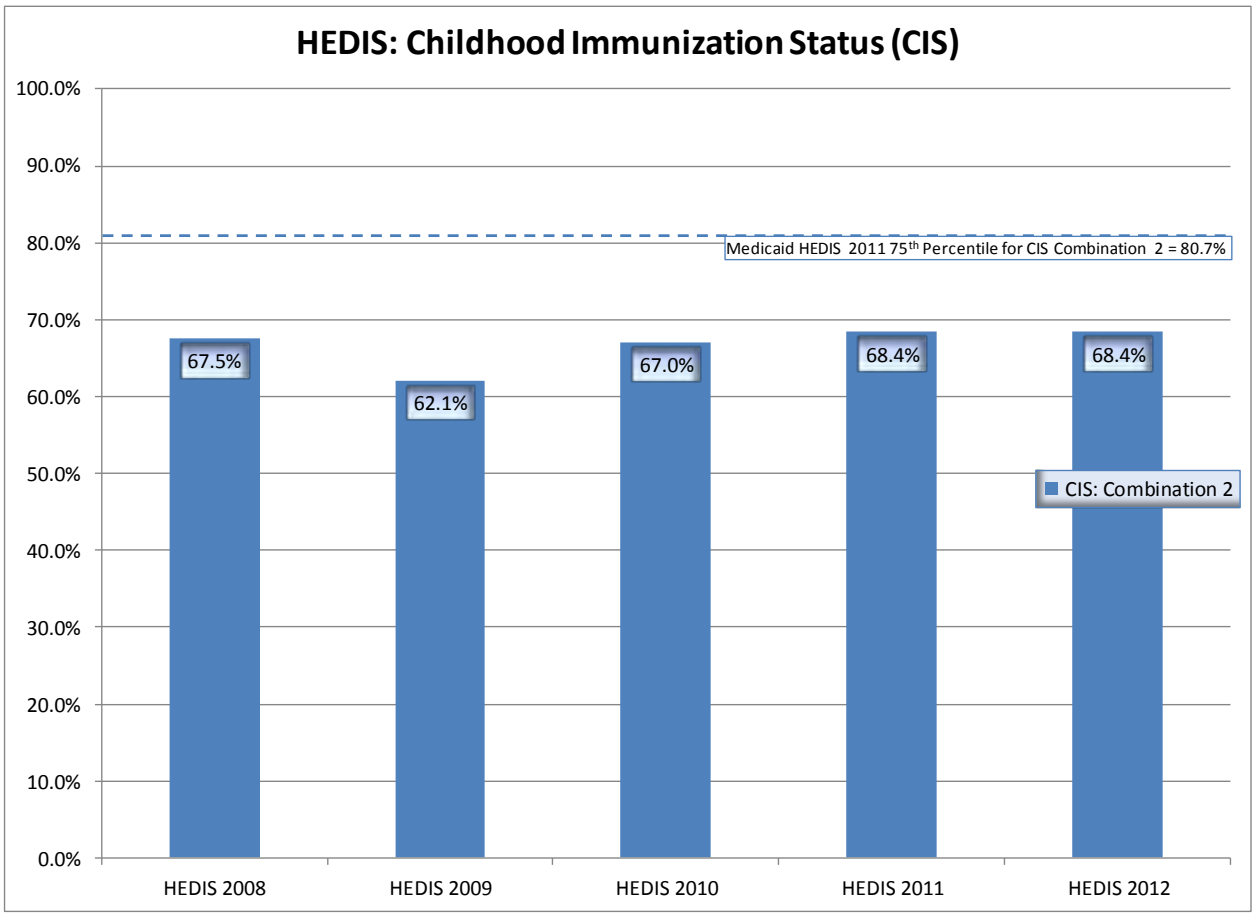


CBP:

- The statewide Medicaid percentage of members 18-85 years of age who had a diagnoses of hypertension and whose blood pressure was under control varied between 29% and 48% from 2009 to 2012, with the highest rate of 47.1% occurring in 2012 and the lowest rate of 29.9% occurring in 2009. Note that the first year for this measure is 2009.

- There is a clear up trend in the rates of the five years reported. From 2009 thru 2012, each subsequent year's score is higher than the last.

- The HI Quality Strategy target percentage for the CBP Control measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 63.7%, which is higher than all of the years reported.

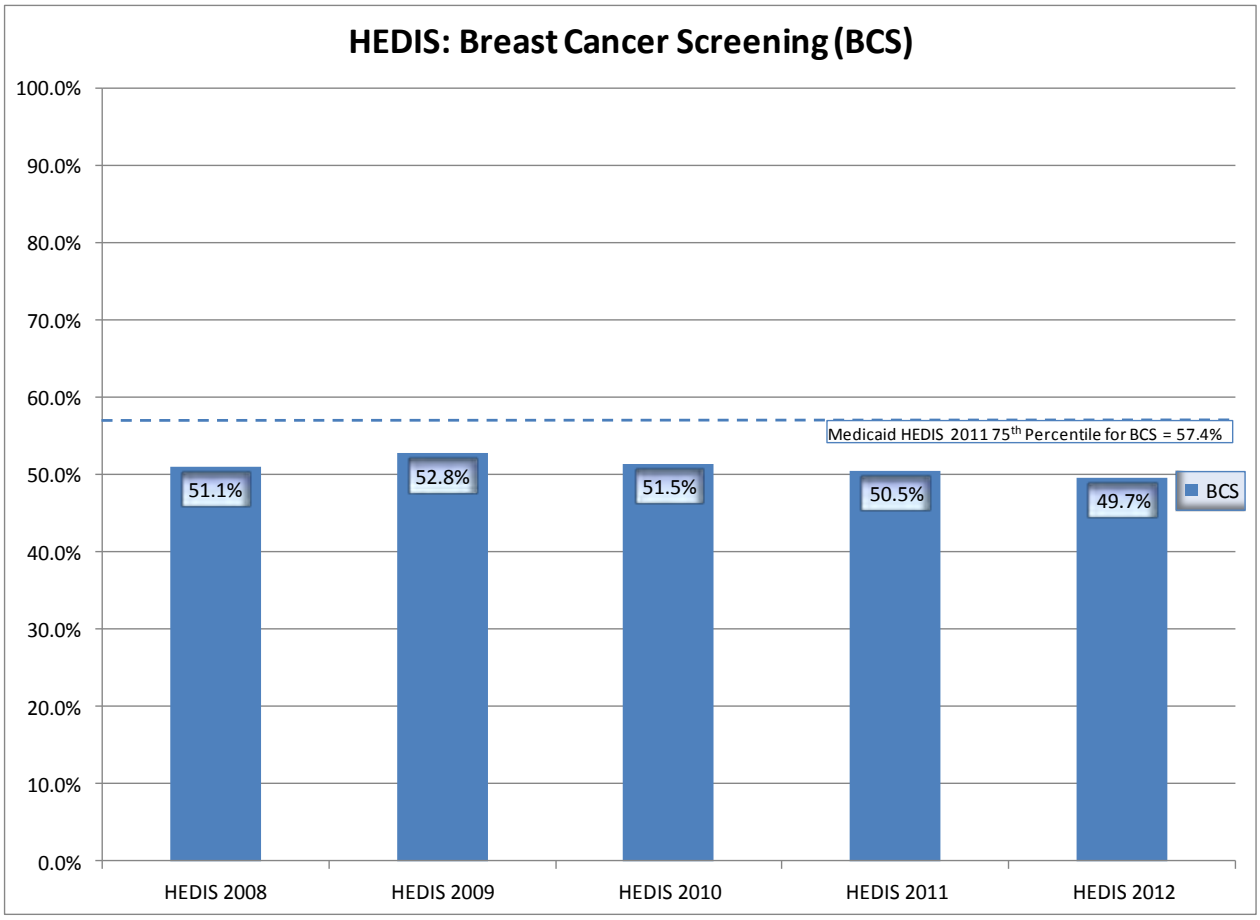


CIS:

- The statewide Medicaid percentage of children 2 years of age who, by their second birthday, had received the entire suite of Combination 2 vaccines (4 DTaP, 3 IPV, 1 MMR, 3 HiB, 3 HepB & 1 VZV) varied between 62% and 69% from 2008 to 2012, with the highest rate of 68.4% occurring in 2011 & 2012 and the lowest rate of 62.1% occurring in 2009.

- There is a slight up trend in the rates of the five years reported. Excluding the 2008 rate, the rates increased from 2009 to 2012 by 4.1 percentage points with not yearly decreases.

- The HI Quality Strategy target percentage for the CIS measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 80.7%, which is higher than all of the years reported.

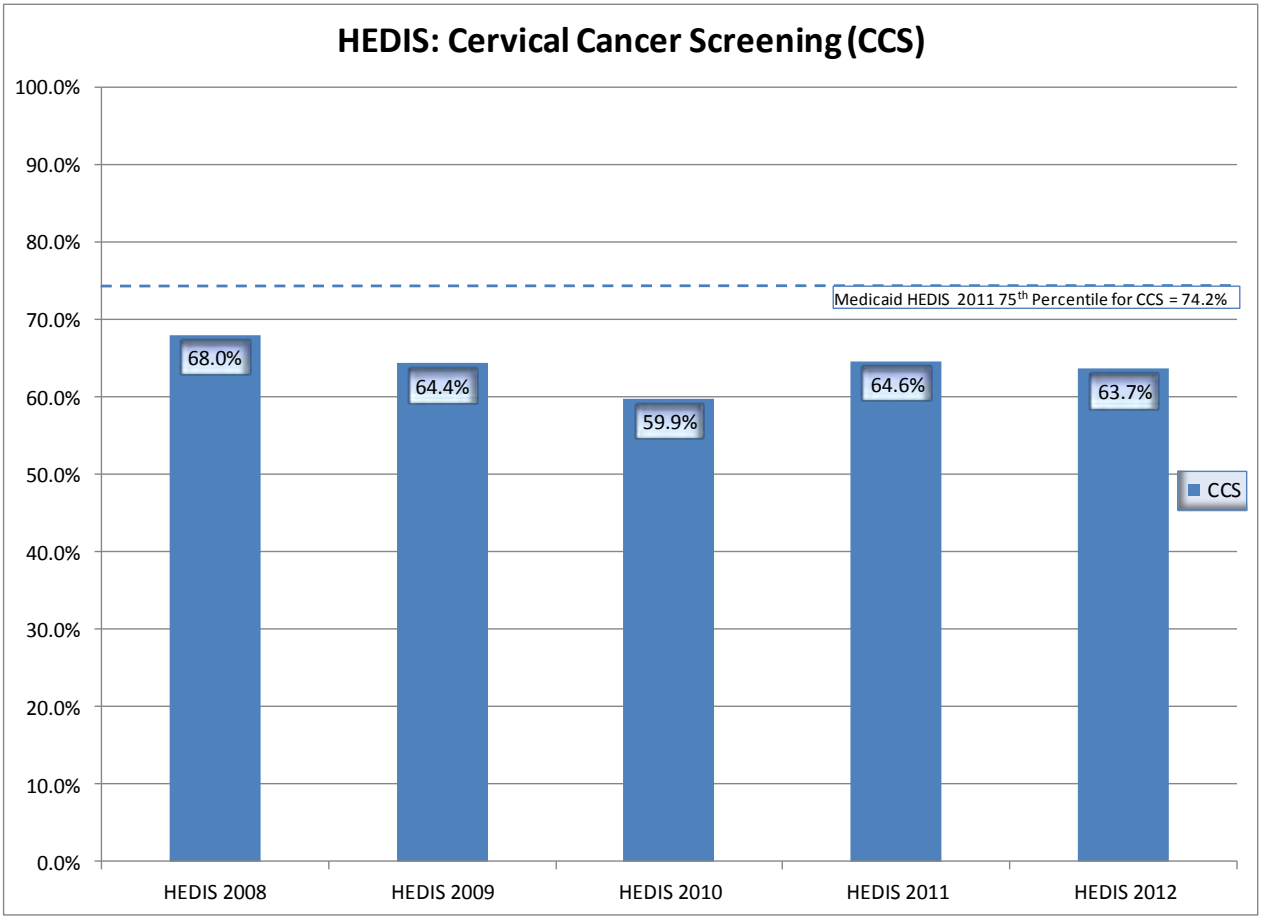


BCS:

- The statewide Medicaid percentage of women 40 - 69 years of age who had a mammogram to screen for breast cancer varied between 49% and 53% from 2008 to 2012, with the highest rate of 52.8% occurring in 2009 and the lowest rate of 49.7% occurring in 2012.

- There is a clear down trend in the rates of the five years reported. Removing the 2008 score, the rates go consistently down approximately 1% per year from 52.8% (2009) to 49.7% (2012).

- The HI Quality Strategy target percentage for the BCS measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 57.4%, which is higher than all of the years reported.

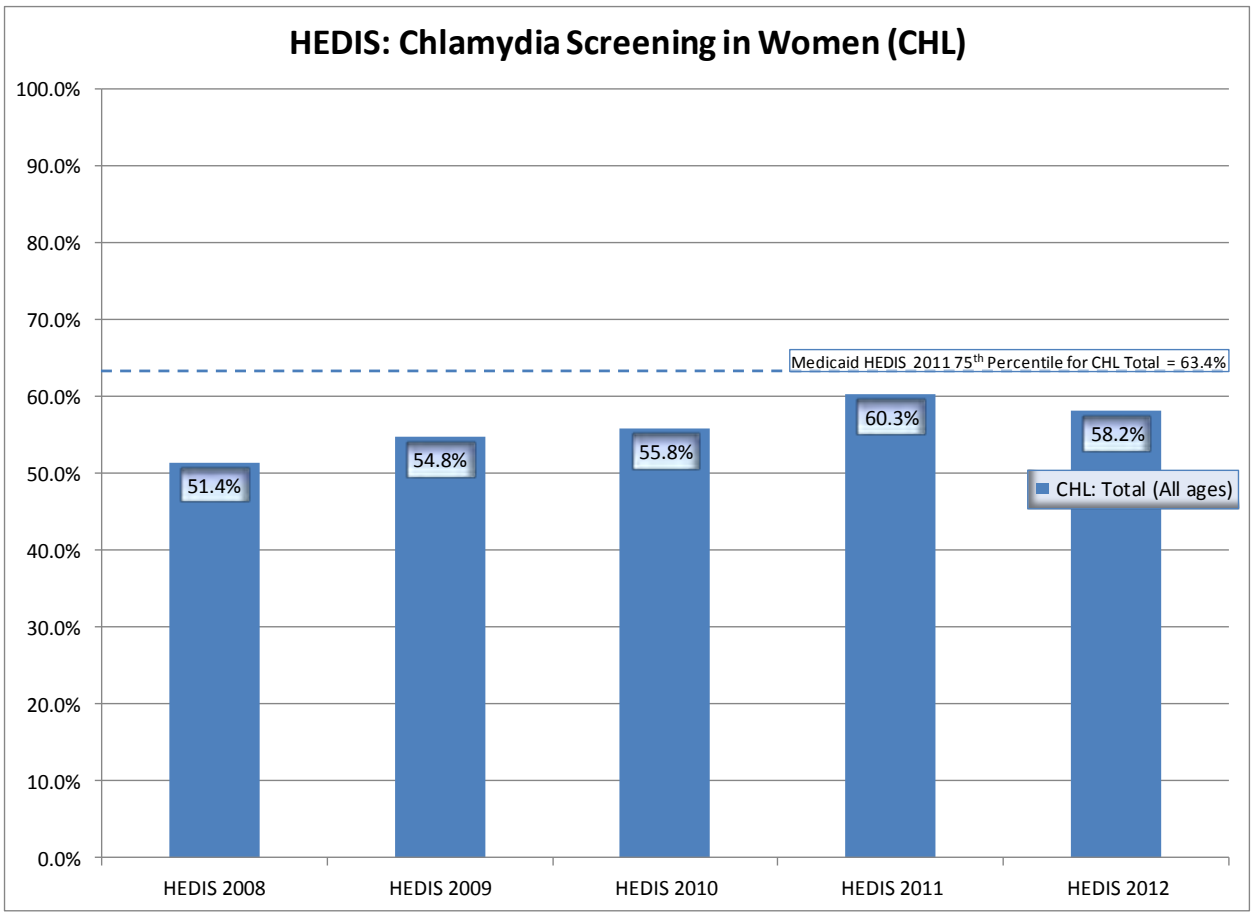


CCS:

- The statewide Medicaid percentage of women 21 - 64 years of age who received one or more Pap tests to screen for cervical cancer varied between 59% and 68% from 2008 to 2012, with the highest rate of 68.0% occurring in 2008 and the lowest rate of 59.9% occurring in 2010.

- There is a slight down trend in the rates of the five years reported. Removing the middle 2010 score, the highest rate (68.0%) is in 2008 and the lowest rate (63.7%) is in 2012.

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 74.2%, which is higher than all of the years reported.

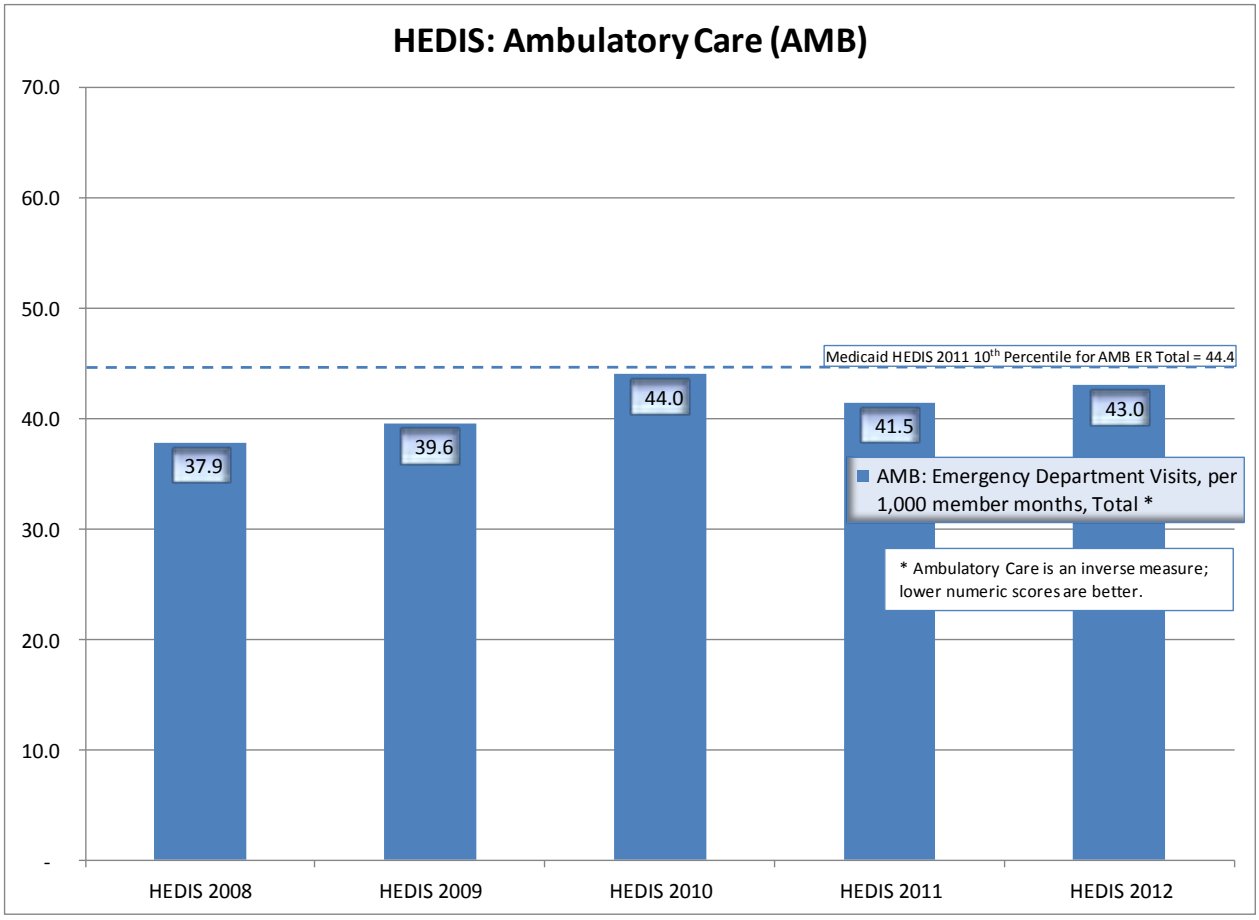


CHL:

- The statewide Medicaid percentage of women 16 - 24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year varied between 51% and 61% from 2008 to 2012, with the highest rate of 60.3% occurring in 2011 and the lowest rate of 51.4% occurring in 2008.

- There is a clear up trend in the rates of the five years reported. Removing the most recent score, the lowest rate (51.4%) is in 2008 and the highest rate (60.3%) is in 2011.

- The HI Quality Strategy target percentage for the CCS measure is the 75th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 63.4%, which is higher than all of the years reported.



AMB:

- The statewide Medicaid rate of emergency department visits per 1,000 member months varied between 37.0 and 44.0 from 2008 to 2012, with the highest rate of 44.0 occurring in 2010 and the lowest rate of 37.9 occurring in 2008. Note that this is an inverse measure, where the higher the numeric rate is the worse the score is.

- There is a clear up trend (bad) in the rates of the five years reported. Putting aside the high rate in 2010, the lowest rate (37.9) occurred in 2008, and the highest rate (43.0) occurred in 2012.

- The HI Quality Strategy target percentage for the CCS measure is the 10th percentile of the national Medicaid population. For the 2011 -- the latest year with national averages -- this target was 44.4, which is higher (good) than all of the years reported.

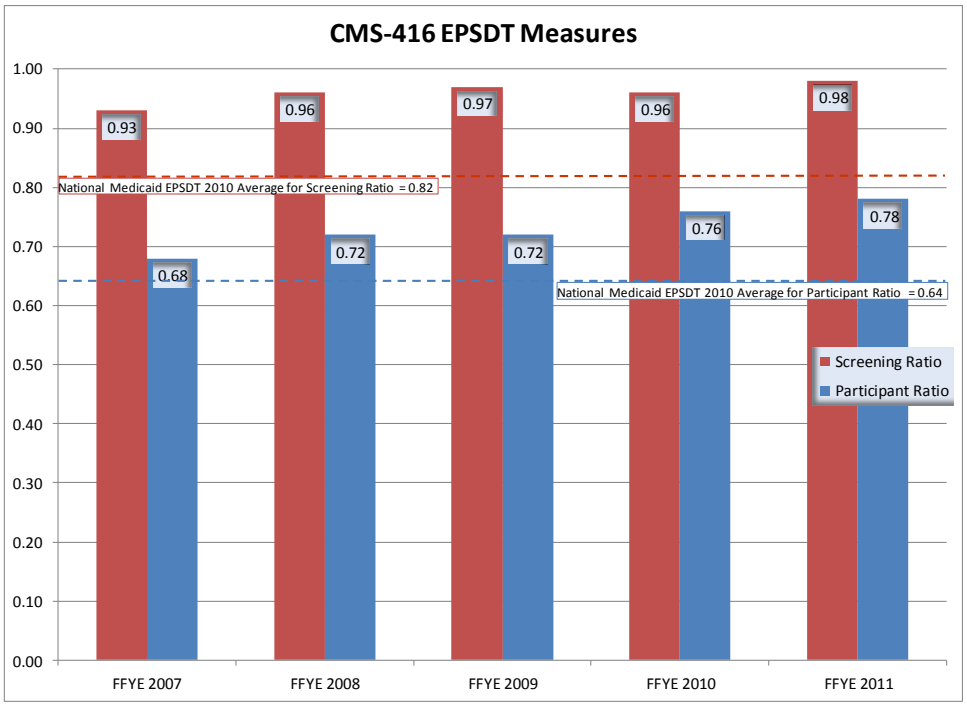
EPSDT Measures

The EPSDT measures are included in this report to measure the degree of comprehensive and preventive child healthcare for individuals under the age of 21.

The EPSDT measures are based on self-reported EPSDT reports received from the five individual plans that are contracted with Med-QUEST – AlohaCare, HMSA, Kaiser, ‘Ohana Health Plan and UnitedHealth Community Plan. The scores from these individual plan reports are then weight-averaged to calculate Hawaii composite scores. All five plans create custom queries to calculate their scores, and all of the EPSDT measures are reported in each year. The format and method of calculation for the various EPSDT measures reported by the plans is no different from the national standard CMS-416 EPSDT format, aside from small differences in the periodicity of visits by state. **Audits on how the plans calculate and report their EPSDT scores are not currently conducted**; future health plan audits on the EPSDT calculation and reporting are being considered. EPSDT reports from the plans are based on the federal fiscal year, a twelve month period beginning in October 1 and ending on September 30 of the report year, and are due to Med-QUEST on the last day of February in the year following the report year. The measures presented below are a small sample of the complete set of EPSDT measures that are reported each year.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Scores are reported for each year from 2007 to 2011. A comparison is made to the National Medicaid EPSDT Average score – the 50th percentile – to bring perspective to where we stand on a national level.

For all of the EPSDT measures, higher numeric scores are considered positive and lower numeric scores are considered negative.



EPSDT – Screening Ratio:

- The statewide Medicaid screening ratio from the EPSDT report varied between 0.93 and 0.98 from 2007 to 2011, with the highest rate of 0.98 occurring in 2011 and the lowest rate of 0.93 occurring in 2007.

- There is a clear up trend in the rates of the five years reported. The lowest rate of 0.93 was reported in the first year (2007), and the highest rate of 0.98 was reported in the last year (2011), with a mostly steady uptrend in between.

- The MQD quality strategy has no benchmark for the EPSDT Screening Ratio. For comparison purposes in 2010 – the latest reported year – then national average is 0.82, which is lower than all of the years reported.

EPSDT – Participant Ratio:

- The statewide Medicaid participant ratio from the EPSDT report varied between a high of 0.78 occurring in 2011 and the lowest rate of 0.68 occurring in 2007.

- There is a clear up trend in the rates of the five years reported. Each year's score was at least equal to, and more often greater than, the previous year's score, ending in a high of 0.78 in 2011.

- The MQD quality strategy has no benchmark for the EPSDT Participant Ratio. For comparison purposes in 2010 – the latest reported year – then national average is 0.64, which is lower than all of the years reported.

CAHPS Measures

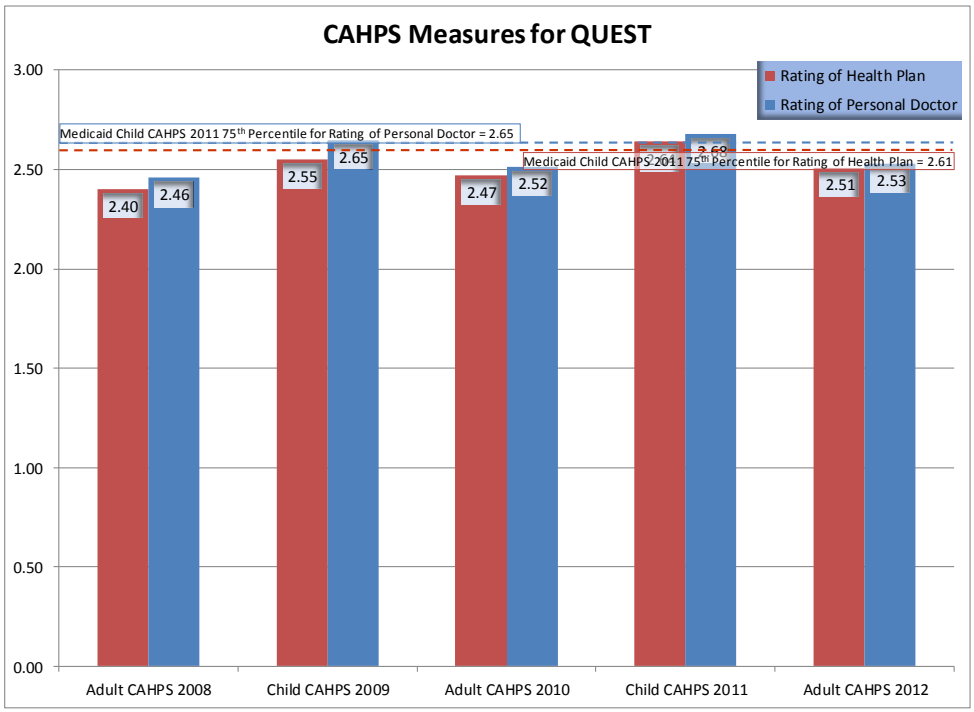
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures are included in this report to measure the degree of recipient satisfaction with Hawaii Med-QUEST.

Med-QUEST is required by the State of Hawaii to conduct an annual HEDIS CAPHS member survey. The CAHPS measures are based on annual surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The method of these surveys and the definitions of the various CAHPS measures strictly adhere to required national standard CAHPS specifications. The surveys were sent to a random sample of recipients. The overall survey response rate was 45% in 2011 and 38% in 2012. The "question summary rates" are reported for the different measures used in this report. The Adult Medicaid surveys were done in 2008, 2010 & 2012, and the Child Medicaid survey was done in 2009 & 2011. All five years results are reported here. The survey asks which health plan the respondent is currently enrolled in, which enables the scores to be summarized by plan as well as program (QUEST vs. QExA). Since the QExA program was begun in February 2009, there are a limited number of years of CAHPS data for QExA. This report presents the rates of the QUEST population and the QExA population in separate charts. Going forward and as required by the State of Hawaii, these surveys will continue to be done annually, with the Child and Adult surveys being done in alternating years. The measures presented below are but a small sample of the entire slate of questions that were presented on the survey.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Because the populations surveyed are different between the Adult and Child surveys, these surveys are analyzed separately as the data allows. A comparison is made to the National Medicaid Child CAHPS 2011 75th percentile score to bring perspective to where we score on a national level; at the time of this report the National Medicaid Child CAHPS 2012 percentile scores were not available. The National Medicaid 75th percentile score will be the target score for all of the CAHPS measures, as is specified in our Quality Strategy.

For the CAHPS measures, higher numeric scores are considered positive and lower numeric scores are considered negative.

CAHPS for QUEST – Rating of Health Plan:



- The statewide CAHPS – Rating of Health Plan for the QUEST population varied between a high rate of 2.64 occurring in 2011 and the lowest rate of 2.40 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.40 to 2.47 to 2.51. The Child years show a similar pattern, moving from 2.55 to 2.64.

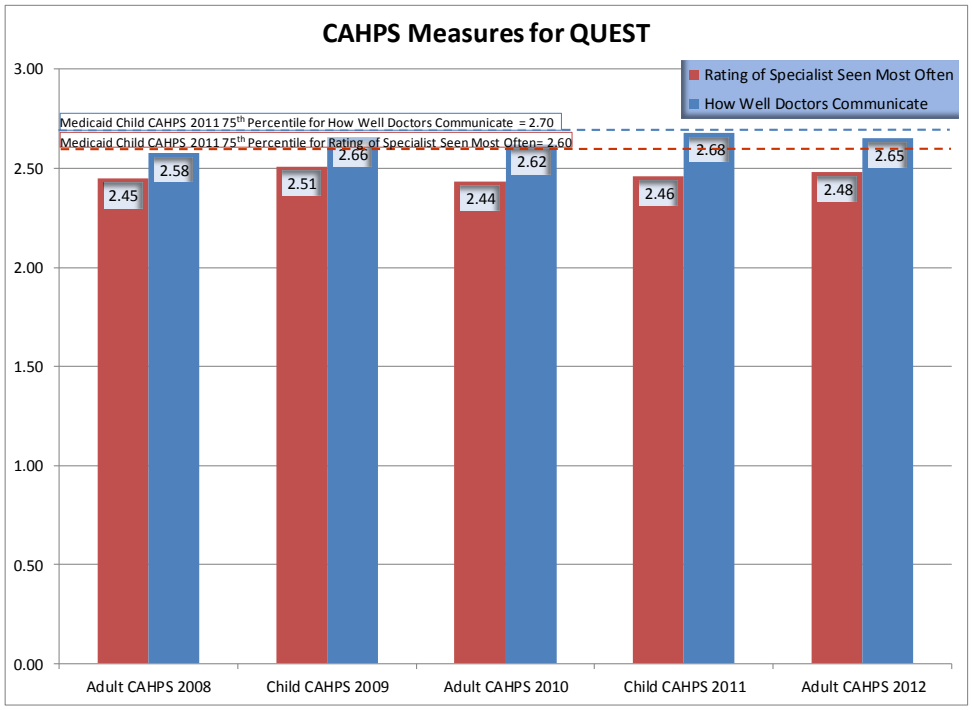
- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.61, which was exceeded by the 2.64 rate reported in 2011.

CAHPS for QUEST – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.46 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.46 to 2.52 to 2.53. The Child years show a similar pattern, moving from 2.65 to 2.68.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was exceeded by the 2.68 rate reported in 2011.



CAHPS for QUEST – Rating of Specialist Seen Most Often:

- The statewide CAHPS – Rating of Specialist Seen Most Often for the QUEST population varied between a high rate of 2.51 occurring in 2009 and the lowest rate of 2.44 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move slightly up from 2.45 to 2.44 to 2.48. The Child years show a down pattern, moving from 2.51 to 2.46.

- The HI Quality Strategy target percentage for the CAHPS Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.60, which was higher than all of the reported year.

- Improving the QUEST scores for CAHPS – Rating of Specialist Seen Most Often have involved: 1) Emphasizing telemedicine as an option for neighbor island clients seeking specialist services, 2) Increasing the frequency of specialists visits to neighbor islands, and 3) Implementing communication programs for physicians focused on skill building in the area of dealing with challenging situations.

CAHPS for QUEST – How Well Doctors Communicate:

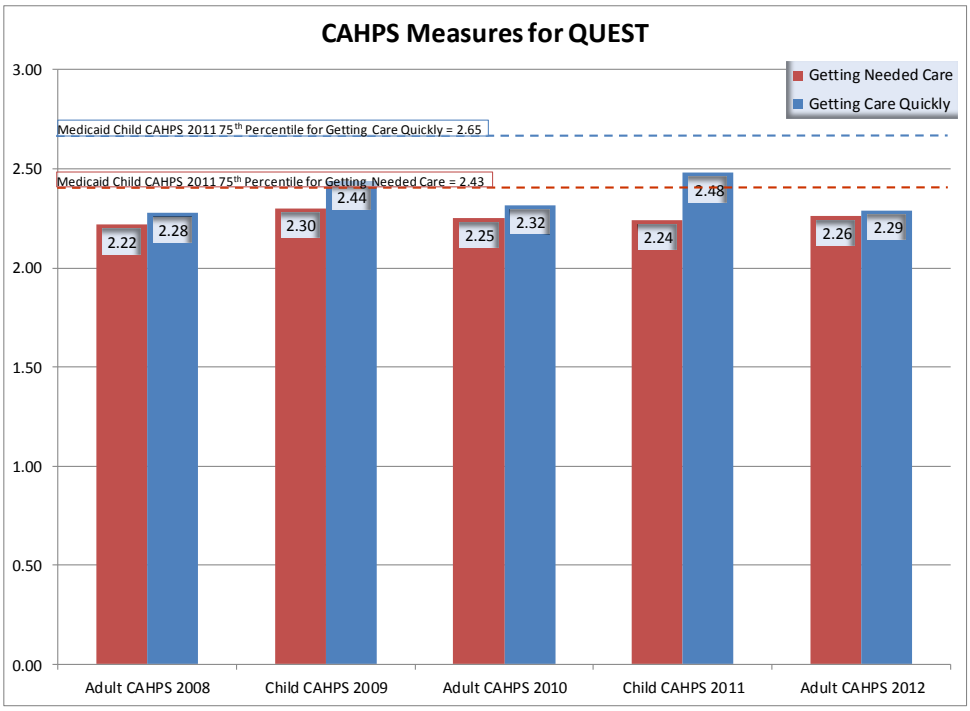
- The statewide CAHPS – How Well Doctors Communicate for the QUEST population varied between a high rate of 2.68 occurring in 2011 and the lowest rate of 2.58 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is a clear up trend in the rates of the five years reported. Focusing on the Adult years, the rates move from 2.58 to 2.62 to 2.65. The Child years show a similar pattern, moving from 2.66 to 2.68.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.70, which was higher than all of the reported year.

- The QUEST plans have taken the following step to improve the CAHPS – How Well Doctors Communicate rates: 1) Improving the care coordination and communication between member and the primary care team.

CAHPS for QUEST – Getting Needed Care:



- The statewide CAHPS – Getting Needed Care for the QUEST population varied between a high rate of 2.30 occurring in 2009 and the lowest rate of 2.22 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move slightly up from 2.22 to 2.25 to 2.26. The Child years show a down pattern, moving from 2.30 to 2.24.

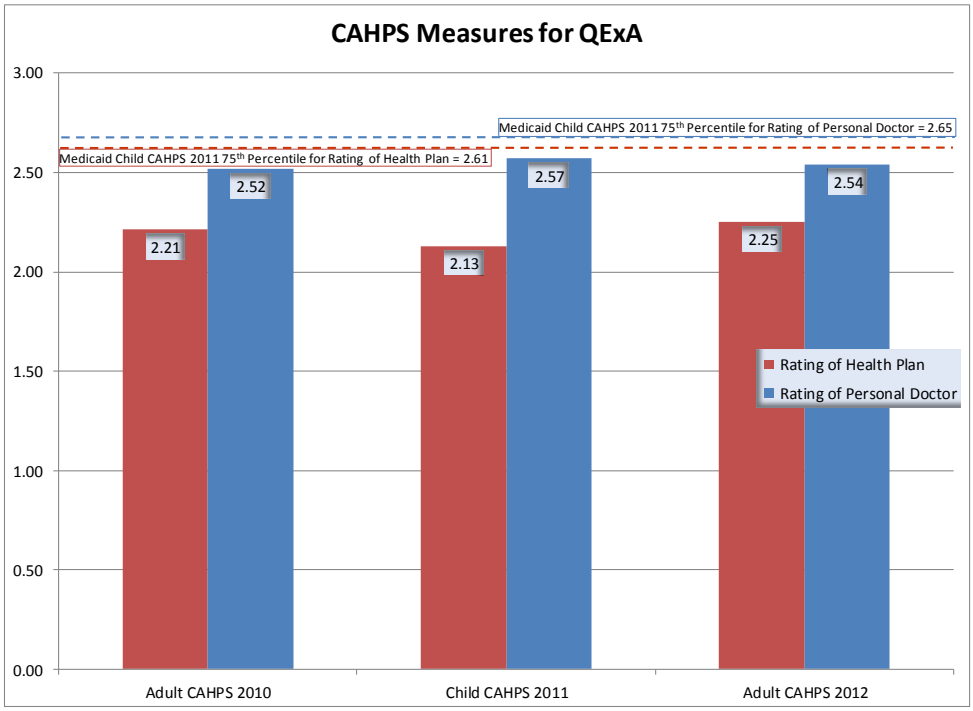
- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.43, which was higher than all of the reported year.

CAHPS for QUEST – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QUEST population varied between a high rate of 2.48 occurring in 2011 and the lowest rate of 2.28 occurring in 2008. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the five years reported. Focusing on the Adult years, the rates move sideways from 2.28 to 2.32 to 2.29. The Child years show an up trend, moving from 2.44 to 2.48.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported year



CAHPS for QExA – Rating of Health Plan:

- The statewide CAHPS – Rating of Health Plan for the QExA population varied between a high rate of 2.25 occurring in 2012 and the lowest rate of 2.13 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child. Also note that the QExA program began in February 2009, which limits the number of data points.

- There is a flat trend in the rates of the three years reported. The low point in 2011 was the only data point for the Child population.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Health Plan is the 75th percentile of the national Medicaid population. For the 2011 year this target was 2.61, which was better than all reported rates.

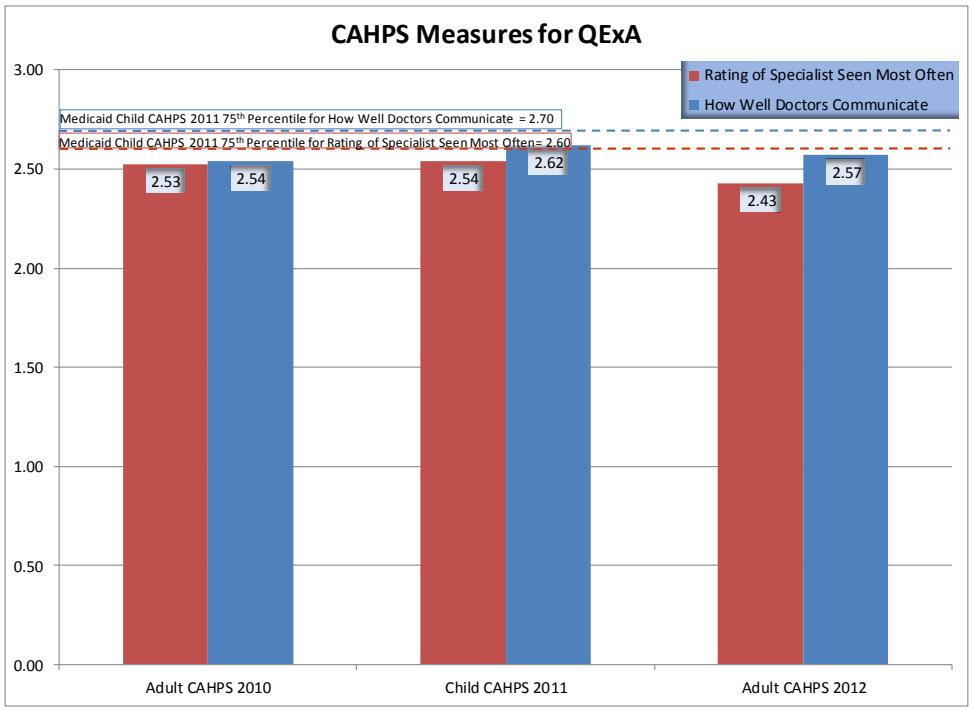
CAHPS for QExA – Rating of Personal Doctor:

- The statewide CAHPS – Rating of Personal Doctor for the QExA population varied between a high rate of 2.57 occurring in 2011 and a low rate of 2.52 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the three years reported. All years lie within a 0.05 point window.

- The HI Quality Strategy target percentage for the CAHPS – Rating of Personal Doctor is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported years' rates.

CAHPS for QExA – Rating of Specialist Seen Most Often:



- The statewide CAHPS – Rating of Specialist Seen Most Often for the QExA population varied between a high rate of 2.54 occurring in 2011 and a low rate of 2.43 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the three years reported.

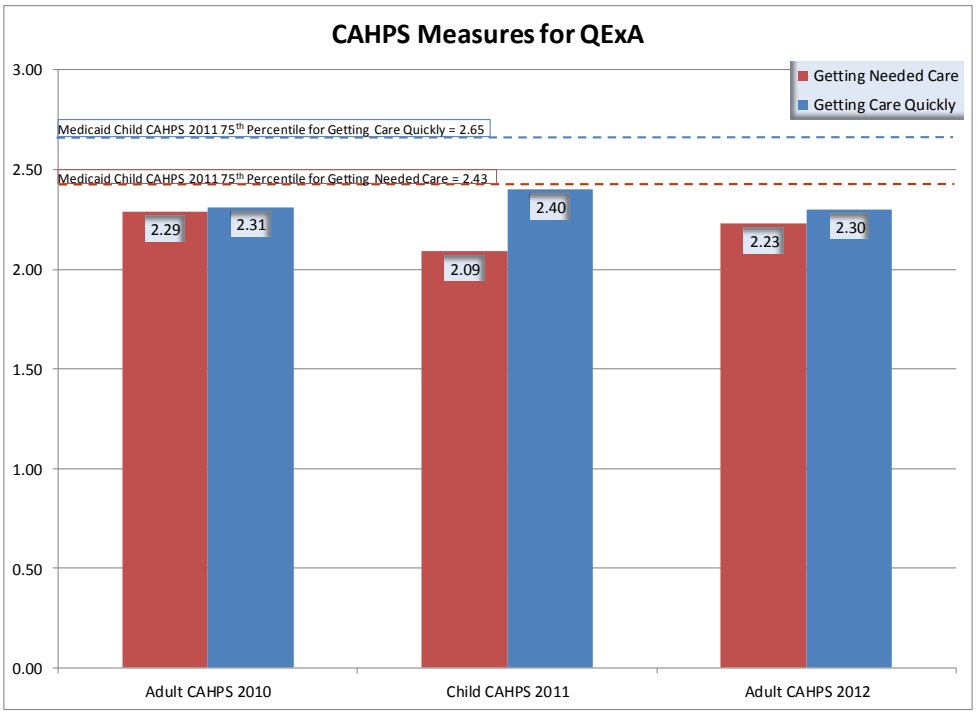
- The HI Quality Strategy target percentage for the CAHPS – Rating of Specialist Seen Most Often is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.60, which was higher than all of the reported year.

CAHPS for QExA – How Well Doctors Communicate:

- The statewide CAHPS – How Well Doctors Communicate for the QExA population varied between a high rate of 2.62 occurring in 2011 and the lowest rate of 2.54 occurring in 2010. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no trend in the rates of the three years reported. Removing the Child year in 2011, the Adult score moves from 2.54 to 2.57 from 2010 to 2012.

- The HI Quality Strategy target percentage for the CAHPS – How Well Doctors Communicate is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.70, which was higher than all of the reported year.



CAHPS for QExA – Getting Needed Care:

- The statewide CAHPS – Getting Needed Care for the QExA population varied between a high rate of 2.29 occurring in 2010 and the lowest rate of 2.09 occurring in 2011. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the three years reported.

- The HI Quality Strategy target percentage for the CAHPS – Getting Needed Care is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.43, which was above each of the reported years.

CAHPS for QExA – Getting Care Quickly:

- The statewide CAHPS – Getting Care Quickly for the QExA population varied between a high rate of 2.40 occurring in 2011 and the lowest rate of 2.30 occurring in 2012. Note that alternating years have alternating survey populations, either Adult or Child.

- There is no clear trend in the rates of the three years reported.

- The HI Quality Strategy target percentage for the CAHPS – Getting Care Quickly is the 75th percentile of the national Medicaid population. For the 2011 year -- the latest year with national averages -- this target was 2.65, which was higher than all of the reported year.

Physicians' Assessment Measures

The Physician Assessment measures are included in this report to measure the degree of provider satisfaction with the Hawaii Med-QUEST program as well as the individual plans that contract with Med-QUEST to provide services to the QUEST recipients. The survey includes ONLY physicians and related professionals.

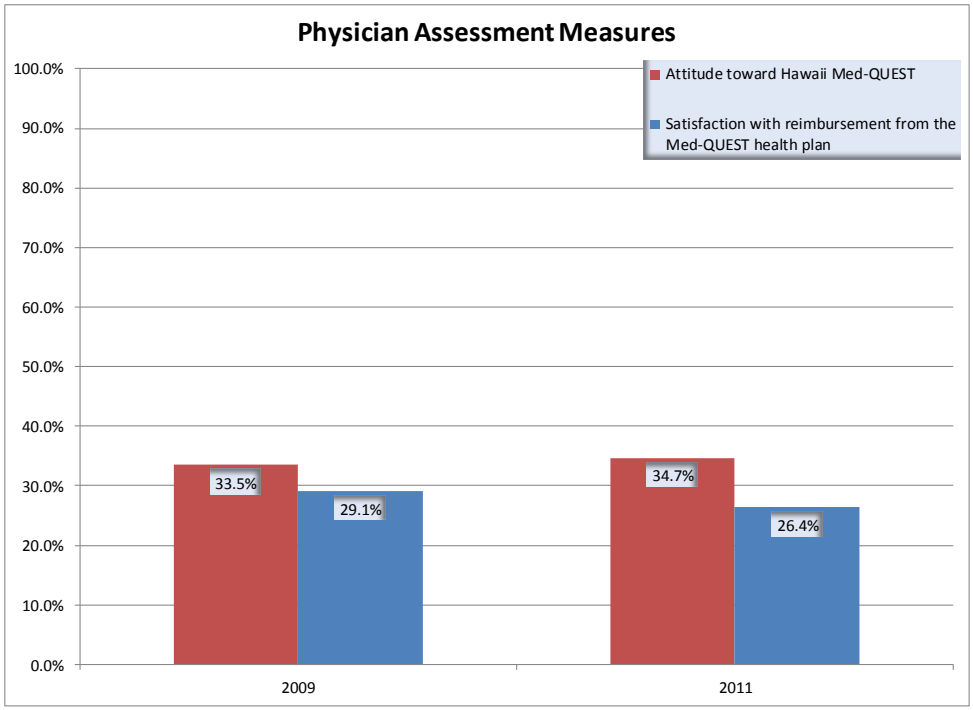
The Physician Assessment measures are based on surveys conducted by the EQRO entity under contract with, and under the direction of, Med-QUEST. The scores are based on clean responses from a survey of randomly selected PCPs and high-volume specialties, and are expressed as percentage scores. The overall survey response rate was 30% in 2009 and 26% in 2011. Going forward, these surveys will not be done every year. The measures presented below are but a small sample of the entire slate of questions that were presented on the survey.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of years. Scores are reported for 2009 and 2011. Unfortunately, there are no national standards that can bring perspective to where we score on a national level.

For the Physician Assessment measures, higher numeric scores are considered positive and lower numeric scores are considered negative.

Physician Assessment – Attitude Toward Hawaii Med-QUEST:

- The statewide Physician Assessment –Attitude Toward Hawaii Med-QUEST went from 33.5% in 2009 to 34.7% in 2011.



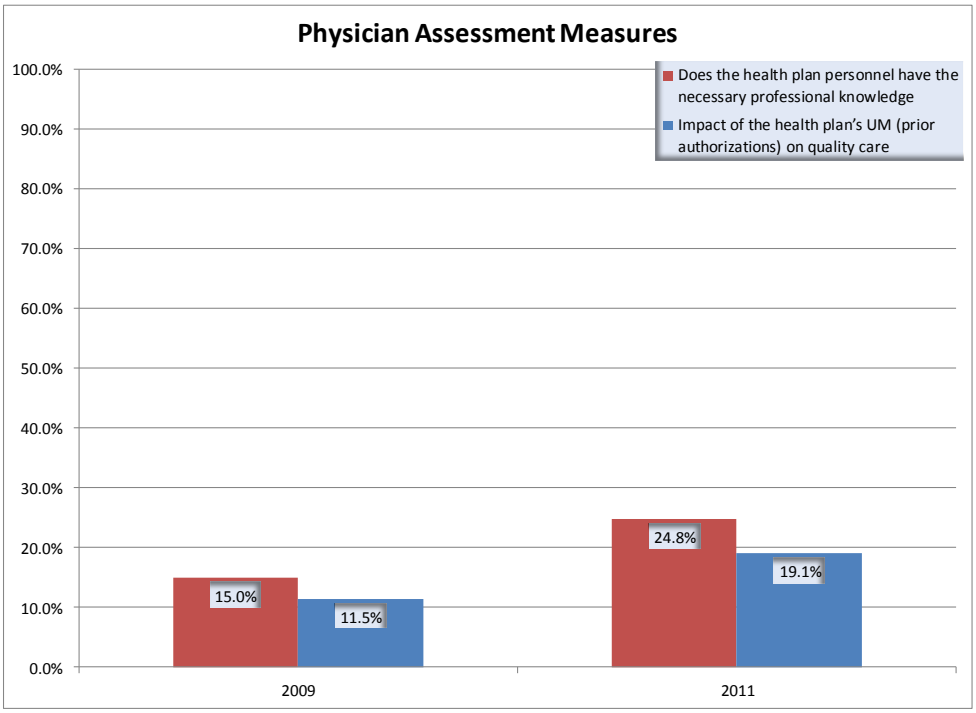
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

Physician Assessment – Satisfaction with reimbursement from the Med-QUEST health plan:

- The statewide Physician Assessment – Satisfaction with reimbursement from the Med-QUEST health plan went from 29.1% in 2009 down to 26.4% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

Physician Assessment – Necessary Professional Knowledge:

- The statewide Physician Assessment – Necessary Professional Knowledge went from 15.0% in 2009 to 24.8% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.



Physician Assessment – Impact of the health plan's UM:

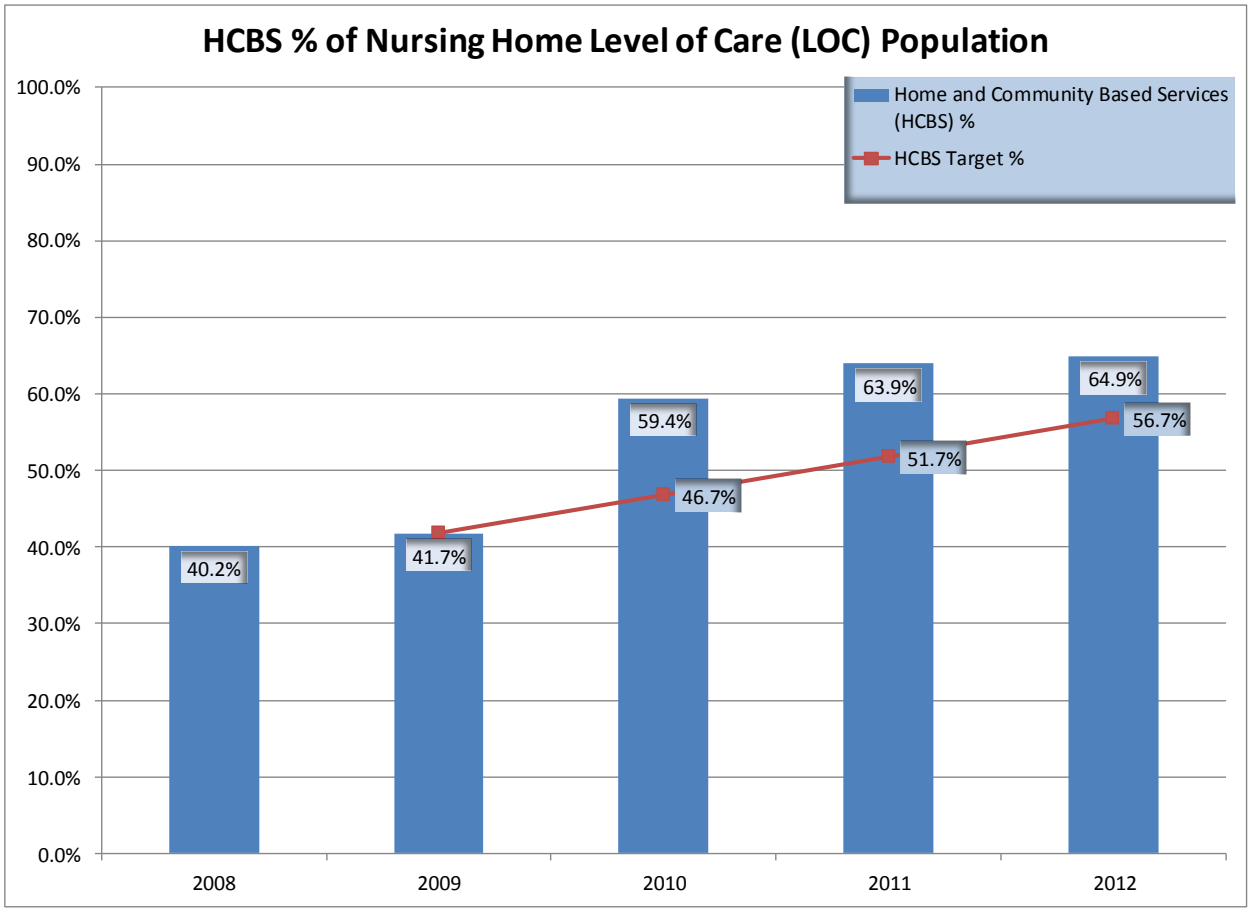
- The statewide Physician Assessment – Impact of the health plan's UM went from 11.5% in 2009 down to 19.1% in 2011.
- With only two data points, a clear trend in the rates cannot be established.
- There are no National average percentages available for the Physician Assessment Measures.

Med-QUEST Internal Measures

The Med-QUEST internal measures are included in this report to measure the financial aspects of the Hawaii Med-QUEST program. How is money being spent, and on how many and what type of recipients, is the focus of these measures.

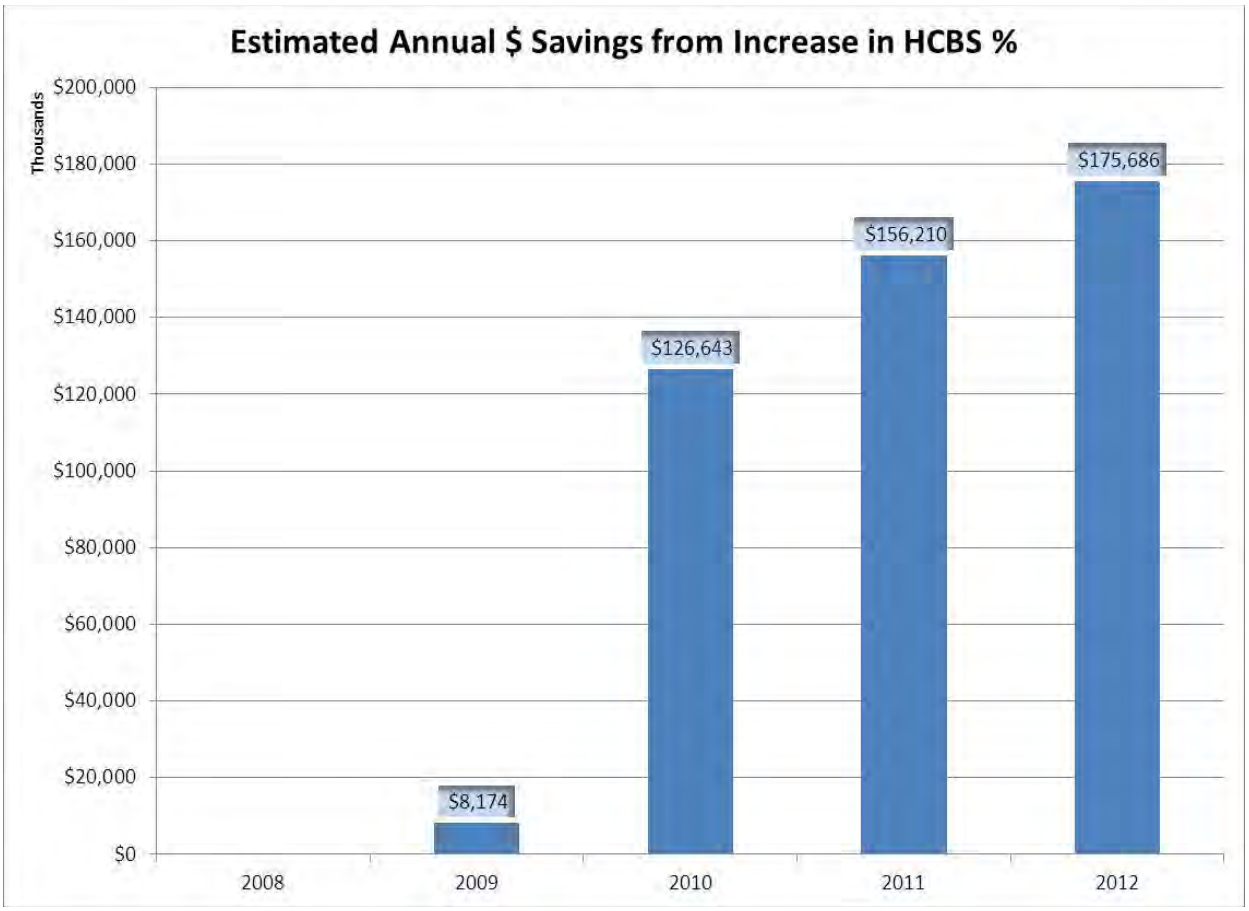
The QUEST Expanded Access (QExA) program began February 1, 2009 and moved aged, blind, and disabled. One of the goals of QExA was to increase the percentage of nursing home level of care (LOC) clients in Home and Community Based Services (HCBS) provided to nursing home level of care (LOC) clients is an alternate service delivery model to traditional nursing home institutions. Instead of nursing home clients staying in an institution, they are out in the community and interacting. HCBS facilitate the continued social and mental stability of the client, as well as reduce the cost of serving this population. The average monthly $ PMPM difference between a HCBS client and an institutional client was $6,194.86 in calendar year 2011. We look at both the increase in HCBS % of the total nursing home LOC population as well as the MQD's cumulative annual dollars saving from this increase in HCBS %. The cumulative dollar savings is calculated by determining taking the difference between the current year's HCBS % and the 2009 HCBS%, multiplying it by the total nursing home LOC population to get a monthly savings figure, and then multiplying it by twelve to get an annual savings figure.

The member month measure used is a sum of member months, and will consist of entire populations based on reports run at the end of each month. The capitation payment file is a detail of all capitation payments made to each plan, and is the source of member month data. This file has enrollments for retro payments reflected in the month that payment was made. Initial months are paid pro-rated daily amounts based on the start date. Termination always occurs at the end of the month, except for retro termination for disability or death.



HCBS % of Nursing Home LOC Population:

- The statewide HCBS % of Nursing Home LOC Population went from 40.2% in 2008 to 64.9% in 2012.
- There is a clear upward trend in the rates. The QExA program began in February of 2009, and the largest percentage jump occurred between 2009 and 2010.
- Our Quality Strategy sets as a target a 5% per year increase in the HCBS % for our QExA program. Since beginning in February 2009 to the current year, this goal has been exceeded in each year.
- Prior to July 2010, the MQD had a fiscal incentive for the QExA health plans to move nursing home LOC clients from an institutional setting to a HCBS setting, which involved different capitation payments for HCBS vs. institutional settings. Beginning July 2010, the QExA health plans were paid a composite (average) capitation payment for all nursing home LOC clients, which changed the method of financial incentive in moving clients into an HCBS setting. This would explain the flattening off of the increases in percentage of clients that are in an HCBS setting.

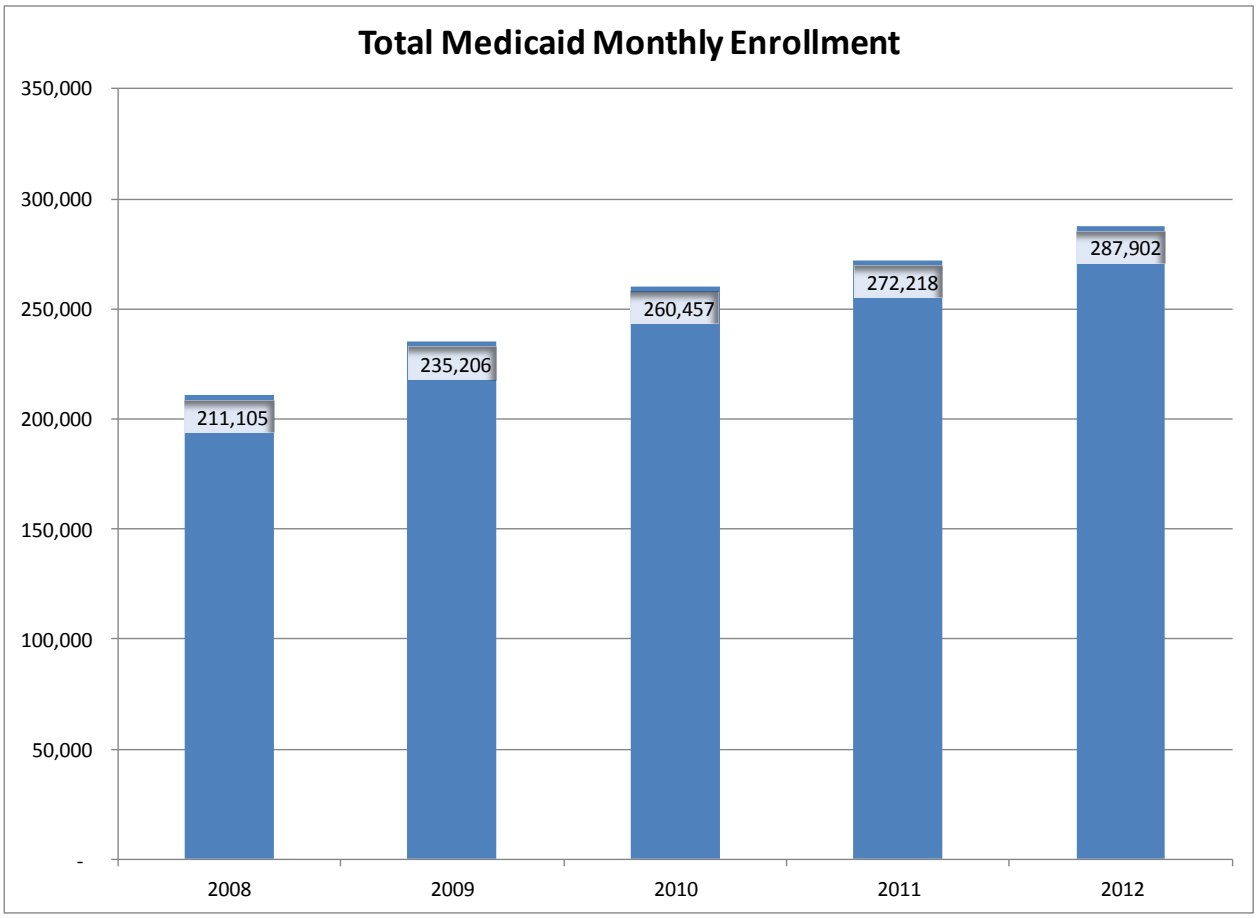


Estimated Annual $ Savings from Increase in HCBS %:

- The statewide Estimated Annual $ Savings from Increase in HCBS % went from $8,174,000 in 2009 to $175,686,000 in 2012. The 2011 actual differential in $ pmpm cost between institutional care and HCBS care is $6,194.86, and this was used in the calculation of cost savings.

- Following the clear upward trend in the HCBS %, there is a corresponding cumulative increase in the dollars saved from this transition to HCBS.

- There is no National average available for dollars saved based on the move to HCBS.



Total Medicaid Monthly Enrollment:

- The statewide Total Medicaid Monthly Enrollment went from 211,105 in 2008 to 287,902 in 2012, which equates to an average annual increase of 5.8%.
- There is a clear upward trend in Medicaid enrollment, with each year logging consistent gains.
- There is no National average available for annual Medicaid enrollment increase.
- The Hawaii economy and unemployment rate continue to hover above 2008 pre-recession levels, causing the Hawaii Medicaid enrollment to continue to rise.
- With implementation of the Affordable Care Act (ACA), MQD does not expect a decrease of enrollment.

Budget Neutrality Savings

Budget neutrality savings is a reflection of the fiscal performance of the waiver. Specifically, it compares the expenditures with the waiver in place – inclusive of all the demonstration group costs -- against the hypothetical expenditures if the waiver were not in place at all. If the "With Waiver" expenditures are less than the "Without Waiver" expenditures, then Budget Neutrality Savings will result. The following table details the budget neutrality calculation through Demonstration Year 18 (DY18) of the 1115 waiver. The overall total computable savings is $1,833,414,530. An additional version of the Budget Neutrality information is found in Appendix A.

Hawaii 1115 QUEST Waiver								
TOTAL COMPUTABLE		12	13	14	15	16	17	18
		Std Renewal /Extension			**Renewal**			
WITHOUT WAIVER	**FMAP**	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081
		58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%
	MEG Description and Comments	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%
					67.35%		62.63%	
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	$261.16	$281.11	$302.59	$322.62	$343.98	$366.75	$391.03
	TANF Adults	$458.35	$493.37	$531.07	$564.90	$600.88	$639.18	$679.87
	Aged				$1,204.63	$1,281.84	$1,364.01	$1,451.44
	Blind/Disabled				$1,489.42	$1,597.11	$1,712.58	$1,836.40
Mem ber Months								
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,978	422,741
	Aged				98,211	228,008	236,945	234,307
	Blind/Disabled				115,266	273,836	288,269	286,344
	Total Without Waiver Member Months	**1,282,911**	**1,261,533**	**1,193,278**	**1,540,890**	**1,994,062**	**2,130,996**	**2,166,975**
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	$402,056,806	$424,960,513	$443,327,661	$837,493,616	$1,343,204,149	$1,520,758,456	$1,631,791,072
DSH		$80,364,047	$81,971,327	$83,856,667	$87,546,360	$89,735,019	$91,350,249	$94,547,507
Total Ceiling		**$482,420,853**	**$506,931,840**	**$527,184,328**	**$925,039,976**	**$1,432,939,168**	**$1,612,108,705**	**$1,726,338,579**
WITH WAIVER	1115	$0	$0	$0	$0	$0	$0	$0
	1902 R 2	$0	$0	$0	$0	$0	$0	$0
	1902 R 2X	$0	$0	$0	$0	$0	$0	$0
	1902R2	$0	$0	$0	$0	$0	$0	$0
	AFDC	$0	$0	$0	$0	$0	$0	$0
	Aged w /Mcare	$0	$0	($295)	$121,310,557	$314,957,371	$350,728,888	$330,293,296
	Aged w /o Mcare	$0	$0	$0	$2,424,989	$17,555,107	$24,896,097	$19,060,304
	B/D w /Mcare	$0	$0	($13,736)	$31,795,707	$74,850,400	$81,249,425	$77,690,468
	B/D w /o Mcare	$0	$0	($28,991)	$81,514,842	$211,801,011	$248,768,345	$251,740,251
	Breast Cervical Cancer Treatment (BCCT)	$0	$0	$0	$0	$4,051	$545,195	$734,188
	CURRENT	$0	$0	$0	$0	$0	$0	$0
	CURRENT POP	$0	$0	$0	$0	$0	$0	$0
	Current-Haw aii Quest	$0	$0	$0	$0	$0	$0	$0
	Demo Elig Adults	$127,983,510	$129,458,220	$154,645,707	$177,396,443	$201,629,508	$238,017,265	$245,339,887
	FosterCare(19-20)	$0	$0	$91,499	$83,366	$94,158	$137,233	$77,745
	Haw aiiQuest-1902(R)(2)	$0	$0	$33,061	$26,332	$8,001	$0	$0
	HCCP	$0	$0	$135,520	$683,159	$0	$0	$0
	HealthQuest-Current	($2,325,152)	$0	$0	$0	$0	$0	$0
	HealthQuest-Others	($621,643)	$0	$0	$0	$0	$0	$0
	Med Needy Adults	$56,504	$120,767	$115,693	$58,345	$117,005	$109,837	$8,305
	Med Needy Children	$0	$0	$0	$7,715	$3,960	$0	$0
	MFCP	$0	$0	$122,839	$581,513	$0	$0	$0
	NH w /o W	$0	$0	$5,100,418	$16,199,737	$0	$0	$0
	Opt St Pl Children	$76,678	$103,084	$80,075	$257,166	$253,182	$31	$0
	Others	$0	$0	$0	$0	$0	$0	$0
	Others-Haw aii Quest	$0	$0	$0	$0	$0	$0	$0
	OthersX	$0	$0	$0	$0	$0	$0	$0
	QUEST ACE	($2,751)	$798,681	$5,696,094	$14,353,208	$23,872,001	$30,434,166	$28,884,029
	RAACP	$0	$0	$7,862,479	$17,432,949	$0	$0	$0
	St Pl Adults-Preg Immig/COFAs	$0	$0	$0	$0	$24,990	$2,622,138	$2,718,679
	State Plan Adults	$111,983,043	$118,021,622	$109,034,691	$128,225,127	$132,187,409	$123,786,545	$118,966,463
	State Plan Children	$181,803,156	$179,673,972	$155,394,295	$168,854,083	$203,903,281	$214,486,295	$199,141,564
	Supp. - Private	$0	$0	$0	$0	$0	$0	$0
	Supp. - State Gov.	$0	$0	$0	$0	$0	$0	$0
	UCC-Governmental	$15,688,221	$22,546,108	$18,919,184	$16,356,580	$24,507,605	$34,064,491	$40,634,690
	UCC-Private	$10,056,500	$3,403,710	$7,500,000	$7,500,000	$7,500,000	$7,500,000	$0
		$444,698,066	**$454,126,164**	**$464,688,533**	**$785,061,818**	**$1,213,269,040**	**$1,357,345,951**	**$1,315,289,869**
		-$1,459,097	-$1,189,919	-$660,309	-$4,962,002	-$38,297,536	-$43,476,661	-$38,375,159
		$443,238,969	**$452,936,245**	**$464,028,224**	**$780,099,816**	**$1,174,971,504**	**$1,313,869,290**	**$1,276,914,710**
		$39,181,885	**$53,995,595**	**$63,156,104**	**$144,940,160**	**$257,967,664**	**$298,239,415**	**$449,423,868**
		$565,691,724	**$619,687,319**	**$682,843,423**	**$827,783,582**	**$1,085,751,247**	**$1,383,990,662**	**$1,833,414,530**
		-$334,903	-$352,488	-$217,644	-$22,587	-$15,945,497	-$15,835,580	-$10,164,390
		-$323,973	-$263,058	-$239,466	-$19,777	-$6,517,946	-$9,185,458	-$9,300,862
		-$347,005	-$279,056	-$147,219	-$22,317	-$9,503,023	-$9,356,037	-$9,335,080
		-$453,216	-$295,317	-$55,980	-$4,897,321	-$6,331,070	-$9,099,586	-$9,574,826

QUEST Expanded Member Months

The most basic measure of how many members you are impacting through your waiver program is member months. The capitation payment file, which is a detail of all capitation payments made to each plan, is used to calculate these figures. These amounts represents paid member month through June 30, 2012. A detailed copy of the member months may be found in Appendix B.

Expenditures for QUEST-ACE Program

The QUEST Adult Coverage Expansion (QUEST-ACE) is program that provides medical assistance to a childless adult who is unable to enroll in the QUEST program due to the limitations of the statewide enrollment cap of QUEST as indicated in §17-1727-26. The enrollment cap for this program is currently set by CMS at 12,000. The QUEST-ACE benefit package encompasses the same limited package of benefits currently provided under the QUEST-Net program, which includes limited medical benefits. A childless adult under the QUEST-ACE program is defined as a person who is:

- Between nineteen years of age through age 64;
- Is not a child under age twenty-one who is in foster care placement or is covered by a subsidized adoption agreement; and
- Does not have a dependent child in the home.

QUEST-ACE started offering coverage for recipients on April 1, 2007. Financial expenditures for QUEST-ACE beneficiaries are approximately $28 to $30 million per year in demonstration years 17 and 18 respectively. More information on QUEST-ACE expenditures may be found in Budget Neutrality calculations in Appendix A.

Recent Initiatives on Measures

The following section will discuss initiatives that the health plans have taken recently to improve the rates of the various measures discussed above.

HEDIS Initiatives

Use of Appropriate Medications for People with Asthma (ASM) Initiatives:

- Implemented health education programs for asthma and physician/patient education on medication.
- Provided community education and outreach activities.
- In 2012, one plan implemented pay-for performance for HEDIS ASM (age5-20) and (age21-64) for child and adult primary care providers.

Comprehensive Diabetes Care (CDC) Initiatives:

- Is an MQD Quality Strategy measure.
- Improving the health of members with diabetes is a focus in MQD's Quality Strategy. CDC – LDL < 100 mg/dL is a QUEST pay for performance measure.
    - One health plan has allocated $1.75 million each year for the past 3 years in a QI Incentive Program to provide support for provider-based quality improvement projects and to reward quality improvements. In 2012 this health plan implemented pay-for performance for the following HEDIS CDC measures: Eye exam, HbA1c control, and LDL-C control.
- Implemented health education programs for a variety of diabetes-related issues, including healthy eating and weight loss programs, monitoring of alcohol consumption, smoking cessation programs, and physician/patient education on medication. This includes both written and electronic health education materials.
    - In 2011, one health plan reported more members have participated in their Health Media: Care for Diabetes, which is an online program that is free to their members. The program is customized specifically by assessing a member's daily routine, general health and providing ways to manage their diabetes more effectively. The member receives follow-up emails to track their progress. After completing a questionnaire, the member receives an action plan and tools that are tailored to their preferences, and their willingness and ability to use them. The member can review their plan online, or print a copy to discuss with their physician at the next office visit.
- Implemented reminder systems to inform diabetics of needed preventive services and to contact non-compliant members using letters and/or calls. Several health plans also inform providers of members who were overdue for preventive visits and screenings.

- Provide outreach to diabetics by identifying new diabetic members in a new welcome call assessment. One health plan also sends a letter and diabetes member toolkit, called the "ABCs of Diabetes" to all members who were identified as diabetic. This toolkit included an educational brochure and diabetes checklist for members to use in managing their diabetes.

- Distributing periodic newsletters with diabetes articles and updates.

Cholesterol Management for Patients with Cardiovascular Conditions (CMC) and Controlling High Blood Pressure (CBP) Initiatives:

- Provided education to member and provider to increase awareness of cholesterol management and the importance of medication compliance.

- Implemented reminder systems for members who have had cardiovascular condition. These reminder systems may be in various forms, including postcards phone calls, or e-mails.

    - One health plan initiated process management improvements by identifying patients discharged for MI or CVA/TIA for referral for lipid management and partner with the cardiology department to help identify and refer CVD patients for HTN/lipid management.

    - One health plan implemented a "Hospital to Home" care management program for those high-risk members who have been hospitalized in which a service coordinator conducts an assessment within 3 days of hospital discharge on the member's understanding of his/her disease and care management and the ability of the member to manage their care post-hospitalization. Interventions are applied as appropriate to the individual member's case.

Childhood Immunization Status (CIS) Initiatives:

- Provided physicians with a list of patients who are due or past due for routine immunizations so the physician can follow up with the patient.

- Established patient reminder and recall systems that include: 1) Postcard reminders, and 2) Telephone to non-responders for missed appointments and/or immunizations.

    - One plan has a unique alert system for the customer service representatives. When a member calls customer service for assistance, upon completion of assisting the member with their request, the alert system informs the customer service representative of an outstanding care gaps (non-compliant HEDIS measures) in which the member is overdue. The customer service representative briefly explains the care gap and offers to assist the member in making an appointment with his or her provider.

- Conducted regular assessments of immunization rates.

- One plan reports on the trends and performance: clinic level via the Keiki Score Card-Provider specific Level via the How Are we Doing Reports and conducts systems and process improvement recommendations for underperforming clinics.

- Implemented provider incentives and/or a comparison of performance to a goal or standard.
    - Several plans meet with providers regularly to provide them with their HEDIS reports and discuss their progress.

- Implemented mechanisms to collect and report the data in a supplemental database so that immunizations that are provided without a claim being submitted to the plan can still be tracked and reported.

Breast Cancer Screening (BCS), Cervical Cancer Screening (CCS), & Chlamydia Screening in Women (CHL) Initiatives:

- Implemented reminder systems that inform patients of upcoming mammogram, cervical cancer screening appoints and eligible females who have not received a screening for Chlamydia in the recommended time frame.

- Reduced barriers that may be preventing the patient from receiving a mammogram.
    - One health plan reports success with their Mobile Health Vehicle and plans to expand this service in 2012 to include diagnostic breast imaging in addition to screening mammography
    - One health plan is trialing evening outreach for pap appointments and focusing pap clinics in areas with highest screening needs.

- Improved the capture of screenings for members who have been screened.
    - One plan executed contract amendments with the two main laboratories in Hawaii to assure lab results' supplemental data are obtained for those performance measures which require a result determination.
    - One plan receives supplemental data from an FQHC that does not submit claims to the health plan for Chlamydia screening. The health plan obtains a list of members who have received a screening as well as a sample of the Electronic Health Records for primary source verification, which is then reviewed by an auditor for compliance. This supplemental data had a positive impact on the 2011 HEDIS rate as there was an increase of 10% in the number of members receiving a Chlamydia test during the measurement year for the QUEST population.

Ambulatory Care (AMB) Initiatives:

- Implemented education of members on appropriate ER use.

- One health plan provided intervention for high utilizers with active case management by clinicians and case managers. Case managers assigned to these members directed them to appropriate care, ensuring that the patient has an assigned PCP, identified any barriers in care, reason for frequent visits to the ER and provided education on appropriate use of the ER.

- One health plan has Disease Management staff address care gaps during the assessment process and follow-up calls, in addition to supporting and reminding members of the importance of complying with disease management recommendations.

CMS-416 EPSDT Measures Initiatives

In 2011 health plans began receiving aggregated reports based on Hawaii EPSDT forms that contained the following information: BMI metrics, immunizations, screenings, referrals, care coordination, and abnormal screenings. These reports will assist the health plans in determining gaps in EPSDT visits/screenings, and to follow-up with referrals and care coordination.

CAHPS (QUEST & QExA) Initiatives

Rating of Health Plan & Rating of Personal Doctor Initiatives:

- Utilized online and technology assets to outreach to members.

    - One plan launched a new Health & Wellness section on its website, along with notifying member of this new section.

    - One plan updated their secure member portal, to add functionality to include ordering and printing ID cards, change PCPs, and update demographic information.

- Used face-to-face meetings to assess and evaluate the membership experience with the health plan.

    - One plan conducted member educations sessions on various health topics as well as emphasizing the need to communicate with their doctors.

    - One plan conducted quarterly focus groups to gain a better understanding of the member needs, expectations and dissatisfactions.

- Utilized "hard copy" media to outreach to the member and increase member satisfaction with the health plans.

    - One plan sent out members-specific letters detailing preventive visits and screenings or tests that are coming due, as well as an explanation as to the necessity of these visits.

- One plan created and deployed a new set of documents for the Service Coordinators to share with the member that will improve their understanding of their benefits, and how the plan supports these benefits.

- Conducted an internal review of information flow to improve health plan responsiveness to member problems.
    - One plan recently improved its process to reimburse dual-eligible members for erroneously paid co-pays. Service coordinator and call center staff were re-trained to follow new protocols to speed the identification and reimbursement to the member. Provider education was provided on appropriate billing for dual-eligible members to prevent this from occurring in the first place.

Rating of Specialist Seen Most Often & How Well Doctors Communicate Initiatives:

- Utilized online and technology assets to outreach to provider to improve care delivery.
    - One plan made available members' HEDIS care gaps to providers via secure online content. Providers could then close these recommended care gaps with their members.

- Incentivized providers to improve care.
    - One plan offered $100 per member incentives to providers to complete care gaps for dual eligible members.

Getting Needed Care & Getting Care Quickly Initiatives:

- Utilized online and technology assets to improve the ability of members to connect to providers.
    - One plan streamlined the provider search functionality on their website.
    - One plan increased the update frequency of the online provider directories to daily.
    - One plan improved the online provider directory by adding hospital privileges, and increasing the update frequency to monthly.
    - One plan added online 'enter' and 'view' functionality for prior authorizations, admissions and referrals

- Reached out to members to gauge provider access and care delivery.
    - One plan conducted telephonic member surveys on access to provider care, and relaying these findings to providers during regular, periodic training visits.
    - One plan conducted ongoing member surveys to further gauge timely access to care.

- Personally assisted members with obtaining needed provider appointments.
    - One plan coordinated the scheduling of appointments for "hard to find" specialists such as Neurosurgeons, Pulmonologists, Gastroenterologists, etc. when the member was having a difficult time doing this on their own.
    - One plan encouraged open access scheduling models at physician offices, where part of the physician's schedule is left open for same-day patient access or urgent visit reservations.
    - One plan merged systems that track gaps in HEDIS-related care with customer service, so that during member calls the customer service rep can reminder the member that they need to see a provider and even offer to set up an appointment.
    - One plan implemented a Complex Case Management program to assist members that have experienced a critical event or diagnoses that requires extensive use of resources. This program provides a comprehensive assessment of the member's condition, development and implementation of a care plan, and monitoring and follow-up with the member's PCP.
- Other miscellaneous improvements were made.
    - All of the QUEST plans simplified the drug prior authorization process by standardizing the form across all QUEST plans.
    - One plan made physician biography cards available at clinic locations to facilitate physician comparisons and selection.
    - One plan allocated $300,000 over the past four years to support recruitment and retention of providers, particularly on the neighbor islands.
    - One plan implemented a 24-hour nurse triage call line equipped with specialty trained nurses and an audio health library.
    - One plan added the ability of QUEST members to email the plan's QUEST department directly from the health plan website.
    - One plan began implementation of Patient-Centered Medical Homes in key FQHCs. A data analyst and care advocate works with the FQHC to provide data on care opportunities, and to assist with coordination of care related to these opportunities.

Physicians' Assessment Initiatives

Attitude Toward Hawaii Med-QUEST & Satisfaction with Reimbursement from the Med-QUEST Health Plan Initiatives:

- Utilized online and technology assets to improve the ability of members to connect to providers.

- One plan created a centralized email inbox to streamline provider inquiries to the health plan's provider relations department, including reimbursement and claim issues.

- Created internal advocacy for provider needs and interests.
    - One plan started a Provider Advisory Group within the Health Plan to take the provider's point of view, and to review new provider forms and programs.

Does the Health Plan Personnel have the Necessary Professional Knowledge & Impact of the Health Plan's UM (prior authorizations) on Quality Care Initiatives:

- Improved the knowledge base of their employees through various training modalities.
    - One plan implemented an on-line learning system containing all staff training material, and pre- and post-testing, made available to all front-line staff.
    - One plan added training on appeals and grievance, benefits, authorization and utilization management to basic New Employee Orientation agendas.
    - One plan increased staff coaching and mentoring activities.
    - One plan conducted monthly knowledge quizzes to gauge whether additional training is needed.

- Initiated improvements to the prior authorization process.
    - One plan reviewed notification and prior authorization (PA) requirements, and eliminated PA requirements for many behavioral health services and cardiology services.
    - One plan added an online PA application to streamline the PA process.
    - One plan increased provider training and education related to the online PA process.
    - One plan distributed handouts on the PA process during periodic provider relations visits.
    - One plan conducted statewide provider workshops to educate providers on referrals and pre-certifications, and had follow-up Q&A opportunities post-workshop as well as through evaluation forms.
    - One plan analyzed the rate of PA approvals by specialty category, and for those categories with high approval rates removed the PA requirement for those services.
    - One plan reviewed the compliance to the health plan's clinical review criteria for selected providers, and eliminated the PA requirement where compliance was consistent.

Home and Community Based Services (HCBS) Initiatives

- Streamlined ability to receive HCBS instead of nursing facility placement since start of QExA
    - By moving HCBS from the 1915(c) waivers into an 1115 demonstration waiver in health plans, MQD was able to minimize the silos that existed previously to "get into a waiver."
    - Health plan members are assessed for their choice of placement for long term supports and services (LTSS).
    - Choices offered include:
        - Their home with support provided by home care agencies or family members provided as a health plan paid consumer-directed personal assistant
        - Residential settings such as community care foster family homes or assisted living facilities
        - Institutional setting
    - Once member is assessed for needing long term supports and services, health plans are able to provide LTSS within approximately thirty (30) days.
    - DHS had a wait list of approximately 1,000 for all four 1915(c) waivers combined prior to QExA implementation
- Standardized assessment tools for HCBS
    - At the start of QExA, MQD and the health plans developed a standardized personal assistance and skilled nursing tool to assure consistency with health plan assessments for receipt of HCBS
    - The use of these assessment tools have helped to streamline receipt of services

Hawaii Medicaid Enrollment Initiatives

- MQD is focused on assuring processing of applications for Medicaid within 45-days or else providing presumptive eligibility.
- MQD has enacted eligibility for beneficiaries five-days prior to submittal of application to assure that medical services received will be covered.
- MQD has amended its 1115 demonstration waiver to provide eligibility up to 133% of Federal Poverty Level to be prepared for implementation of ACA.

Recommendations

Though the MQD has seen improvement in many of its performance measures over the past five years, we are not meeting the requirements that we have established in our Quality Strategy of at least 75th percentile of the national Medicaid population. MQD has the following recommendations for improving health plan performance:

1. Improve process for gathering information from providers

   The majority of Medicaid providers in Hawaii are single providers (i.e., not part of a group practice and are not part of an Independent Physician Association (IPA)). In addition, up to this point, both the QUEST and QExA health plans provide information to Hawaii Medicaid providers retrospectively. It has been very difficult to make changes in HEDIS results for critical areas such as diabetes or cardiovascular disease when the penetration into the provider community is provider-by-provider.

   Some recommendations for the future are:
   A. Encourage providers to move to electronic medical records and achieve meaningful use by implementing the Electronic Health Record (HRE) initiative that is part of the ACA.
   B. Offer reminders to providers in real-time for best practices (i.e., reminders for preventative screenings).

2. Explore mechanisms to improve health plans' supplemental data collection

   Health plans have identified that immunizations and certain screenings like Chlamydia are often performed and paid for outside the health plan. Therefore, these services are not captured for coordination of care or for reporting in the health plan's HEDIS measures. MQD is committed to support and encourage collaborative endeavors by the health plans to work with FQHCs and other large providers to obtain data for services paid through federal grants for Medicaid members.

3. Increase the Pay for Performance withhold from health plans

   MQD implemented a Pay for Performance (P4P) withhold from the QUEST program in 2010. In this program, MQD withholds $1.00 PMPM for every capitation payment for each member that has been with them for the entire month. Annually, MQD will review the health plans' HEDIS and CAHPS results compared to 75th percentile of the national Medicaid population as well as look to see if they have improved their results by at least 50% over the past year. If a health plan has met one of the desired results, then they receive a payment of $0.20 PMPM for each performance measure they have met.

   The results of the first year of the program are listed below.

	AlohaCare	HMSA	Kaiser
Childhood Immunization (HEDIS 2010)	No	No	Yes
Clamydia Screening (HEDIS 2010)	No	Yes	Yes
LDL Control- Comprehensive Diabetes Care (HEDIS 2010)	No	No	Yes
Getting Needed Care- Child CAHPS (CAHPS 2011)	No	No	No
Getting Needed Care- Adult CAHPS (CAHPS 2010)	Yes	No	No
ED Visits/1000 (HEDIS 2010)	Yes	Yes	Yes
Total PMPM	$0.40	$0.40	$0.80

MQD has increased the P4P withhold to $2.00 PMPM to encourage the health plans to strive for quality in the care they are providing to their members. In addition, payment of the P4P is based solely on meeting 75th percentile of the national Medicaid population.

4. Implement auto-assignment percentages based upon results of HEDIS and CAHPS results

   In the new QUEST contract that is effective July 1, 2012, MQD will revise the auto-assignment percentages based upon results of HEDIS and CAHPS results. These auto-assign percentages will be revised annually based upon previous year results. The first auto-assign percentages will be implemented on January 1, 2014.

5. Implement Health Plan Collaborative with EQRO

   Part of the Quality Strategy is to have two health plan collaboratives annually. In the health plan collaborative, MQD and its EQRO will meet with health plans to review performance measures over the past year. During these meetings, the health plans and MQD will strategize on techniques to improve the quality of services provided to Medicaid beneficiaries.

   The collaborative consist of MQD staff, EQRO staff, health plan administrators, medical directors, and quality improvement staff. MQD will have its first health plan collaborative in the fall of 2012.

6. Revise and update Quality Strategy

   MQD will update its quality strategy to add its P4P initiatives. In addition, MQD will expand on the CAHPS requirements in its P4P. These changes will be made to its Quality Strategy by the end of the calendar year.

Conclusion

MQD has seen some improvement in the results of the program over the past five years. However, additional changes are required to assure better preventative screening and disease treatment of our beneficiaries. Through implementation of the recommendations provided, MQD anticipates improved health plan performance and better quality of services to our beneficiaries.

Appendix A

Hawaii 1115 QUEST Waiver								
TOTAL COMPUTABLE		12	13	14	15	16	17	18
		Std Renewal /Extension			**Renewal**			
WITHOUT WAIVER	**FMAP**	0.58725	0.57865	0.567625	0.640275	0.6735	0.6546	0.5081
		58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%
	MEG Description and Comments	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%
					67.35%		62.63%	
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	$261.16	$281.11	$302.59	$322.62	$343.98	$366.75	$391.03
	TANF Adults	$458.35	$493.37	$531.07	$564.90	$600.88	$639.18	$679.87
	Aged				$1,204.63	$1,281.84	$1,364.01	$1,451.44
	Blind/Disabled				$1,489.42	$1,597.11	$1,712.58	$1,836.40
Mem ber Months								
	TANF (AFDC), Foster Children, GA children							
	SHIP Children							
	TANF (AFDC), Foster Children, GA children, SHIP Children	943,063	930,199	891,143	979,228	1,101,814	1,183,804	1,223,583
	TANF Adults	339,848	331,334	302,135	348,185	390,404	421,978	422,741
	Aged				98,211	228,008	236,945	234,307
	Blind/Disabled				115,266	273,836	288,269	286,344
	Total Without Waiver Member Months	**1,282,911**	**1,261,533**	**1,193,278**	**1,540,890**	**1,994,062**	**2,130,996**	**2,166,975**
Ceiling Without DSH	Total Without Waiver Expenditures including HCBS	$402,056,806	$424,960,513	$443,327,661	$837,493,616	$1,343,204,149	$1,520,758,456	$1,631,791,072
DSH		$80,364,047	$81,971,327	$83,856,667	$87,546,360	$89,735,019	$91,350,249	$94,547,507
Total Ceiling		**$482,420,853**	**$506,931,840**	**$527,184,328**	**$925,039,976**	**$1,432,939,168**	**$1,612,108,705**	**$1,726,338,579**
WITH WAIVER	1115	$0	$0	$0	$0	$0	$0	$0
	1902 R 2	$0	$0	$0	$0	$0	$0	$0
	1902 R 2X	$0	$0	$0	$0	$0	$0	$0
	1902R2	$0	$0	$0	$0	$0	$0	$0
	AFDC	$0	$0	$0	$0	$0	$0	$0
	Aged w /Mcare	$0	$0	($295)	$121,310,557	$314,957,371	$350,728,888	$330,293,296
	Aged w /o Mcare	$0	$0	$0	$2,424,989	$17,555,107	$24,896,097	$19,060,304
	B/D w /Mcare	$0	$0	($13,736)	$31,795,707	$74,850,400	$81,249,425	$77,690,468
	B/D w /o Mcare	$0	$0	($28,991)	$81,514,842	$211,801,011	$248,768,345	$251,740,251
	Breast Cervical Cancer Treatment (BCCT)	$0	$0	$0	$0	$4,051	$545,195	$734,188
	CURRENT	$0	$0	$0	$0	$0	$0	$0
	CURRENT POP	$0	$0	$0	$0	$0	$0	$0
	Current-Haw aii Quest	$0	$0	$0	$0	$0	$0	$0
	Demo Elig Adults	$127,983,510	$129,458,220	$154,645,707	$177,396,443	$201,629,508	$238,017,265	$245,339,887
	FosterCare(19-20)	$0	$0	$91,499	$83,366	$94,158	$137,233	$77,745
	Haw aiiQuest-1902(R)(2)	$0	$0	$33,061	$26,332	$8,001	$0	$0
	HCCP	$0	$0	$135,520	$683,159	$0	$0	$0
	HealthQuest-Current	($2,325,152)	$0	$0	$0	$0	$0	$0
	HealthQuest-Others	($621,643)	$0	$0	$0	$0	$0	$0
	Med Needy Adults	$56,504	$120,767	$115,693	$58,345	$117,005	$109,837	$8,305
	Med Needy Children	$0	$0	$0	$7,715	$3,960	$0	$0
	MFCP	$0	$0	$122,839	$581,513	$0	$0	$0
	NH w /o W	$0	$0	$5,100,418	$16,199,737	$0	$0	$0
	Opt St Pl Children	$76,678	$103,084	$80,075	$257,166	$253,182	$31	$0
	Others	$0	$0	$0	$0	$0	$0	$0
	Others-Haw aii Quest	$0	$0	$0	$0	$0	$0	$0
	OthersX	$0	$0	$0	$0	$0	$0	$0
	QUEST ACE	($2,751)	$798,681	$5,696,094	$14,353,208	$23,872,001	$30,434,166	$28,884,029
	RAACP	$0	$0	$7,862,479	$17,432,949	$0	$0	$0
	St Pl Adults-Preg Immig/COFAs	$0	$0	$0	$0	$24,990	$2,622,138	$2,718,679
	State Plan Adults	$111,983,043	$118,021,622	$109,034,691	$128,225,127	$132,187,409	$123,786,545	$118,966,463
	State Plan Children	$181,803,156	$179,673,972	$155,394,295	$168,854,083	$203,903,281	$214,486,295	$199,141,564
	Supp. - Private	$0	$0	$0	$0	$0	$0	$0
	Supp. - State Gov.	$0	$0	$0	$0	$0	$0	$0
	UCC-Governmental	$15,688,221	$22,546,108	$18,919,184	$16,356,580	$24,507,605	$34,064,491	$40,634,690
	UCC-Private	$10,056,500	$3,403,710	$7,500,000	$7,500,000	$7,500,000	$7,500,000	$0
		$444,698,066	**$454,126,164**	**$464,688,533**	**$785,061,818**	**$1,213,269,040**	**$1,357,345,951**	**$1,315,289,869**
		-$1,459,097	-$1,189,919	-$660,309	-$4,962,002	-$38,297,536	-$43,476,661	-$38,375,159
		$443,238,969	**$452,936,245**	**$464,028,224**	**$780,099,816**	**$1,174,971,504**	**$1,313,869,290**	**$1,276,914,710**
		$39,181,885	**$53,995,595**	**$63,156,104**	**$144,940,160**	**$257,967,664**	**$298,239,415**	**$449,423,868**
		$565,691,724	**$619,687,319**	**$682,843,423**	**$827,783,582**	**$1,085,751,247**	**$1,383,990,662**	**$1,833,414,530**
		-$334,903	-$352,488	-$217,644	-$22,587	-$15,945,497	-$15,835,580	-$10,164,390
		-$323,973	-$263,058	-$239,466	-$19,777	-$6,517,946	-$9,185,458	-$9,300,862
		-$347,005	-$279,056	-$147,219	-$22,317	-$9,503,023	-$9,356,037	-$9,335,080
		-$453,216	-$295,317	-$55,980	-$4,897,321	-$6,331,070	-$9,099,586	-$9,574,826

Appendix B

Medicaid Eligibility Groups	FPL Level and/or other qualifying Criteria	DY 12	DY13	DY14	DY15	DY16	DY17	DY18
Mandatory State Plan Groups								
Pregnant women and infants under age 1	Up to 185 % FPL	150,628	148,567	153,476	178,999	189,018	166,869	139,838
Pregnant IMM/COFA						1,954	8,929	6,198
Children 1-5	Up to 133% FPL	312,242	314,820	304,250	341,362	381,974	408,973	416,975
Children 6-18	Up to 100% FPL	499,619	491,766	472,432	505,116	583,763	635,484	663,188
Adult/Children AFDC related family members covered by Section 1931	Up to 100% FPL	270,986	255,563	235,530	253,126	287,428	332,051	353,628
Transitional Medicaid (Section 1925) Children	Coverage is for two six-month or one four-month periods due to increased earnings or child support, respectively, make an individual ineligible for continued coverage under Section 1931. In the second six month period, family income may not exceed 185% FPL	30,924	32,168	18,780	29,595	29,465	33,520	41,623
Section 1925 Transitional Medicaid Adults	Coverage is for two six-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 six month period, family income may not exceed 185% FPL	18,055	17,604	7,165 1	6,619 1	5,317 1	9,267 2	4,467
Optional State Plan Groups								
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement	Up to 100% FPL	456	442	594	496	538	689	407
Children through the S-CHIP Medicaid expansion	101 - 200% FPL and for whom the State is claiming Title XXI funding	187,674	195,679	201,322	215,957	250,263	254,863	269,437
Medically Needy Adults and Children	Up to 300% FPL, if individuals otherwise eligible under State Plan groups described above spend down to Medicaid income limits. (Benefits are FFS)				2	7,097	41,552	41,185
CHIPRA								
Children who are not eligible for SCHIP	201- 300% FPL - who could be eligible through 1902 (r) (2) and for whom the State is claiming Title XIX funding. Eligibility criteria requiring prior enrollment in QUEST or Medicaid fee for service is eliminated in QUEST Expanded.	1	603	1,051	2,100	2,761		
Demonstration Eligible Groups								
Adult AFDC related family members who are TANF cash recipients who are otherwise ineligible for Medicaid.	Up to 100% FPL (using TANF methodology)	1,913	1,541	1,814	613	259	169	170
Childless adults who are General Assistance (GA) cash recipients but are otherwise ineligible for Medicaid.	Up to 100% FPL (using GA methodology)	38,252	39,232	41,860	48,602	49,051	53,112	54,883
Childless adults who meet Medicaid asset limits.	Up to 100% FPL (subject to an enrollment cap presently set at 125,000)	270,673	256,759	268,786	296,483	355,006	422,282	457,190
Quest Net Adults	Up to 100% FPL Eligible to enroll in QUEST but elected QUEST-Net	4,711	4,383	4,433	3,115	3,179	3,324	3,690
Quest Net Adults	Up to 300% FPL but exceed QUEST asset or income	10,377	10,071	9,997	9,790	9,458	9,372	9,059
QUEST ACE		1,132	22,587	7 0,038	115,481	135,427	150,098	
QUEST-Net-Children								
Demonstration Eligible Groups	**FPL Level and/or other qualifying Criteria**							
Children who could be eligible for SCHIP	201-300% FPL for whom the State is claiming Title XXI funding. Eligibility criteria requiring prior enrollment in QUEST or Medicaid fee for service is eliminated in QUEST Expanded.	8,943	10,129	20,253	29,714	35,478	42,539	46,322
Total		1,806,586	1,801,914	1,811,781	2,047,170	2,337,436	2,583,093	2,528,260

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

SEP 17 2012

Ms. Patricia McManaman
Director
Hawaii Department of Human Services
P.O. Box 339
Honolulu, Hawaii 96809-0339

Dear Ms. McManaman:

Thank you for your recent request to extend the state's QUEST Expanded section 1115 demonstration (11-W-00001/9). The Centers for Medicare & Medicaid Services (CMS) received your extension request on June 29, 2012. On July 13, 2012 CMS completed a preliminary review of your extension request in accordance with the April 27th final rule. We determined at that time that the state's extension request had not met the requirements for a complete extension request as specified under section 42 CFR 431.412(c) because it required more detail regarding the evaluation and the state's future goals for the demonstration.

In response to our letter, on September 5, 2012, you submitted a draft evaluation and the state's future goals. We have completed a preliminary review of the additional information, and have determined that with additional materials the state's extension request has met the requirements for a complete extension request as specified under section 42 CFR 431.412(c).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's extension request. The 30-day Federal comment period, as required under 42 CFR 431.416(b), begins on September 20, 2012 ends on October 20, 2012. The state's extension request is available at http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html.

We look forward to working with you and your staff to extend the state's demonstration. If you have additional questions or concerns, please contact your project officer Alexis E. Gibson, Division of State Demonstrations and Waivers, at (410) 786-2813, or at alexis.gibson@cms.hhs.gov.

Sincerely,

/Angela D. Garner/

Angela D. Garner, Deputy Director
Division of State Demonstrations and Waivers

cc: Victoria Wachino, CMCS
Gloria Nagle, Associate Regional Administrator, Region IX
Alexis E. Gibson, CMCS