

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850



State Demonstrations Group

October 14, 2020

Judy Mohr Peterson
Med-QUEST Division Administrator
State of Hawai'i, Department of Human Services
601 Kanokila Blvd, Room 518
PO Box 700190
Kapolei, HI 96709-0190

Dear Dr. Mohr Peterson:

The Centers for Medicare & Medicaid Services (CMS) has approved the evaluation design for Hawai'i's section 1115 demonstration entitled, "Hawai'i QUEST Integration" (Project Number 11-W00001/9), and effective through July 31, 2024. We sincerely appreciate the state's commitment to a rigorous evaluation of your demonstration.

CMS has added the approved evaluation design to the demonstrations Special Terms and Conditions (STC) as Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved evaluation design may now be posted to the state's Medicaid website within thirty days. CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an interim evaluation report, consistent with the approved evaluation design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application if the state chooses to extend the demonstration. Likewise, a summative evaluation report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period.

We look forward to our continued partnership with you and your staff on the Hawai'i QUEST Integration section 1115 demonstration. If you have any questions, please contact your CMS project officer, Mr. Michael Trieger. Mr. Trieger may be reached by email at Michael.Trieger1@cms.hhs.gov.

Sincerely,

Danielle Daly
-S

Digitally signed by
Danielle Daly -S
Date: 2020.10.14
09:29:35 -04'00'

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

Angela D.
Garner -S

Digitally signed by Angela
D. Garner -S
Date: 2020.10.14
13:55:58 -04'00'

Angela D. Garner
Director
Division of System Reform
Demonstrations

cc: Brian Zolynas, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00001/9

TITLE: QUEST Integration Medicaid Section 1115 Demonstration

AWARDEE: Hawaii Department of Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authorities, shall apply to the demonstration project effective from August 1, 2019 through July 31, 2024, unless otherwise stated. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted subject to the STCs for the QUEST Integration Medicaid Section 1115 Demonstration. These waivers shall apply to all demonstration enrollees.

1. Medically Needy **Section 1902(a)(10)(C) and Section 1902(a)(17)**

To enable the state to limit medically needy spend-down eligibility in the case of those individuals who are not aged, blind, or disabled to those individuals whose gross incomes, before any spend-down calculation, are at or below 300 percent of the federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, for whom there is no gross income limit.

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

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

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary to enable the state to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. To enable Hawaii to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932. No waiver of freedom of choice is authorized for family planning providers.

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00001/9

TITLE: QUEST Integration Medicaid Section 1115 Demonstration

AWARDEE: Hawaii Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration extension, August 1, 2019 through July 31, 2024, be regarded as expenditures under the state's title XIX plan, unless otherwise stated, but are further limited by the Special Terms and Conditions (STCs) for the QUEST Integration Section 1115 demonstration.

For enrollees in All Components of the Demonstration:

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

Expenditures under contracts with managed care organizations (MCOs) that do not meet the requirements under section 1903(m)(2)(A)(vi) of the Act insofar as that provision requires compliance with requirements in section 1932(a)(4)(A)(ii)(I) of the Act, including as it is implemented and interpreted in 42 CFR 438.56(c)(2)(i)). With this expenditure authority, the state may restrict enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, described in STC 36. Enrollees may disenroll for cause at any time and may disenroll without cause at least once every 12 months, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, including as it is implemented and interpreted in 42 CFR 438.56(c)(2)(ii), except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.

Expenditures for capitation payments to MCOs, and PIHPs, in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3)(A) and federal regulations at 42 CFR section 438.52(a)(1).

2. **Quality Review of Eligibility.** Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.
3. **Demonstration Expansion Eligibility.** Expenditures to provide coverage to the following demonstration expansion populations:

- a. Demonstration Population 1. Parents and caretaker relatives who are living with an 18-year-old who would be a dependent child but for the fact that the 18-year-old has reached the age of 18, if such parents would be eligible if the child was under 18 years of age.
- b. Demonstration Population 2. Aged, blind, and disabled individuals in the 42 C.F.R. § 435.217 like group who are receiving home- and community- based services, with income up to and including 100 percent of the federal poverty limit using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.
- c. Demonstration Population 3. Aged, blind, and disabled medically needy individuals receiving home-and community-based services, who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income.
- d. Demonstration Population 4. Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance, who would not otherwise be eligible under the state plan, with the same income limit that is applied for Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement under the state plan.
- e. Demonstration Population 5. Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance) when placed from age 16 to 18 years of age, or would otherwise be eligible under a different eligibility group but for income, and were enrolled in the State plan or waiver while receiving assistance payments.

4. **Home and Community-Based Services (HCBS) and Personal Care Services.**

Expenditures to provide HCBS not included in the Medicaid state plan and furnished to QUEST Integration enrollees, as follows:

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

- b. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, *i.e.*, the “at risk” population.

The state may maintain a waiting list, through a health plan, for home and community-based services (including personal care services). No waiting list is permissible for other services for QUEST Integration enrollees.

- c. The state may impose an hour or budget limit on home and community based services provided to individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the “at risk” population), as long as such limits are sufficient to meet the assessed needs of the individual.

5. **Additional Benefits:** Expenditures to provide the following additional benefits.

- a. **Specialized Behavioral Health Services:** The services listed below (and further described in Attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
 - i. Supportive Employment.
 - ii. Financial management services.
- b. **Cognitive Rehabilitation Services:** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical, occupational or speech therapist. Services must be medically necessary and prior approved.
- c. **Habilitation Services.** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.
- d. **Community Integration Services.** Pre-tenancy and tenancy sustaining services as defined in STC 23 of the STCs are available for beneficiaries who are 18 years or older and meet the criteria specified in STC 23.
- e. **Community Transition Services Pilot Program.** Expenditures for the Community Transition Services Pilot Program as set forth in STC 23.

All requirements of the Medicaid program expressed in law, regulation, and policy statement shall apply to the demonstration expansion populations, except those expressly identified on the waiver list or listed below as not applicable.

Title XIX Requirements Not Applicable to Demonstration Expansion Populations

Cost Sharing

Section 1902(a)(14) insofar as it incorporates 1916 and 1916A

To enable the state to charge cost sharing up to 5 percent of annual family income.

To enable the state to charge an enrollment fee to Medically Needy Aged, Blind and Disabled QUEST Integration health plan enrollees (Demonstration Population 3) whose spend-down liability is estimated to exceed the QUEST Integration health plan capitation rate, in the amount equal to the estimated spend-down amount or where applicable, the amount of patient income applied to the cost of long-term care.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00001/9

TITLE: QUEST Integration Medicaid Section 1115 Demonstration

AWARDEE: Hawaii Department of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Hawaii's QUEST Integration section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the Hawaii Department of Human Services (hereinafter "state") and the Centers for Medicare & Medicaid Services (CMS). CMS has granted waivers of requirements under section 1902 of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable under section 1903 of the Act, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. These STCs are effective from August 1, 2019 through July 31, 2024, unless otherwise stated. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

- I.** Preface
- II.** Program Description, Objectives, and Historical Context
- III.** General Program Requirements
- IV.** Eligibility for the Demonstration
- V.** Enrollment
- VI.** Benefits
- VII.** Community Integration Services
- VIII.** Delivery System
- IX.** Cost Sharing
- X.** General Reporting Requirements
- XI.** Monitoring
- XII.** Evaluation of the Demonstration
- XIII.** General Financial Requirements Under Title XIX
- XIV.** Monitoring Budget Neutrality for the Demonstration
- XV.** Schedule of State Deliverables During the Demonstration Extension Period

In the event of a conflict between any provision of these STCs and any provision of an attachment to these STCs, the STCs must take precedence.

The following attachments have been included to provide supplemental information and guidance for specific STCs. The following attachments are incorporated as part of these STCs.

Attachment A: Developing the Evaluation Design
Attachment B: Preparing the Interim and Summative Evaluation Reports
Attachment C: Evaluation Design
Attachment D: Home and Community-Based Services (HCBS) and Long-Term Care Provider Guidelines and Service Definitions
Attachment E: Behavioral Health Services Protocol
Attachment K: Emergency Preparedness and Response

II. PROGRAM DESCRIPTION, OBJECTIVES, AND HISTORICAL CONTEXT

QUEST Integration is a continuation of the state's ongoing demonstration, which is funded through Title XIX, Title XXI and the state. QUEST Integration uses capitated managed care as a delivery system unless otherwise noted below. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria to beneficiaries eligible under the state plan and to the demonstration populations described in STC 21.

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

The QUEST program covered adults with incomes at or below 100 percent of the federal poverty level (FPL) and uninsured children with family incomes at or below 200 percent FPL. In addition, the QUEST-Net program provided a full Medicaid benefit for children with family incomes above 200, but not exceeding 300 percent FPL and a limited benefit package for adults with incomes at or below 300 percent FPL.

Since its implementation, CMS has renewed the QUEST demonstration six times. In 2007, the QUEST demonstration was renewed under the new name QUEST Expanded. In February 2010, CMS approved an amendment to implement the Hawaii Premium Plus program to encourage employment growth and employer sponsored health insurance in the State. In July 2010, CMS approved an amendment to eliminate the unemployment insurance eligibility requirement for the Hawaii Premium Plus program. In August 2010, CMS approved an amendment to add pneumonia vaccines as a covered immunization.

In April 2012, CMS approved an amendment which reduced the QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL and eliminated the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. Hawaii also requested

to increase the benefits provided to QUEST-Net and QUEST-ACE under the demonstration; eliminate the QUEST enrollment limit for childless adults; terminate the Hawaii Premium Plus program; and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

In December 2012, the state submitted its request to extend the QUEST demonstration under section 1115(a) of the Social Security Act for 5 years under the name QUEST Integration. This extension of the demonstration included the following program changes:

- Consolidated the 4 programs within the demonstration into a single “QUEST Integration” program;
- Transitioned the low-income childless adults and former foster care children from demonstration expansion populations to state plan populations;
- Added additional new demonstration expansion populations, including a population of former adoptive and kinship guardianship children;
- Increased the retroactive eligibility period to 10 days for the non-long term services and supports population;
- Provided additional benefits, including cognitive rehabilitation, habilitation, and certain specialized behavioral health services;
- Removed the QUEST-ACE enrollment-related benchmarks from the UCC pool; and
- Required additional evaluation on UCC costs after January 1, 2014.

This demonstration integrated the demonstration’s eligibility groups and benefits within the context of the Affordable Care Act (ACA). From a benefit perspective, Hawaii provided all beneficiaries with access to the same benefits based on clinical criteria and medical necessity through capitated-managed care or through managed-fee-for-service delivery systems in certain circumstances.

CMS approved the demonstration renewal in September 2013 for the demonstration period of October 2013 through December 2018. In October 2018, CMS approved an amendment to provide community integration supportive housing services to the population described in STC 22. A temporary extension of the demonstration was approved on December 8, 2018 to extend the demonstration through June 30, 2019. A second temporary extension was issued for July 1, 2019 through July 31, 2019.

Hawaii submitted a request to extend the demonstration in September 2018 for a 5 year period beginning on August 1, 2019. The 2019 extension made the following changes to the demonstration:

- Ended Hawaii’s waiver of retroactive eligibility; and
- Authorized expenditure authority for Community Transition Services Pilot program.

The objectives for the 2019-2024 demonstration approval period are:

- Improve health outcomes for Medicaid beneficiaries covered under the demonstration;

- Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth; and
- Address health determinants to improve health outcomes and lower healthcare costs.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 2. Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.
 - b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely

through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.
- 7. Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

 - a. An explanation of the public process used by the state, consistent with the requirements of STC 13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
 - b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
 - c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - d. An up-to-date CHIP allotment worksheet, if necessary;
 - e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.
- 8. Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 442 Code of Federal Regulations

(CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit phase-out plan consistent with the requirements of STC 9.

- 9. Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
 - b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.
 - c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
 - d. Transition and Phase-out Procedures: The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210 and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid or CHIP eligibility under a different eligibility category prior to termination, as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
 - e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).
 - f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the

demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

- g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

11. Adequacy of Infrastructure. The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

12. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

13. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted

entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

- 15. Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

IV. ELIGIBILITY FOR THE DEMONSTRATION

- 16. Eligibility Groups Affected by the Demonstration.** Mandatory and optional State Plan groups derive their eligibility through the Medicaid and CHIP State plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid and CHIP State Plan, except as expressly waived under authority granted by this demonstration or as described in these STCs. Any Medicaid and CHIP State Plan Amendments to the eligibility standards and methodologies for these eligibility groups will apply to this demonstration.

The beneficiary eligibility groups described below who are made eligible for QUEST Integration by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid and/or CHIP laws, regulations, and policies unless otherwise specified in the not applicable expenditure authorities for this demonstration.

QUEST Integration Medicaid and CHIP State Plan Mandatory and Optional groups

Mandatory State Plan Groups	
Eligibility Group Name	Qualifying Criteria
Parents or caretaker relatives	Up to and including 100% FPL
Pregnant Women	Up to and including 191% FPL
	Extended and continuous eligibility for pregnant women
Infants	Infants up to age 1, up to and including 191% FPL

	Deemed newborn children
	Continuous eligibility for hospitalized children
Children	Children ages 1 through 18, up to and including 133% FPL
	Continuous eligibility for hospitalized children
Low Income Adult Age 19 Through 64 Group	Up to and including 133% FPL
Children with adoption assistance, foster care, or guardianship care under title IV-E.	<p>An adoption assistance agreement is in effect under title IV-E of the Act; or</p> <p>Foster care or kinship guardianship assistance maintenance payments are being made by a State under title IV-E.</p>
Former Foster Children under age 26	No income limit
State Plan Mandatory Aged, Blind, or Disabled Groups	ABD individuals who meet more restrictive requirements for Medicaid than the SSI requirements. Uses SSI payment standard.
	Qualified severely impaired blind and disabled individuals under age 65
	Other ABD groups as described in the State Plan
Transitional Medical Assistance	Coverage for one twelve month period due to increased earnings that would otherwise make the individual ineligible under Section 1931

1931 Extension	Coverage for four months due to receipt of child or spousal support, that would otherwise make the individual ineligible under Section 1931
Qualified Medicare beneficiaries*	Standard eligibility provisions for this population as described in the State Plan.
Specified low-income Medicare beneficiaries*	Standard eligibility provisions for this population as described in the State Plan.

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

Optional State Plan Groups	
Eligibility Group Name	Qualifying Criteria
Optional Coverage of Families and Children and the Aged, Blind, or Disabled	ABD individuals who do not receive cash assistance but meet income and resource requirements
	Individuals eligible for assistance but for being in a medical institution
	Individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care
	ABD individuals in domiciliary facilities or other group living arrangements
	Aged or disabled individuals with income up to and including 100% FPL
Optional targeted low- income children	Up to and including 308% FPL including for children for whom the State is claiming Title XXI funding
Certain Women Needing Treatment for Breast or Cervical Cancer	No income limit; must have been detected through NBCCEDP and not have creditable coverage

Medically Needy Non- Aged, Blind, or Disabled Children and Adults	Up to and including 300% FPL, if spend down to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	Medically needy income standard for household size using SSI methodology
Foster Children	Children with non IV-E adoption assistance
Foster Children (19-20 years old)	Receiving foster care maintenance payments or under adoption assistance

QUEST Integration Demonstration Expansion Population Groups

Expansion Population	
Eligibility Group Name	Qualifying Criteria
Parents or caretaker relatives with an 18-year old dependent child	Parents or caretaker relatives who (i) are living with an 18-year- old who would be a dependent child but for the fact that s/he has reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age
Individuals in the 42 C.F.R. § 435.217 like group receiving HCBS	Income up to and including 100% FPL
Medically needy ABD individuals whose spend-down exceeds the plans' capitation payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance	Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in the state plan or waiver while receiving assistance payments

- 17. Post-Eligibility Treatment of Income and Resources.** All individuals receiving nursing facility long-term care services must be subject to the post-eligibility treatment of income rules set forth in section 1924 and 42 CFR section 435.733. Available income after appropriate deductions, such as for a personal needs allowance, allowances for a spouse and/or family members, and incurred medical expenses, shall be the amount by which Medicaid's payment is reduced for the relevant long-term services and supports. Individuals receiving HCBS must be subject to the post-eligibility treatment of income rules

set forth in section 1924 and 42 CFR section 435.735 if they are medically needy, with or without spend-down, or individuals who would be eligible for Medicaid if institutionalized as set forth in 42 CFR section 435.217.

- 18. Financial Responsibility/Deeming.** The state must determine eligibility using the income of household members whose income may be taken into account under the Medicaid financial responsibility and deeming rules, including institutional deeming for aged, blind, and disabled individuals.
- 19. Quality Review of Eligibility.** On March 4, 2010 CMS approved the state's MEQC plan to reflect programmatic changes as a result of the section 1115 demonstration program implementation integrating a major portion of the FFS population into Managed Care. The state shall remain relieved of any liability from disallowance for errors that exceed the 3 percent tolerance. CMS permits the state to continue with its effort to implement administrative renewal and MEQC reviews must take that policy into account.

V. ENROLLMENT

20. Spend-Down for Medically Needy Individuals.

- a. **Pregnant Women and Children Medically Needy State Plan Groups** are eligible upon determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to STC 20(d). Individuals in this group whose gross income exceeds 300 percent FPL are not eligible.
- b. **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is not expected to exceed the health plans' monthly capitation payment** will be enrolled in a QUEST Integration health plan upon the determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to STC 20(d).
- c. **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is expected to exceed the health plans' monthly capitation payment** will be eligible under the demonstration subject to STC 20(d) and an enrollment fee equal to the medically needy spend-down amount or, where applicable, the amount of patient income applied to the cost of long-term care. This group will receive all services through QUEST Integration health plans.
- d. **Medically needy individuals who are expected to incur expenses sufficient to satisfy their spend-down obligation for a retroactive period only** will not be enrolled in a QUEST Integration health plan. They will receive services on a fee-for-service basis. (This category might include, for example, persons who become medically needy for a short-term retroactive period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically and thus will not meet their spend-down obligations every month.)

VI. BENEFITS

21. QUEST Integration Benefits. Benefits provided under authority of this demonstration are delivered through mandatory managed care (except as specified in STC 21(d), and are as follows, for all populations under the demonstration (except as otherwise provided in this STC):

- a. **Full Medicaid State Plan.** Individuals eligible under the demonstration will receive comprehensive benefits including all services as defined in the Medicaid state plan.
- b. **Alternative Benefit Plan:** The Affordable Care Act (ACA) New Adult Group will receive benefits provided through the state's approved alternative benefit plan (ABP) SPA.
- c. **Managed Care Plan Change.** Beneficiaries may change managed care plans per 42 CFR 438.56(d)(2)(iv) if their residential or employment support provider is no longer available through their current plan.
- d. **Benefits Provided to the ID/DD Population.** Medicaid eligibles with developmental disabilities will receive the full Medicaid state plan benefit package through QUEST Integration managed care plans. Case management, section 1915(c) HCBS, and ICF/ID benefits for this group will remain carved out of the capitated benefit package. All QUEST Integration health plans will be required to coordinate the state plan benefits received by the ID/DD population with the HCBS that are provided on a fee-for-service basis from the Department of Health's (DOH) Developmental Disabilities Division.
- e. **Behavioral Health Benefits.** All QUEST Integration plans must provide a full array of standard behavioral health benefits (including substance abuse treatment) to beneficiaries who may need such services as set forth in the Behavioral Health Services Protocol in Attachment E. The state must also provide specialized behavioral health services to beneficiaries with SMI, SPMI, or SEBD. The state must submit the Behavioral Health Services Protocol to CMS for review within 150 calendar days after approval of this demonstration extension. Failure to submit this deliverable to CMS will result in a funding deferral (STC 49). The Behavioral Health Services Protocol must include the following:
 - i. Services provided by the DOH Child and Adolescent Mental Health Division (CAMHD) to children with serious emotional behavioral disorders (SEBD).
 - ii. Services provided to adults with SMI or SPMI by the Med-QUEST division's Community Care Services (CCS) behavioral health program, or the contracted plans.
 - iii. Reimbursement methodology
 - iv. A memorandum of agreement (MOA) between each MCO and the state that reflects the current interagency agreement for behavioral health services provided by the DOH to beneficiaries.
 - v. The process(es) and protocol(s) used for referrals between MCOs and the DOH or CCS, as well as the DOH or CCS and MCOs.

- f. **Additional Benefits.** Under the demonstration, the state will provide benefits in addition to Medicaid state plan and alternative benefit plan benefits based on medical necessity and clinical criteria. These additional benefits include home and community based services (HCBS), specialized behavioral health benefits, cognitive rehabilitation benefits, and habilitation benefits, as described below.
- h. **HCBS: QUEST** Integration health plans must provide access to a comprehensive HCBS benefit package for individuals who meet institutional level of care and are able to choose to receive care at home or in the community and an expanded sub-set of HCBS services for individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the “At Risk” population, re-named from “Personal Care-Level I/Chore” population) in order to prevent a decline in health status and maintain individuals safely in their homes and communities. The service definitions and provider types are found in Attachment D of these STCs. The amount, duration, and scope of all covered long-term care services may vary to reflect the needs of the individual in accordance with the prescribed Care Coordination Plan. The HCBS benefits that will be provided through managed care health plans include the following:

Service	Available for individuals who are assessed to be risk of deteriorating to institutional level of care	Available for individuals who meet institutional level of care (“1147 certified”)
Adult day care	X*	X
Adult day health	X*	X
Assisted living facility		X
Community care foster family homes		X
Counseling and training		X
Environmental accessibility adaptations		X
Home delivered meals	X*	X
Home maintenance		X
Moving assistance		X
Non-medical transportation		X
Personal assistance	X	X
Personal emergency response system	X*	X
Residential care		X
Respite care		X
Private duty nursing	X	X
Specialized case management		X
Specialized medical equipment and supplies		X

* Denotes new services for the “At Risk” population under QUEST Integration.

- i. **Specialized Behavioral Health Services:** The services listed below (and further described in Attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
 - i. Supportive Employment.
 - ii. Financial management services.
- j. **Cognitive Rehabilitation Services:** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical, occupational or speech therapist. Services must be medically necessary and prior approved.
- k. **Habilitation Services.** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.

VII. COMMUNITY INTEGRATION SERVICES

22. Community Integration Services (CIS).

- a. Eligibility Criteria. These eligibility criteria apply to all CIS benefits described in this STC.
 - i. Individual meets at least one of the following health needs-based criteria and is expected to benefit from community integration services:
 - 1. Individual assessed to have a behavioral health need which is defined as one or both of the following criteria:
 - 2. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or
 - 3. Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1 indicating the need for outpatient day treatment for Substance Use Disorder (SUD) treatment.
 - 4. Individual assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).
 - ii. Including STC 22(a)(i), the individual must have at least one of the following risk factors:
 - 1. Homelessness, defined as lacking a fixed, regular, and adequate nighttime residence, meaning:
 - a. Has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for

- human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; or
 - b. Living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low income individuals).
2. At risk of homelessness, defined as an individual who shall lose their primary nighttime residence:
 - a. There is notification in writing that their residence will be lost within 21 days of the date of application for assistance;
 - b. No subsequent residence has been identified; and
 - c. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter; or
 - d. History of frequent and/or lengthy stays in a nursing facility
 - e. Frequent is defined as more than one contact in the past 12 months.
 - f. Lengthy is defined as 60 or more consecutive days within an institutional care facility.
 - iii. The state must require that the MCO determine all enrollee's eligibility for the CIS Programs based on the eligibility criteria set forth in STC 22. Once an enrollee is determined eligible to participate in the CIS Program, the state must require that the MCO seek consent from the enrollee to participate in the CIS Program and the enrollee will have the option to opt-out at any time from the CIS Program. An eligible enrollee must have the option to re-enroll in the program at any time following the enrollee's voluntary disenrollment, after being reassessed foreligibility. Enrollees who do not opt-out will remain enrolled in the CIS Program until they no longer meet the eligibility criteria or do not require the applicable services to address an unmet need as determined in the eligibility reassessment. Eligibility reassessments must take place at least quarterly.
 - iv. Enrollees determined ineligible must have the opportunity to request to have their eligibility status be reassessed when there is an indication the enrollee's health status or social risk factors have changed. Upon a determination of ineligibility, the state must require that the MCO communicate to the enrollee the process to request a reassessment and provide a right to appeal the determination of ineligibility. The process for such an appeal must comply with the requirements in 42 C.F.R. §§ 438.400 through 438.24 for an adverse benefit determination. Eligibility reassessments will consist of utilizing the same tools previously used to evaluate the enrollee in the initial assessment.
 - b. Determinations. The state must require the MCOs to use an assessment tool using standardized questions to screen possibly eligible enrollees to determine whether they meet the eligibility criteria to receive Community Integration Services. The state must require that each MCO determines the services to be provided and will review the plan of care with the enrollee after the assessment is complete.
 - c. CIS Benefits. These services are furnished only to the extent it is reasonable and

necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. This Program is voluntary for beneficiaries.

i. Pre-Tenancy Supports:

1. Conducting a functional needs assessment identifying the beneficiary's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); providing assistance in budgeting for housing and living expenses;
2. Assisting beneficiaries with connecting to social services to help with finding and applying for housing necessary to support the individual in meeting their medical care needs.
3. Developing an individualized plan based upon the functional needs assessment as part of the overall person centered plan. Identifying and establishing short and long-term measurable goal(s), and establishing how goals will be achieved and how concerns will be addressed.
4. Participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
5. Providing supports and interventions per the person-centered plan.

ii. Tenancy Sustaining Services:

1. Service planning support and participating in person-centered plan meetings at redetermination and/or revision plan meetings, as needed.
2. Coordinating and linking the recipient to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
3. Entitlement assistance including assisting beneficiaries in obtaining documentation, navigating and monitoring application process, and coordinating with the entitlement agency.
4. Assistance in accessing supports to preserve the most independent living such as individual and family counseling, support groups, and natural supports.
5. Providing supports to assist the beneficiary in the development of independent living skills, such as skills coaching, financial counseling, and anger management.
6. Providing supports to assist the beneficiary in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
7. Coordinating with the beneficiary to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
8. Connecting the beneficiary to training and resources that will assist the individual in being a good tenant and lease compliance, including ongoing support with activities related to household management.

- d. **Requirements for CIS Program.** The following requirements apply to the CIS Program:
- i. MCO Responsibilities. The state must require the MCO to develop an enrollee care plan for each enrollee in the CIS Program. The state must require the MCO to also do the following:
 - 1. Screen Medicaid managed care beneficiaries to identify those who are eligible for receiving services through this program.
 - 2. Obtain consent for enrollment in the program.
 - 3. Determine and authorize the specified services that are necessary and appropriate for beneficiaries.
 - 4. Work in collaboration with providers to track the provision of services.
 - 5. Participation in “learning communities” to ensure that MCOs and providers are sharing and adopting best practices throughout the duration of the five-year demonstration period.
 - 6. Track and report the services provided to beneficiaries, ensuring accountability for service delivery and payment, monitoring against fixed allotments.
 - 7. Conduct periodic audits of payments to verify accurate reporting and spending. These audits must include verification that services reported are actually received by beneficiaries.
- e. **Program Integrity.** The state must maintain program integrity standards in the program, including:
- 1. Quarterly accounting on delivered services
 - i. Encounter data must include:
 - a. Beneficiary name and Medicaid identification number
 - b. Provider organization name
 - c. Description of services(s) rendered
 - d. Date(s) and/or duration of services(s) delivery
 - e. Number of unit(s) of services(s) delivered
 - f. Cost of services(s) delivered
 - g. Service indicator (reason for service delivery)
 - ii. MCO Role. MCOs must report the following to the state on a quarterly basis:
 - a. Number of enrollees who receive each CIS service.
 - b. Total costs for each CIS service.
- f. **Audit Process.** The state must require the MCOs to ensure Medicaid payments are for services covered under this program that were actually provided and properly billed and documented by the providers through the following processes:
- 1. Encounter Data Analysis
 - i. As part of their general Medicaid program integrity requirements, the state must require that MCOs analyze claims submitted by providers to ensure that they: (1) accurately and appropriately represent the delivery of authorized services, and (2) identify irregularities, discrepancies, or outliers requiring further investigation.
 - ii. To the extent that MCOs identify irregularities, the state must require MCOs to refer those irregularities to their Special Investigations Unit for follow-up and report them to the state’s Program Integrity Division.

2. Visit Verification Procedures
 - i. In accordance with the state's Medicaid program integrity requirements, the state must require the MCOs regularly validate services, including those delivered through the pilots, that were rendered as provided and properly billed and documented by pilot providers through conducting visit verification procedures on a random sample of claims/invoices. Verification procedures may include:
 - a. Outreach to beneficiaries to confirm receipt of services
 - b. Outreach to providers to require documentation of provided services
3. As part of the state's overarching oversight strategy, the state's Program Integrity Division must review and monitor the MCOs' policies, including sample sizes and targeted provider types, and sample visit verification cases. Ensuring action is taken to address identified non-compliance.
4. Recoupment of Overpayments. Under the state's Medicaid program integrity requirement, the state must require the MCOs to monitor payments and identify issues of overpayment. MCOs must regularly monitor their payments to providers to identify potential overpayments.
5. Suspension, Withhold, Sanctions and Termination Activities due to Findings of Fraud or Abuse. In accordance with the state's Medicaid program integrity requirements:
 - i. The state reserves the right to direct a MCO to impose a payment suspension or withhold on any provider due to a credible allegation of fraud in accordance with 42 CFR 455.23.
 - ii. The state and MCOs will have the right to terminate a provider for reasons related to actions consistent with 42 CFR 455.
 - iii. The state will have the right to impose other sanctions or intermediate sanctions on, or require a corrective action plan from a MCO or pilot provider.
 - iv. The state must require MCOs to submit monthly reports to the state on all pilot provider terminations or non-renewals due to fraudulent behavior.
 - a. Auditing compliance. The state must audit MCOs to ensure their compliance with the program requirements and take action to address any identified non-compliance.
 - b. Pilot Termination. The state may suspend or terminate the entire CIS Program if it is found to be ineffective in meeting the state's goals or beneficiaries needs.
- g. **Community Participation.** The state, either directly or through its MCO contracts, must ensure that participants' engagement and community participation is supported and facilitated to the fullest extent desired by each participant.
- h. **CIS Exclusions.** The following are prohibited under CIS:
 1. Payment of ongoing rent or other room and board costs;
 2. Capital costs related to the development of housing;
 3. Expenses for ongoing regular utilities or other regular occurring bills;
 4. Goods or services intended for leisure or recreation;
 5. Duplicative services from other state or federal programs

6. Services furnished to individuals in a correctional institution or an IMD (other than services that meet an exception to the IMD exclusion).
- i. **Pathway to Value-Based Payments (VBP).** The state must use its existing managed care contracts to incentivize the delivery of high quality care to CIS beneficiaries through MCOs by progressively linking payments to progress towards improved health and socioeconomic outcomes among beneficiaries during the demonstration period by using a combination of the following strategies:
 1. Withhold arrangements, as defined in and consistent with 42 CFR 438.6, may be used to incentivize plans to establish processes and protocols to support a variety of mechanisms required for data exchange, reporting, and beneficiary enrollment, as well as to enhance the quality of service delivery and improve beneficiary outcomes.
 2. Incentive arrangements, as defined in and consistent with 42 CFR 438.6, may be used to incentivize plans to enhance the quality of service delivery and improve beneficiary outcomes.
 3. The state must also establish VBP strategies directed at a range of providers to incentivize the delivery of high quality care for CIS Program beneficiaries. The state must work with stakeholders to develop a VBP strategy focused on providers that serve CIS Program beneficiaries. These stakeholders may include, but would not be limited to, hospitals, primary care providers, CIS providers, and post-acute providers. These VBP arrangements will be effectuated through managed care, but the state will need to seek directed payments authority under 42 CFR 438.6 to put payment arrangements into place.
 4. Year by Year Breakdown for Managed Care Plan Incentives
 - i. Year 1: In the first year of the CIS Program, a withhold measure may be established to provide the MCOs with time to establish a provider network, develop processes and protocols for program operationalization, operationalize enrollment criteria, collaborate to develop shared data collection forms, and standardize the collection of appropriate process measures and outputs from service providers to support the reporting requirements of the state. The withhold will be released contingent upon submission of the full package of instruments, protocols, and processes, along with a demonstration through test data submission of the ability for MCOs to fully comply with all reporting requirements of the program; the withhold may be treated as a process measure, with full release of payment upon satisfactory completion of requirements within the established timelines.
 - ii. Year 2: In the second year of the CIS Program, a withhold arrangement may support evidence of enrollment of beneficiaries in the CIS Program, and the use of various components of the CIS Program. The state must require that MCOs be evaluated on their ability to assess, consent, and enroll beneficiaries into the CIS Program, and sharing information with the state on enrollment phase. The state must require that data submitted by MCOs must demonstrate use of multiple new services offered through the benefit. Reporting must meet data quality standards, and adequately capture data at the desired level of granularity. Output measures such as percent of potentially eligible beneficiaries referred to the CIS Program, percent of qualifying beneficiaries enrolled in the CIS Program may be used to track MCO progress in identifying potential beneficiaries,

- conducting assessments to determine eligibility for the CIS Program, and enrolling consenting beneficiaries.
- iii. Year 3: In the third year of the CIS Program, a combination of withhold and incentive arrangement measures may be implemented to support increased service utilization. A withhold may be used to support the MCOs' implementation of performance incentives for one or more types of providers in the CIS network to support the delivery of high quality care. Withholds and/or incentive arrangements may be used by the state to incentivize MCOs to (a) support continued enrollment and engagement of beneficiaries, and (b) provide services consistent with the benefit. Types of additional metrics required may include percent of CIS enrolled beneficiaries who have completed a functional needs assessment, and percent of CIS Program enrolled beneficiaries who have an individualized service plan.
 - iv. Year 4: By the fourth year of the CIS Program, the state must require MCOs to demonstrate short and intermediate outcomes from the program, including appropriate healthcare utilization and use of community-based social supports. Withhold and/or incentive arrangements may be used to incentivize MCO efforts to increase the percentage of CIS beneficiaries who are stably housed, as well as demonstrating re-engagement in the receipt of healthcare services. Indicators selected may include percent of CIS Program beneficiaries with one or more primary care visits since enrollment; enhanced receipt of specialty treatment and behavioral health services among beneficiaries, based on specific needs, may also be tracked.
 - v. Year 5: By the fifth year, the state anticipates improvement in health outcomes among beneficiaries enrolled in the program, including decreased ER and inpatient utilization. Withholds may be used to continue enrollment, engagement, and ongoing service utilization; while withholds and withhold and incentive arrangements may be provided for decreases in use of emergency departments and inpatient hospitalizations among beneficiaries enrolled in the program. Other types of quality measures that indicate greater control of conditions may also be included.
 - j. **Evaluation of the CIS Program.** The state must incorporate the CIS Program into the demonstration evaluation design. The evaluation design must meet the requirements of section XII of these STCs. In addition to the evaluation design requirements, the state must include the following in the evaluation design:
 - 1. The state must develop a pilot services evaluation strategy that will incorporate rapid cycle assessments (RCAs) into the process to obtain timely information on the effectiveness of pilot services. These evaluations will allow the state to discontinue services determined to have minimal effectiveness and redeploy resources to more valuable strategies, serving as another mechanism for promoting value within the program. RCAs must be conducted by an independent entity identified by the state. The state, in collaboration with stakeholders, must develop process-based and outcome-based metrics, which must be submitted for review and approval by CMS in the evaluation design, and the state must report annually to CMS on these metrics.
 - 2. The state, in consultation with stakeholders, must develop process-based and outcome-based metrics, many of which would be relevant for evaluating

demonstration implementation and demonstration impact, and must be submitted for review and approval by CMS in the evaluation design. Some of these same and a few other process and outcome measures may also be appropriate for routine annual monitoring. The state must finalize any such metrics in discussion with CMS, and report annually to CMS in the monitoring reports or in the RCAs, as appropriate. The state must develop metrics for pre-tenancy supports, housing stability, tenancy sustaining services, and health needs based criteria that are quantifiable, and for which data sources can be identified. Outcome measures of housing stability, health status, utilization, and cost of care should be identified – as applicable – for the short, medium and long-term assessment of the pilot program.

23. Community Transition Services Pilot Program. The state will be authorized to establish Community Transition Services under the CIS program throughout the state from August 1, 2019 through July 31, 2024. The state must provide services to beneficiaries who meet the eligibility criteria in STC 22 on a voluntary basis.

a. Community Transition Services Pilot Program Benefits:

Service Category	Community Transition Services
Transitional Case Management Services	<p>Services that will assist the individual with moving into stable housing, including assisting the individual in arranging the move, assessing the unit's and individual's readiness for move-in, assisting the individual) (excluding financial assistance) in obtaining furniture and commodities. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.</p> <p>Funding related to one-time utility set-up and moving costs provided that such funding is not available through any other program.</p>
Housing Quality and Safety Improvement Services	<p>Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing occupant's health condition, as documented by a health care professional, and remediation is not covered under any other program. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources.</p> <p>Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) when necessary to ensure occupant's health and modification is not covered under any other provision such as the Americans with Disabilities Act.</p>
Legal Assistance	<p>Assisting the individual by connecting the enrollee to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. This pilot service does not include legal representation or payment for legal representation.</p>

Service Category	Community Transition Services
Securing House Payments	Provide a one-time payment for security deposit and/or first month's rent provided that such funding is not available through any other program. This payment may only be made once for each enrollee during the life of the demonstration, except for state determined extraordinary circumstances such as a natural disaster. This pilot service is furnished only to the extent it is reasonable and necessary as clearly identified through beneficiary's individualized care and the beneficiary is unable to meet such expense or when the services cannot be obtained from other sources.

4. HCBS Standards. The state must assure compliance with CMS standards for HCBS settings as articulated in current section 1915(c) and 1915(i) policy and as modified by subsequent regulatory changes. HCBS requirements include the following:

- a. **HCBS Electronic Visit Verification System.** The state must demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.
- b. **HCBS Quality Systems and Strategy.** The state must is expected to implement systems that measure and improve its performance to meet the waiver assurances set forth in 42 CFR 441.301 and 441.302. The Quality Review provides a comprehensive assessment of the state's capacity to ensure adequate program oversight, detect and remediate compliance issues and evaluate the effectiveness of implemented quality improvement activities.
- c. **For 1915(c)-Approvable HCBS,** for services that could have been authorized to individuals served under a 1915(c) waiver, the state must have an approved Quality Improvement Strategy and is required to develop and measure performance indicators for the following waiver assurances:
 - i. **Administrative Authority:** A performance measure should must be developed and tracked identifying any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.
 - ii. **Level of Care:** Performance measures are required for the following two sub-assurances: applicants with reasonable likelihood of needing services receive a level of care determination and the processes for determining level of care are followed as documented. While a performance measure for annual levels of care is not required to be reported, the state is expected to must be sure that annual levels of care are determined.
 - iii. **Qualified Providers:** The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.

- iv. **Service Plan:** The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.
- v. **Health and Welfare:** The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.
- vi. **Financial Accountability:** The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. The state must have performance measures that track that it provides evidence that claims are coded and paid for in accordance for services rendered, and that it provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.
- vii. **Medicaid Authorities Transition.** During the demonstration period, the state must evaluate which portions of the demonstration could be transitioned to 1915(c) and 1915(i) authorities. There will be a five year transition plan as follows:
 1. January 2019 through December 2021 – CMS and the state conduct joint transition planning activities in order to identify which portions can be transferred.
 2. January 2022 through December 2022 – The state must develop and submit 1915(c) and 1915(i) authorities for the portions to be transitioned for CMS review and approval.
 3. January 2022 through December 2023 – The state and CMS will work to approve any 1915(c) waivers or 1915(i) SPAs no later than December 31, 2023.

25. The state must submit a report to CMS following receipt of an Evidence Request letter and report template from the Regional Office no later than 21 months prior to the end of the approved demonstration period which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. (1915(c) and 1915(i) HCBS). The Regional Office will send a DRAFT report to the state which will have 90 days to respond to the DRAFT report. The Regional Office will issue a FINAL report to the state 60 days following receipt of the state's response.

26. The CMS Regional Office will evaluate each evidentiary report to determine whether the assurances have been met and will issue a final report to the state 12 months prior to expiration to the demonstration.
27. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS waiver assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year.
28. **For 1915(i)-Approvable HCBS**, for services that could have been authorized to individuals served under a 1915(i) waiver, the state must have an approved Quality Improvement Strategy and is required to develop performance measures to address the following requirements:
- a. Service plans that:
 - i. address assessed needs of 1915(i) participants;
 - ii. are updated annually; and
 - iii. document choice of services and providers.
 - b. Eligibility Requirements: The state will must ensure that:
 - i. an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future;
 - ii. the processes and instruments described in the approved program for determining 1915(i) eligibility are applied appropriately; and
 - iii. the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually (end of demonstration year) or if more frequent, as specified in the approved program.
 - c. Providers meet required qualifications.
 - d. Settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1) and (2).
 - e. The SMA retains authority and responsibility for program operations and oversight.
 - f. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
 - g. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.
 - h. The state must also describe the process for systems improvement as a result of aggregated discovery and remediation activities.
29. **Person-centered planning.** The state must assure there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan must be developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(c) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The person-centered service plan is reviewed, and revised upon

reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

30. **Conflict of Interest:** The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.
31. Each beneficiary eligible for long term services and supports must have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options. (MLTSS with self-direction)
32. The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant. (MLTSS)
33. The state must assure compliance with the characteristics of HCBS settings as described in 1915(c) and 1915(i) regulations in accordance with implementation/effective dates as published in the Federal Register.
34. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan. (MLTSS).
 - a. Any revisions to the QUEST Integration delivery system for Behavioral Health Services as defined in this STC requires a revision to Attachment E.
 - b. **Cost of Room and Board Excluded from Capitation Rate Calculations.** For purposes of determining capitation rates, the cost of room and board is not included in noninstitutional care costs.

VIII. DELIVERY SYSTEM

35. **Forms of Managed Care.** The state is authorized to contract with Managed Care Organizations (MCOs) and Prepaid inpatient health plans (PIHPs) all of which are defined under 42 CFR 438.2. The state must comply with 42 CFR 438 in connection with managed care offered under this demonstration unless specified otherwise herein.
36. **QUEST Integration Plans.** QUEST Integration (QI) plans are MCOs as defined under 42 CFR 438.2. Eligible individuals will be enrolled in a QI plan upon initial eligibility consistent with 42 CFR 438.54 and as outlined here. Eligible individuals will choose among participating QI plans offered to provide the full range of primary, acute, home and community based services and standard behavioral health benefits (including substance abuse treatment). Eligible individuals must be provided with information on the available health plans by the state. The state must ask each applicant to select a health plan upon determination of eligibility. If an eligible individual does not make a selection at the time of the approval of eligibility, the individual is automatically assigned to a plan that operates on

the island of residence, consistent with 42 CFR 438.54, and will have 15 days from the date of auto assignment to select a different health plan from the list provided. The state must send a notice of enrollment upon auto assigning the individual. The state may place an enrollment limit on health plans in order to assure adequate capacity and sufficient enrollment in all participating health plans, as long as at least two QI health plans operating on an island do not have an enrollment limit.

37. Specialized Behavioral Health plan. Acting as a PIHP as defined under 42 CFR 438.2, the Community Care Services (CCS) provides standard behavioral health services to all beneficiaries, and specialized behavioral health services to beneficiaries 18 and older with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral disorder (SEBD).

38. Physical and Behavior Health Integration. If the state chooses to integrate the specialized behavioral health services provided to any beneficiaries or subset of beneficiaries with SMI, SPMI, or SEBD into the QI Plans, the state must assess readiness pursuant to § 438.66(d). Assignment of any beneficiaries or subset of beneficiaries with SMI, SPMI, or requiring SEBD into the QI Plans must comply with § 438.54 and may only begin when each QI Plan has been determined by the state and CMS to meet certain readiness and network requirements. The state must notify CMS of the intended integration at least 9 months prior to the assignment of beneficiaries. Any beneficiaries or subset of beneficiaries with SMI, SPMI, or SEBD, may be mandatorily enrolled into a QI Plan providing fully integrated services pursuant to the state's expenditure and waiver authorities that provide for plan choice.

39. Enrollment and Disenrollment Processes.

- a. **Enrollment process.** The state must maintain a managed care enrollment and disenrollment process that complies with 42 CFR Part 438, except that disenrollment without cause from a MCO will be more limited in cases where the enrollee was not passively enrolled to the MCO. If the enrollee was not passively enrolled to the MCO, the state must maintain a process by which the enrollee may change MCOs (consistent with STC 36) only if both MCOs agree to the change. The state must track and report to CMS these requests on an annual basis;
- b. **Disenrollment With and Without Cause.** The provisions of 42 CFR section 438.56(c), relating to disenrollment with and without cause, must apply to individuals enrolled in QUEST Integration health plans, except that the without cause change period after enrollment in a plan will be 60 days, rather than 90 days. The state must accommodate and grant all reasonable plan change requests from aged, blind and disabled beneficiaries that occur days 61-90. The state must track the number of plan change requests from aged, blind and disabled beneficiaries that occur during that timeframe and include this data in quarterly reports described in STC 51.
 - i. Individuals who have been enrolled in a plan within the last 6 months will be reassigned to the prior plan unless the beneficiary exercises his/her option to disenroll for cause.

- 40. Member Services.** Following the selection of a health plan, the plan will call the individual or send the individual a survey to identify special health needs (such as the need for long-term services and supports). If the individual is sent a survey and does not respond, the health plan shall be required to call the individual.
- 41. Service Coordination Model.** After a beneficiary selects a health plan and completes the function described in STC 36, the health plan will assign a licensed or qualified professional as the beneficiaries' service coordinator. The following are required to ensure QUEST Integration program integrity.
- a. **Service Coordinator Responsibilities.**
- i. Assuring that the health plan promptly conducts a face-to-face health and functionality assessment (HFA) for each individual who is identified as having special health needs as described in STC 40. Members who are identified as having special health needs will receive a face-to-face HFA within 15 days of the documentation of special health needs through STC 40;
 - ii. Referring any member appearing to meet a nursing facility level of care to the state's Contractor for a functional eligibility review;
 - iii. Providing options counseling regarding institutional placement and HCBS alternatives;
 - iv. Coordinating services with other providers such as physician specialists, Medicare fee-for-service and/or Medicare Advantage health plans and their providers, mental health providers and DD/ID case managers;
 - v. Facilitating and arranging access to services;
 - vi. Seeking to resolve any concerns about care delivery or providers;
 - vii. Leading a team of decision-makers to develop a care plan for those members meeting functional eligibility. The care planning team may include the primary care provider (who may be a specialist); the beneficiary, family members, and significant others (when appropriate); legal guardians, an Ombudsman if so requested by the beneficiary; and other medical care providers relevant to the beneficiary needs; and
 - viii. For those members meeting functional eligibility, leading the care planning team in the development of a case-specific, person-centered, cost-effective plan of care in the community, using industry best practices and guidelines established in STC 41(b) below.
- b. **Written Comprehensive Care Plans.** For each enrollee who meets the functional Level of Care (LOC) or "At Risk" assessment for long-term care, the state must require that the MCOs develop and implement a person-centered written care plan that analyzes and describes the medical, social, HCBS, and/or long-term care institutional services that the member will receive. In developing the care plan, the state must that require the MCOs consider appropriate options for the beneficiary related to his/her medical, behavioral health, psychosocial, case-specific needs at a specific point in time, as well as for longer term strategic planning and must emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. Service plans must be updated annually or more frequently in conjunction with the health and functional assessment.
- c. **Ombudsman Program.** The state must require that the Ombudsman Program must be available to all beneficiaries under the demonstration. The purpose of the program is to

ensure access to care, to promote quality of care, and to strive to achieve recipient satisfaction with QUEST Integration. The Department of Human Services (DHS) must seek a qualified independent organization to assist and represent members in the resolution of problems and conflicts between the health plan and its members regarding QUEST Integration services to act as the Ombudsman prior to the initial date for delivery of services.

- i. **Delivery of Ombudsman Services.** The Ombudsman must assist in the resolution of issues/concerns about access to, quality of, or limitations to, services. The contracting organization must not be affiliated with any of the QUEST Integration health plans contracted by DHS and operate independently of the Med-QUEST Division.
- ii. **Services Offered by Ombudsman Program.** Ombudsman services must be available to QUEST Integration members to navigate and access covered health care services and supports to include choice counseling, general program-related information, access point for complaints, concerns related to health plan enrollment, and access to services.
- iii. **Scope of the Ombudsman Program.** The Ombudsman Program must not replace the grievance and appeals process that all health plans that contract with the state must have in place, nor replace the right of a recipient to an administrative hearing. The Ombudsman may assist and represent members up to the point of an Administrative Hearing under state law. They may also assist a member during the hearing process but must not represent the member in an Administrative Hearing. The QUEST Integration member shall file a grievance or appeal with the contracted health plan. An Administrative Hearing may be filed once the health plan's appeal process has been exhausted.

42. Contracts. All contracts and contract modifications of existing contracts between the state and Managed care entities must be prior approved by CMS in accordance with 42 C.F.R. 438.3. The state must provide CMS with a minimum of 90 days to review changes for consideration of approval.

43. Statewideness. For rural and non-rural Islands on which only one health plan is available, the state must require the health plan assure that members have a choice of primary care providers (PCPs).

44. Dual-eligible Beneficiaries. Dual eligible beneficiaries may select a PCP and will be assigned a service coordinator to assure coordination of Medicare and Medicaid services.

45. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The MCOs must fulfill the state's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b)(services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

46. Monitoring Activities by State and/or External Quality Review Organization (EQRO). The state's EQRO process must meet all the requirements of 42 CFR §438 Subpart E. In addition, the state, or its EQRO having sufficient experience and expertise and oversight by

the State Medicaid Agency (SMA), must monitor and annually evaluate the MCOs' and/or contracting providers performance on the HCBS requirements under QUEST Integration. These include but are not limited to the following:

- a. Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with the Community Benefit have been assessed to meet the required level of care for those services.
- b. Service plans – to ensure that MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.
- c. MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.
- d. Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

IX. COST SHARING

47. Cost sharing. Cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447(b) applies to the demonstration.

48. Enrollment fee. Notwithstanding subparagraph (a), the following enrollment fee is permitted under QUEST Integration:

Population	Amount
Medically Needy with Spend-down	An enrollment fee equal to the spend-down obligation or, where applicable, the amount of patient income applied to the cost of long-term care.

X. GENERAL REPORTING REQUIREMENTS

49. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

- a. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.
 1. The follow process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the

requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- i. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
 - ii. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.
 - iii. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
 - iv. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.
- b. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

50. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state must work with CMS to:

- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
- b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
- c. Submit deliverables to the appropriate system as directed by CMS.

XI. MONITORING

51. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The fourth quarter information that would ordinarily be provided in a separate report must be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60) calendar days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) calendar days following the end of the DY. The reports must include all required elements as per 42 CFR 431.428, and must not direct readers to links outside the report.

Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion must also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report must also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.
- b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This must also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and must follow the framework provided by CMS to support federal tracking and analysis.
- c. Budget Neutrality and Financial Reporting Requirements- Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements (Section XIII) of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration must be reported separately.
- d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state must include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The discussion must also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant recruitment, if applicable.

52. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

53. Close-Out Report. Within 120 calendar days after to the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

- a. The draft report must comply with the most current guidance from CMS.

- b. The state must present to and participate in a discussion with CMS on the close-out report.
- c. The state must take into consideration CMS' comments for incorporation into the final close-out report.
- d. The final close-out report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
- e. A delay in submitting the draft or final version of the c-out report may subject the state to penalties described in STC 49.

54. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

55. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XII. EVALUATION OF THE DEMONSTRATION

56. Independent Evaluator. Upon approval of the demonstration, the state must begin arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The state must require the independent party to sign an agreement that the independent party must conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

57. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

- 58. Draft Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) calendar days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design must not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.
- 59. Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) calendar days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state must publish the approved Evaluation Design to the state's website within thirty (30) calendar days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.
- 60. Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component must have at least one hypothesis and pertinent research question(s) to test each hypothesis. In addition, the state must include a hypothesis and evaluation questions focusing specifically on CIS programs. The state must also include additional hypotheses and evaluation questions that measure progress in any areas identified as needing improvement during the previous demonstration period. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
- 61. Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report must be posted to the state's website with the application for public comment.
- a. The interim evaluation report must discuss evaluation progress and present findings to date as per the approved evaluation design.
 - b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
 - c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and

hypotheses, and how the design was adapted must be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

- d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e. The Interim Evaluation Report must comply with Attachment B of these STCs.

62. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period August 1, 2019 – June 30, 2024, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

63. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

64. Public Access. The state must post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

65. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS must be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS must be provided a copy including any associated press materials. CMS must be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

66. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and

record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 50.

XIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

- 67. Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.¹
- 68. Unallowable Expenditures.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:
- a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
 - b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
 - c. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
 - d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the “inpatient psychiatric services for individuals under age 21” benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.
- 69. Standard Medicaid Funding Process.** The standard Medicaid funding process must be used for this demonstration. The state must provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures for services provided under this demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state’s estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

¹ For a description of CMS’s current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

- 70. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in Section XIV:
- a. Administrative costs, including those associated with the administration of the demonstration;
 - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
 - c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.
- 71. Sources of Non-Federal Share.** The state certifies that its match for the non-federal share of funds for this demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.
- a. The state acknowledges that CMS has authority to review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
 - b. The state acknowledges that any amendments that impact the financial status of the demonstration must require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- 72. State Certification of Funding Conditions.** The state must certify that the following conditions for non-federal share of demonstration expenditures are met:
- a. Units of government, including governmentally operated health care providers, may certify that state or local monies have been expended as the non-federal share of funds under the demonstration.
 - b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
 - c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot then be used as the state share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

- d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local monies and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.
- e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

73. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

74. Medicaid Expenditure Groups (MEG). MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Master MEG Chart

EG subject to BN	Hypothetical (Yes/No)
EG 1 – Children	No
EG 2 – Adults	No
EG 3 – Aged	No
EG 4 – Blind/Disabled	No
EG 5 – Group VIII	Yes
EG 6 - CIS	Yes
EG 7 – CIS Community Transition Pilot	Yes

Table 3: MEG Detail for Expenditure and Member Month Reporting									
MEG (Waiver Name)	Detailed Description	Exclusions	CMS- 64.9 Line(s) To Use	CMS Waiver Forms	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Adults	MEG Includes: 1. <i>Parents and Caretaker Relatives</i> 2. <i>Pregnant Women</i> 3. <i>Former Foster Children under age 26</i> 4. <i>Transitional Medical Assistance (if meet age criteria)</i> 5. <i>1931 Extension (if meet age criteria)</i> 6. <i>Certain Women Needing Treatment for Breast or Cervical Cancer</i> 7. <i>Parents or caretaker relatives with an 18-year old dependent child</i> 8. <i>Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance</i>	NA	Lines 18A - 18B2d used for capitation for MCOs and PIHP, all other lines in the CMS 64 used as necessary (Line 8 for Dental, etc)	State Plan Adults Breast Cervical Cancer Treatment (BCCT) St Pl Adults- Preg Immig/COFAs	Date of service	MAP	Y	NA	Ongoing
Children	MEG Includes: 1. <i>Infants</i> 2. <i>Children</i> 3. <i>Children with adoption assistance, foster care, or guardianship care under title IV-E</i>	NA	Lines 18A - 18B2d used for capitation for MCOs	FosterCare(19- 20) State Plan Children	Date of service	MAP	Y	NA	Ongoing

	4. <i>Transitional Medical Assistance (if meet age criteria)</i> 5. <i>1931 Extension (if meet age criteria)</i> 6. <i>Foster Children</i> 7. <i>Foster Children (19-20 years old)</i> 8. <i>Individuals Age 19 – 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance</i>		and PIHP, all other lines in the CMS 64 used as necessary (Line 8 for Dental, etc)						
Aged	MEG Includes: 1. <i>State Plan Mandatory ABD (when Aged)</i> 2. <i>Optional Coverage of Families and Children and the Aged, Blind, or Disabled (when Aged)</i> 3. <i>Medically Needy Aged, Blind, or Disabled Children and Adults (when Aged)</i> 4. <i>Individuals in the 42 C.F.R. §435.217 like group receiving HCBS (when Aged)</i> 5. <i>Medically Needy ABD (QI Demo Group – when Aged)</i>	NA	Lines 18A - 18B2d used for capitation for MCOs and PIHP, all other lines in the CMS 64 used as necessary (Line 8 for Dental, etc)	Aged w/ Medicare Aged w/o Medicare Aged with Medicare – MFP Aged without Medicare - MFP	Date of service	MAP	Y	NA	Ongoing
Blind/Disabled	MEG Includes: 1. <i>State Plan Mandatory</i>	NA	Lines 18A -	B/D w/Mcare B/D w/o	Date of service	MAP	Y	NA	Ongoing

	<i>ABD (when Blind or Disabled)</i> 2. <i>Optional Coverage of Families and Children and the Aged, Blind, or Disabled (when Blind or Disabled)</i> 3. <i>Medically Needy Aged, Blind, or Disabled Children and Adults (when Blind or Disabled)</i> 4. <i>Individuals in the 42 C.F.R. §435.217 like group receiving HCBS (when Blind or Disabled)</i> 5. <i>Medically Needy ABD (QI Demo Group – when Blind or Disabled)</i>		18B2d used for capitation for MCOs and PIHP, all other lines in the CMS 64 used as necessary (Line 8 for Dental, etc)	Mcare Blind/Disable without Medicare – MFP Blind/Disabled with Medicare - MFP					
Group VIII Combined	MEG Includes: 1. <i>Low Income Adult Age 19 Through 64 Group</i>	NA	Lines 18A - 18B2d used for capitation for MCOs and PIHP, all other lines in the CMS 64 used as necessary (Line 8 for	Expansion State Adults Newly Eligible Adults	Date of service	MAP	Y	NA	Ongoing

			Dental, etc)						
CIS	MEG Includes: <i>CIS</i> (This is just the spend associated with CIS services. It is not an eligibility category)	Only includes the spend associated with CIS services	NA	EG 6 – CIS	Date of service	MAP	Y	NA	Ongoing
CIS Community Transition Pilot	MEG Includes: <i>CIS Community Transition Pilot</i> (This is just the spend associated with CIS services. It is not an eligibility category)	Only includes the spend associated with CIS services	NA	EG 7 – CIS Community Transition Pilot	Date of service	MAP	Y	NA	Ongoing

Notes:

- Qualified Medicare beneficiaries (QMB) and Specified low-income Medicare beneficiaries (SLMB) are not included in the MEGs as eligibility groups. If a member is QMB or SLMB then they are accounted for in the Medicaid eligibility category in which they receive state Medicaid coverage.
- For purposes of budget neutrality, Medically Needy Non-Aged, Blind, or Disabled Children and Adults are not included in the MEGs as their expenditures are paid FFS.
- Optional targeted low- income children have not been counted in budget neutrality historically. We have been reporting the expenditures in the CMS-64 on Form CMS-64.21U. For the recent 1115 renewal, we did include the expenditures in the budget neutrality worksheet. MQD is fine to include or not include optional targeted low- income children in the MEGs.

- 75. Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00001/9). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.
- a. Cost Settlements. The state must report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b, in lieu of lines 9 or 10c. For any cost settlement not attributable to this demonstration, the adjustments must be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
 - b. Premiums and Cost Sharing Collected by the State. The state must report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) must also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year must be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.
 - c. Pharmacy Rebates. Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
 - d. Administrative Costs. The state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the Master MEG Chart table, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
 - e. Member Months. As part of the Quarterly and Annual Monitoring Reports described in

section XI, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the MasterMEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

- f. Budget Neutrality Specifications Manual. The state must create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

76. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Demonstration Years	
Demonstration Year 26	August 1, 2019- July 31, 2020
Demonstration Year 27	August 1, 2020- July 31, 2021
Demonstration Year 28	August 1, 2021- July 31, 2022
Demonstration Year 29	August 1, 2022- July 31, 2023
Demonstration Year 30	August 1, 2023- July 31, 2024

77. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing demonstration’s actual expenditures to the budget neutrality expenditure limits described in Section XIV. CMS will provide technical assistance, upon request.²

² 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration

approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

78. Claiming Period. The state must report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

79. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

- a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets must reflect the phase out of impermissible provider payments by law or regulation, where applicable.
- b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement must be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.
- c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, must result in a modified budget neutrality expenditure limit.

XIV. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

80. Limit on Title XIX Funding. The state must be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

- 81. Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 82. Calculation of Budget Neutrality Limit and How it is Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 83. Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that demonstration waivers granted have not resulted in increased costs to Medicaid, and that federal Medicaid “savings” have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as “WOW Only” or “Both” are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as “Both.”

Main Budget Neutrality Test Table

MEG	TREND	DY 26 PMPM	DY 27 PMPM	DY 28 PMPM	DY 29 PMPM	DY 30 PMPM
Children	1.0%	\$448.48	\$452.96	\$457.49	\$462.07	\$466.69
Adults	3.7%	\$925.47	\$959.72	\$995.23	\$1,032.05	\$1,070.24
Aged	3.4%	\$1,939.17	\$2,005.11	\$2,073.28	\$2,143.77	\$2,216.66
Blind/Disabled	4.4%	\$2,646.76	\$2,763.22	\$2,884.80	\$3,011.73	\$3,144.25

84. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be “hypothetical;” that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS’s current view that states should not have to “pay for,” with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid state plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending by savings elsewhere in the demonstration or to refund the FFP to CMS.

85. Hypothetical Budget Neutrality Tests

- a. **Hypothetical Budget Neutrality Test 1: Group VIII.** Low income adults with FPL up to 133%.
- b. **Hypothetical Budget Neutrality Test 2: CIS.** Expenditures related to the CIS benefits of pre-tenancy supports and tenancy supports; excludes expenditures related to the Community Transition Services Pilot Program.
- c. **Hypothetical Budget Neutrality Test 3: CIS Community Transition Pilot.** Expenditures related to the Community Transition Services Pilot Program.

Hypothetical Budget Neutrality Test Table

MEG	TREND	DY 26 PMPM	DY 27 PMPM	DY 28 PMPM	DY 29 PMPM	DY 30 PMPM
Group VIII	4.8%	\$899.37	\$942.54	\$987.78	\$1,035.20	\$1,084.89
CIS	4.8%	\$1,184.76	\$1,241.63	\$1,301.23	\$1,363.69	\$1,429.15
CIS Community Transition Pilot	4.8%	\$3,231.17	\$3,386.27	\$3,548.81	\$3,719.15	\$3,897.67

- d. The Hypothetical Group VIII and CIS expenditures caps consist of the total computable dollar limits presented in the above table, summed across all DYs. The federal share of

the caps is obtained by multiplying the total computable by the federal share rate for that DY.

- e. If total FFP for a hypothetical group should exceed the federal share of cap, the difference must be reported as a cost against the budget neutrality limit described in STC 88.

86. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration’s approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Main or Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

87. Transitional Phase-Down of Newly Accrued Savings. Beginning with DY 26, the net variance between the without-waiver cost and actual with-waiver cost will be reduced for selected Medical population based MEGs. The reduced variance, calculated as an applicable percentage times the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The applicable percentages have been determined in accordance with the policy for Transitional Phase-Down of Newly Accrued Savings described in State Medicaid Director Letter # 18-009. This provision only applies to the Main Budget Neutrality Test, and to the MEGs that are designated “Both” without-waiver and with-waiver. The MEGs affected by this provision and the applicable percentages are shown in the table below. If the total variance for an MEG in a DY is negative, the applicable percentage is 100percent.

Savings Phase Down Table

MEG					
Children	25%	25%	25%	25%	25%
Adults	25%	25%	25%	25%	25%
Aged	25%	25%	25%	25%	25%
Blind/Disabled	25%	25%	25%	25%	25%

88. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from August 1, 2019 to July 31, 2023. The Main Budget Neutrality Test may incorporate net savings from the immediately prior demonstration period of January 1, 2013 through December 31, 2018 (but not from any earlier approval period). If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget

neutrality test will be based on the time period through the termination date.

- 89. Mid-Course Correction.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Demonstration Year	Cumulative Target Definition	Percentage
DY 1 through DY 26	Cumulative budget neutrality limit	2.0 percent
DY 1 through DY 27	Cumulative budget neutrality limit	1.5 percent
DY 1 through DY 28	Cumulative budget neutrality limit	1.0 percent
DY 1 through DY 29	Cumulative budget neutrality limit	0.5 percent
DY 1 through DY 30	Cumulative budget neutrality limit	0 percent

XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION PERIOD

Due Date	Deliverable
30 calendar days from approval letter date	State Acceptance of Demonstration Extension, STCs, Waivers, and Expenditure Authorities.
120 calendar days from approval letter date	Ensure that all prior MSIS reports are timely and accurate (STC 50)
180 calendar days from approval letter date	Submit Draft Evaluation Design (STC 58)
60 calendar days after receipt of CMS comments	Submit Final Evaluation Design (STC 59)
30 calendar days after CMS Approval	Approved Evaluation Design published to state's website (STC 59)
Quarterly Deliverables Due 60 calendar days after end of each quarter, except 4 th quarter	Quarterly Progress Reports (STC 51)
	Quarterly Expenditure Reports (STC 69)
Annual Deliverables – Due 90 calendar days after end of each 4 th quarter	Annual Report (STC 51)
150 calendar days after the approval of the demonstration extension	Submit Behavioral Health Services Protocol (STC 21)

ATTACHMENT A

Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform both Congress and CMS about Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration must be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

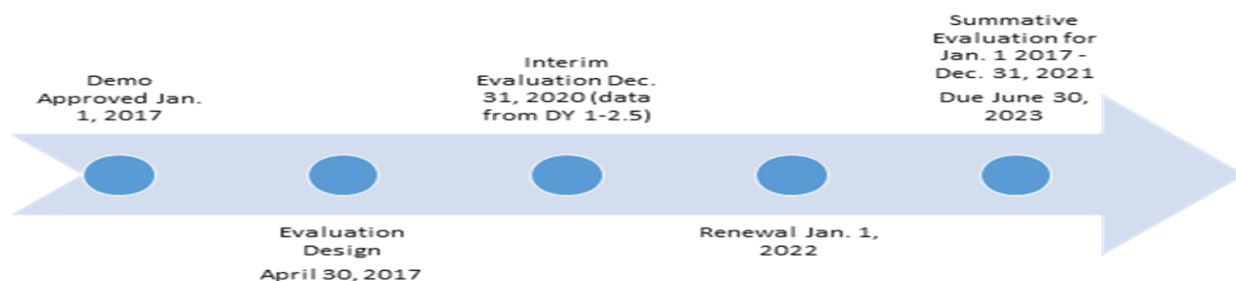
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals.

The format for the Evaluation Design is as follows:

General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in B2 below) must be included with an explanation of the depicted information.

A. General Background Information – In this section, the state must include basic information about the demonstration, such as:

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state must:

- 1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>
- 3) Identify the state's hypotheses about the outcomes of the demonstration:
- 4) Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
- 5) Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section must provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.

- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
- a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
 - e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
 - f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.
- 5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

- 6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section must:
- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.

- b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
 - c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
 - d. The application of sensitivity analyses, as appropriate, should be considered.
- 7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state must also identify any efforts to minimize the limitations. Additionally, this section must include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review. For example:

- 1) When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
- 2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and
 - c. No state issues with CMS-64 reporting or budget neutrality; and
 - d. No Corrective Action Plans (CAP) for the demonstration.

E. Attachments

- 1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design must include "No Conflict of Interest" signed by the independent evaluator.
- 2) **Evaluation Budget.** A budget for implementing the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- 3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design must incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline must also include the date by which the Final Summative Evaluation report is due.

ATTACHMENT B

Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States must have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report must be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

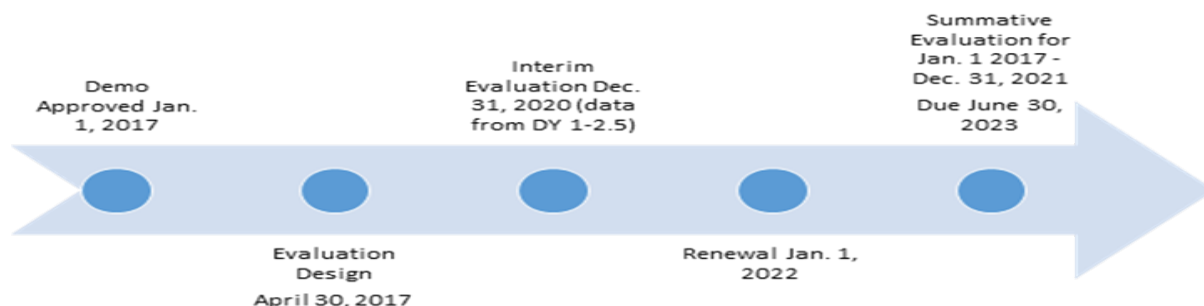
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Guidance is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports is as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;
- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report must present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

- A. Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state must include basic information about the demonstration, such as:
 - 1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
 - 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
 - 3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
 - 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
 - 5) Describe the population groups impacted by the demonstration.
- C. Evaluation Questions and Hypotheses** – In this section, the state must:
 - 1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
 - 2) Identify the state's hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design must also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report must provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design must assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section must provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period* – Describe the time periods for which data will be collected
4. *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

A. Methodological Limitations - This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

B. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings

must visually depict the demonstration results (tables, charts, graphs). This section must include information on the statistical tests conducted.

C. Conclusions – In this section, the state will present the conclusions about the evaluation results.

- 1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
- 2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This must include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section must also include a discussion of the implications of the findings at both the state and national levels.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

E. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

Hawai'i QUEST Integration Section 1115 Waiver Demonstration Proposed Evaluation Design

**STATE OF HAWAI'I, DEPARTMENT OF HUMAN SERVICES,
MED-QUEST DIVISION**

September 23, 2020



Table of Contents

I. General Background Information	3
Demonstration Benefits and Features	4
Long-Term Services and Supports	5
Behavioral Health Services	5
Community Integration Services, including the Community Transition Services Pilot Program	5
II. Demonstration Objectives and Evaluation Hypotheses	6
Demonstration Objectives	6
Demonstration Evaluation Hypotheses	6
Demonstration Driver Diagram	8
Evaluation Priority Area 1: Primary Care	9
Evaluation Priority Area 2: Social Determinants of Health	10
Evaluation Priority Area 3: Home and Community Based Services	10
Evaluation Priority Area 4: Community Integration Services and Community Transition Services	11
Supplemental Evaluation Objective (Evaluation Priority Area 5): Improve Data Quality for Immunization-Related Performance Measures	12
III. Evaluation Methodology	13
Evaluation Design	13
Target and Comparison Populations	13
Evaluation Period	13
Evaluation Measures	14
Data Source	14
Analytic Methods	17
Analytic Considerations	18
Methodological Limitations	18
Analytic Methods	19
Other	19
IV. Project-Level Detail	21
Demonstration Objective 1. Improve health outcomes for Medicaid beneficiaries covered under the Demonstration	21
Demonstration Objective 2. Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth	25

Demonstration Objective 3. Support strategies and interventions targeting the social determinants of health	27
Supplemental Evaluation Objective (Objective 4): Improve data quality for immunization-related performance measures	32
V. Attachments	33
<i>Independent Evaluator</i>	33
<i>Evaluation Budget</i>	33
<i>Timeline and Major Milestones</i>	33
VI. References	35
Appendix 1: Overview of Objectives, Hypotheses, Projects and Research Questions	36

I. General Background Information

The State of Hawai'i, Department of Human Services (DHS), Med-QUEST Division (MQD) is Hawaii's Medicaid agency. MQD first implemented QUEST on August 1, 1994. QUEST was a statewide Section 1115 Demonstration project that initially provided medical, dental, and behavioral health services through a competitive managed care delivery system.

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

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

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

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

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

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

The HOPE Initiative serves as both the foundation and a primary organizing principle for the Demonstration and our evaluation of it. For example, our focus on primary care and social determinants of health is inspired by HOPE and will be effectuated through the managed care authorities in the Demonstration. The principles and strategies outlined in HOPE have been chosen by building on the successes of previous reform efforts and leveraging community initiatives and resources, while also keeping a strong focus on maximizing return on investment, and ensuring broad community support beyond Medicaid. More information on the HOPE Initiative can be found in Attachment A.

The evaluation will encompass all populations described in the Special Terms & Conditions.

Demonstration Benefits and Features

The prior Demonstration provided expenditure authority for additional benefits such as Home and Community Based Services (HCBS) for individuals at risk of deteriorating to an institutional level of care that are continued into this new Demonstration term. In addition, the Demonstration expanded one of the benefits initially approved in the previous demonstration, Community Integration Service (CIS), to add a Community Transition Services (CTS) pilot program.

A brief summary of the additional benefits carried over from the prior Demonstration is found below, followed by a more detailed description of key benefits provided by the managed care program, including LTSS, Behavioral Health Services, and CIS/CTS services.

HCBS: HCBS are offered to both individuals who meet an institutional level of care as well as individuals at risk of deteriorating to an institutional level of care. These HCBS benefits include the following:

Service	Available for individuals who are assessed to be “at risk” of deteriorating to institutional level of care	Available for individuals who meet institutional level of care
Adult day care	X	X
Adult day health	X	X
Assisted living facility		X
Community care foster family homes		X
Counseling and training		X
Environmental accessibility adaptations		X
Home delivered meals	X	X
Home maintenance		X
Moving assistance		X
Non-medical transportation		X
Personal assistance	X	X
Personal emergency response system	X	X
Residential care		X
Respite care		X
Private duty nursing	X	X
Specialized case management		X
Specialized medical equipment and supplies		X

Hawai‘i also continues to include in the QI benefit package the following benefits, subject to clinical criteria and medical necessity:

- **Specialized Behavioral Health Services:** The services listed below are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
 - Supportive Employment.
 - Financial management services.
- **Cognitive Rehabilitation Services:** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living.

- **Habilitation Services:** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition.
- **Community Integration Services (CIS):** Pre-tenancy supports and tenancy sustaining services.
- **Community Transition Services (CTS) Pilot:** Transitional case management services, housing quality and safety improvement services, legal assistance services, and securing house payments for individuals meeting criteria for CIS.

Long-Term Services and Supports

MQD provides long term services and supports (LTSS) in the Demonstration by allowing beneficiaries who meet an institutional level of care to choose between institutional services or HCBS. Access to both institutional and HCBS LTSS is based on a functional level of care (LOC) assessment to be performed by the health plans or those with delegated authority. Each beneficiary who has a disability, or who requests or receives LTSS, receives 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 receives one.

Behavioral Health Services

The Demonstration offers a full array of standard state plan behavioral health services through managed care. It also offers additional, specialized state plan and Demonstration behavioral health services as described in an earlier section.

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). All beneficiaries have access to standard behavioral health services through QI health plans.

Beneficiaries with SMI, SPMI, or SEBD may need 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 MQD's behavioral health program Community Care Services (CCS). 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: intensive case management, partial hospitalization or intensive outpatient hospitalization, psychosocial rehabilitation/clubhouse, therapeutic living supports or specialized residential treatment centers, supportive housing, representative payee, supportive employment, peer specialist and behavioral health outpatient services.

Community Integration Services, including the Community Transition Services Pilot Program

Community Integration Services (CIS) (including the provisions of the Community Transition Services (CTS) pilot program) refers to a set of benefits available to individuals who meet a health needs-based criteria, and additionally are homeless or at risk for homelessness.

CIS benefits include services:

- Pre-Tenancy Supports
- Tenancy Sustaining Services
- Transitional Case Management Services
- Housing Quality and Safety Improvement Service
- Legal Assistance
- Securing House Payments

II. Demonstration Objectives and Evaluation Hypotheses

Demonstration Objectives

MQD consolidated and updated previous demonstration objectives in order to align past efforts with future goals as framed within the HOPE Initiative. Through this process, the following objectives for the current extension of the Demonstration were proposed:

1. Improve health outcomes for Medicaid beneficiaries covered under the Demonstration;
2. Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth; and
3. Support strategies and interventions targeting the social determinants of health.

Demonstration Evaluation Hypotheses

MQD worked extensively with internal and external stakeholders to develop a comprehensive plan for measurement and evaluation of the Demonstration as part of the MQD HOPE Initiative. To assess the effectiveness of the Demonstration in meeting its objectives, the evaluation will document the overall impact of the Demonstration on Hawaii's Medicaid delivery system while simultaneously providing a more in-depth examination of four priority areas: (1) Primary Care, (2) Social Determinants of Health, (3) Home and Community Based Services, and (4) Community Integration Services (including Community Transition Services). The first two priorities evaluate key HOPE strategic areas. The last two priorities evaluate key authorities and services authorized by the current Demonstration. In addition, as requested in the Demonstration Special Terms and Conditions, a fifth in-depth analysis will focus on measuring progress in an area identified as needing improvement during the previous demonstration period, childhood immunization status.

All evaluations of the current Demonstration will be aligned with the evaluation hypotheses noted in the Demonstration application.

Demonstration Objectives	Demonstration Hypotheses
1. Improve health outcomes for Medicaid beneficiaries covered under the Demonstration	H1.1: Increasing utilization for primary care, preventive services, and health promotion will reduce prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.
	H1.2: Improving care coordination (e.g. by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).

2. Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth	H2: Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the MCO level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.
3. Support strategies and interventions targeting the social determinants of health	H3: Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.
4. <i>(Supplemental Evaluation Objective)</i> Improve data quality for immunization-related performance measures	

The evaluation of the overall impact of the Demonstration on Hawaii’s Medicaid delivery system will be based on an assessment of post-Demonstration changes in statewide performance levels, relative to pre-Demonstration baseline performance levels, across the following measurement domains:

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

The in-depth evaluation of high priority project areas will center on assessments of the following aspects:

- Mechanisms to improve primary care with the intent of lowering the total cost of care
- Impacts on health and costs of providing integrated community services and housing assistance to homeless Medicaid recipients
- Differential impacts of home and community-based services (HCBS) on the health and cost of care among individuals receiving HCBS who (a) meet nursing facility level of care, or are (b) “at-risk” beneficiaries
- Potential impacts of addressing social determinants of health on self-reported health outcomes such as satisfaction with one’s health and with the quality of care
- Improvement in childhood immunization data quality

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

All research questions and hypotheses promote the objectives of Title XIX by assessing whether providing high quality, accessible services to individuals with low incomes improves their health outcomes during the Demonstration. In addition, these hypotheses are collectively serve the Triple Aim of better health, better care and sustainable costs – the primary focus of the Demonstration renewal, as well as a core tenet of the HOPE Initiative.

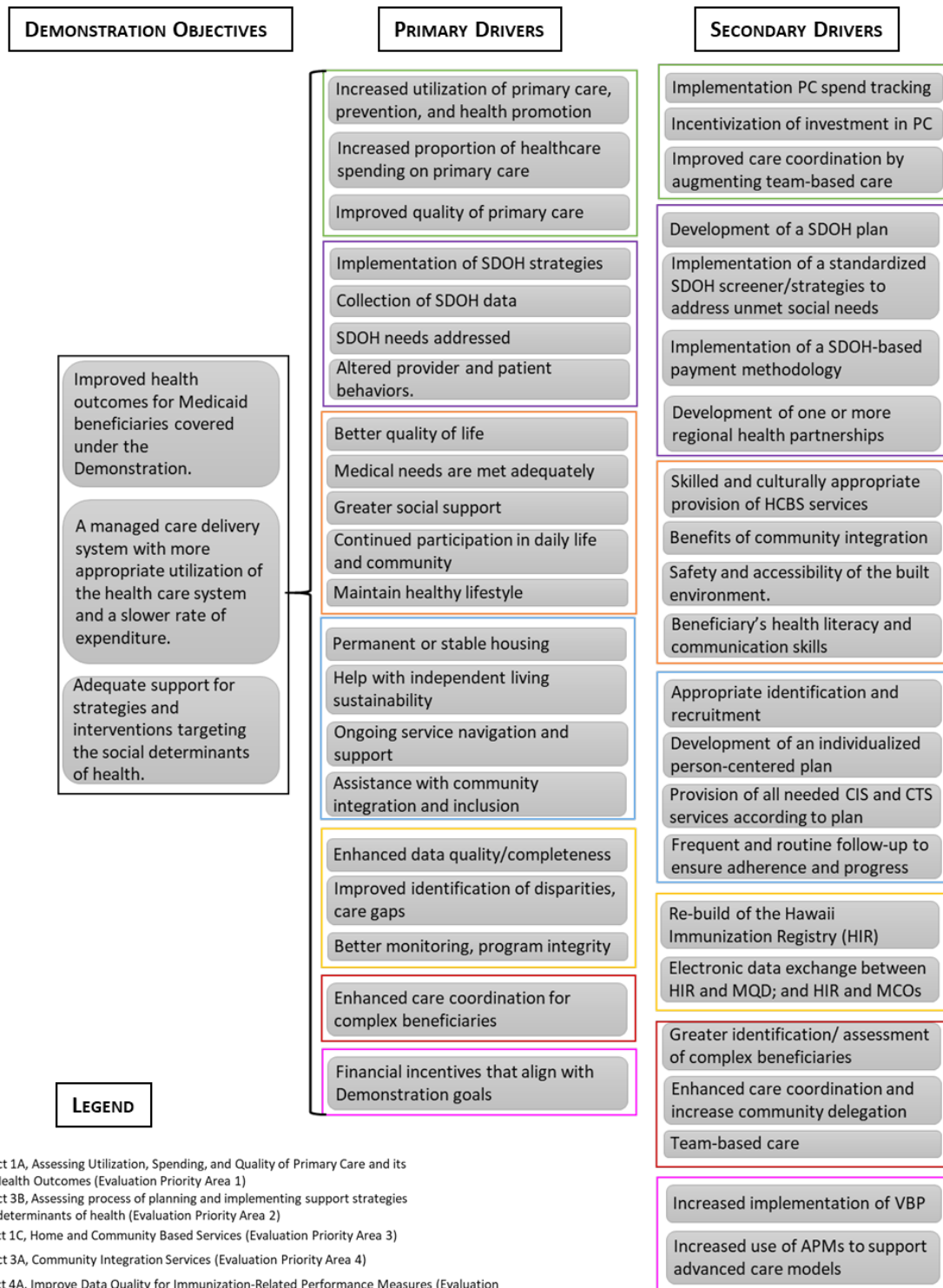
Demonstration Objectives	Demonstration Hypotheses	Key Evaluation Projects
1. Improve health outcomes for Medicaid beneficiaries covered under the Demonstration	H1.1: Increasing utilization for primary care, preventive services, and health promotion will reduce prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.	Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes
	H1.2: Improving care coordination (e.g. by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).	Project 1B: Care Coordination for Beneficiaries with Complex Conditions
		Project 1C: Home- and Community-Based Services (HCBS)
2. Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth	H2: Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the MCO level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.	Project 2A: Value-based purchasing (VBP) reimbursed at the MCO and Provider levels
		Project 2B: Alternative Payment Models (APM) at the Provider level
3. Support strategies and interventions targeting the social determinants of health	H3: Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.	Project 3A: Community Integration Services (CIS)
		Project 3B: Assessing process of planning and implementing support strategies addressing social determinants of health
4. <i>(Supplemental Evaluation Objective)</i> Improve data quality for immunization-related performance measures		Project 4A: Improve Data Quality for Immunization-Related Performance Measures

A table providing a comprehensive crosswalk of Demonstration Objectives, Demonstration Hypotheses, Projects, and Research Questions is included in **Appendix 1**.

Demonstration Driver Diagram

The Demonstration driver diagram, emphasizing the five priority areas of evaluation, is provided below. Each priority area is described in detail subsequently.

DEMONSTRATION DRIVER DIAGRAM



Evaluation Priority Area 1: Primary Care

Evaluation Priority Area 1 is closely tied to the HOPE Initiative, as well as one of MQD's Demonstration objectives – the promotion of appropriate utilization of the health care delivery system. Specifically, the evaluation will focus on the impact of the "Advancing Primary Care Initiative" to support this strategy and achieve the overall goals of the Demonstration. To reach the broad goal of improved health outcomes of Demonstration populations, the Advancing Primary Care Initiative has specific aims of increasing utilization for primary care, preventive services, and health promotion, increasing the proportion of health care spending on primary care, and improving the quality of primary care and outpatient services.

To achieve these aims, MQD proposes to conduct at least three key activities: (1) track primary care spending across three definitions, (2) incentivize investment in primary care, e.g. through performance incentive payments as well as value-based purchasing, and (3) improving care coordination through supporting and augmenting team-based care in patient-centered medical homes, community health centers, clinically integrated health systems, and other entities.

It is hypothesized that these activities will increase utilization of, spending for, and quality of primary care services, preventive services, and health promotion services, which in turn will improve measures of relevant health outcomes. This will be tested by tracking specific measures related to utilization, spending, and quality of primary care for Demonstration populations, using progressively broad definitions of primary care chosen based on consultation with MQD and stakeholder feedback. Selected health outcome indicators will also be collected and assessed for meaningful associations with primary care utilization, spend, and quality.

Evaluation Priority Area 2: Social Determinants of Health

Evaluation Priority Area 2 is closely tied to the HOPE Initiative, as well as our Demonstration objectives. Specifically, the evaluation will focus on the impact of a key initiative to support this strategy, the development and implementation of the state's Social Determinants of Health (SDOH) Transformation Plan. The SDOH Transformation Plan seeks to first develop a strategic plan by DHS, in collaboration with its managed care health plans, on strategies to assess and address SDOH. Then, managed care plans are expected to utilize the statewide transformation plan to, in turn, lead the implementation of strategies that shape, collect, and use SDOH data for analytics, delivery of care, payment methodologies, and providing social supports and needs. These efforts are expected to achieve the broader goals of statewide collaboration, and support the development of Regional Health Partnership (RHP) pilots in interested communities that support innovative strategies to improve care delivery and enhance SDOH efforts within their communities.

The evaluation of the SDOH priority area will focus on assessing effectiveness of (1) MQD's development of a SDOH transformation plan and the operationalization of this plan at the health plan level; (2) MQD's development of a standardized screener to collect SDOH data on beneficiaries and implement strategies to address unmet social needs; (3) MQD's implementation of a payment methodology that incorporates SDOH, its implications on rebalancing/shifting of funding, and its implications for communities/MCOs; and (4) Development of regional health partnerships, and where applicable and feasible, evaluation of impact.

Evaluation Priority Area 3: Home and Community Based Services

With the current Demonstration approval, Hawaii's 1115 HCBS will provide assurances of compliances with CMS standards for HCBS settings as articulated in current section 1915(c) and 1915(i) policy and as modified by subsequent regulatory changes. As noted earlier, MQD provides HCBS services via the Demonstration to two

populations: (1) individuals who meet an institutional level of care requirement and (2) individuals who are assessed to be “at risk” of deteriorating to the institutional level of care. MQD’s goal for beneficiaries meeting criteria for LTSS is to promote independence of LTSS beneficiaries, to the extent feasible and in alignment with the beneficiary’s choice, through the utilization of HCBS. Further, the at risk population have access to a subset of HCBS e.g., specialized case management, home maintenance, personal assistance, adult day health, respite care, and adult day care, among others. The at risk population is defined as Medicaid beneficiaries who do not meet criteria for nursing facility level of care (NF LOC), but who are assessed to be at risk of deteriorating to the institutional level of care.

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

Evaluation Priority Area 4: Community Integration Services and Community Transition Services

Hawai’i has one of the highest homeless rates in the nation. These individuals are frequent patients in the emergency department and require inpatient stays and continued care upon release. Studies have shown that members of the chronically homeless population’s high use of hospital facilities and emergency rooms account for most of this population’s disproportionately high annual health care costs. The CIS benefit includes supportive services related to housing and to health conditions, e.g., mental health needs, substance use disorder, or complex physical health needs (Kushel et al., 2005). CIS aims to decrease utilization of acute services (emergency and inpatient utilization), increase engagement in outpatient care services, and decrease the total cost of care.

The goals of Community Integration Services (CIS) are to (1) improve the health care status of the beneficiaries; (2) minimize administrative burden by streamlining access to care for enrollees with changing health status; (3) garner a slower rate of expenditure growth in managed care; and (4) promote independence and choice among beneficiaries to ensure appropriate utilization of the health care system.

To assess the obtainment of these goals, our evaluation will monitor both program process and outcomes/impacts associated with participating in the CIS program. For the process evaluation, the evaluation team will monitor program implementation and assess fidelity, providing regular feedback to the program providers, and recommend adaptations when warranted. This will include Root Cause Analysis (when appropriate) with MCOs and community partners. Fidelity monitoring tools will be established as details of the program activities are developed. To support the required rapid cycle assessments, the evaluation team will participate in quarterly meetings held by MQD, expected to include stakeholders such as MCOs, hospitals engaged in homelessness initiatives, and homeless service providers. Routine stakeholder collaboration will be mutually beneficial, allowing the evaluation team to receive consultation and feedback, while also providing stakeholders analytic support to evaluate the progress of implementation and process improvement initiatives. The outcomes evaluation will assess the effectiveness of the program by examining provider-level and participant-level outcomes (e.g., physical/mental health, health care utilization).

Supplemental Evaluation Objective (Evaluation Priority Area 5): Improve Data Quality for Immunization-Related Performance Measures

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

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

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

The HIR project has several important anticipated benefits to MQD, DOH, MCOs, Medicaid providers, and Medicaid beneficiaries. As with any IIS, the primary feature of the HIR is to collect, maintain, and share immunization data. The HIR will provide these services for Hawai'i Medicaid providers and beneficiaries, while also providing immunization-related data to MQD and to MCOs. MQD will reciprocate DOH's data sharing by supplying the HIR with immunization history for Medicaid recipients. This bi-directional data sharing between DOH and MQD will enhance the accuracy and completeness of immunization information within both the Medicaid and DOH data systems. Enriched immunization data within the Hawai'i Medicaid data system will support MQD, MCO, and Medicaid provider measurement goals, including those used for pay-for-performance and other initiatives.

The establishment and implementation of the new HIR will also benefit MQD as it will create a mechanism for sharing immunization-related reminders and vaccine recall information that will not only be useful for Medicaid providers, but will also potentially be useful for MQD and DOH as they can be leveraged to support initiatives to improve health outcomes among Medicaid beneficiaries. Clinical decision-making tools and built-in rapid response to updated vaccine recommendation information contained within the HIR also are expected to improve timeliness and age-appropriateness of immunizations administered to Medicaid beneficiaries. This is expected to improve health outcomes for Medicaid beneficiaries while also assisting MQD, MCOs, and Medicaid providers with reaching quality-related targets and objectives.

The exciting and innovative activities related to the MQD-DOH HIR project call for robust evaluation to fully elucidate the degree to which immunization data quality can be improved for Hawai'i Medicaid beneficiaries as well as to quantify the extent to which data quality problems may have impacted past immunization quality measure values for MQD beneficiaries. The focus of the evaluation will be to determine the extent to which the newly adopted HIR accurately captures true rates of childhood immunization for Hawai'i Medicaid beneficiaries and whether the reported childhood immunization rates improve following the implementation of the new HIR and the associated data sharing and data quality improvement efforts. Additionally, the evaluation may examine whether all sectors of the community are being entered into the registry equally and whether the rates of childhood immunizations differ among sociodemographic groups.

III. Evaluation Methodology

The Demonstration addresses a wide range of strategies and interventions to promote healthy outcomes and reduce costs. Accordingly, the evaluation utilizes a variety of research and statistical approaches to assess the impacts and outcomes of the Demonstration interventions and strategies. Overarching elements of the evaluation design that cut across several of the research questions and common features throughout the evaluation are discussed below.

Evaluation Design

Given the nature of the population, random assignment of participants (Medicaid beneficiaries) to programs to establish control and treatment groups is not feasible and generally not ethical. Instead, a variety of quasi-experimental statistical methods, such as pre-post analyses, propensity score matching, and within group comparisons will be used to assess program impacts. These methods are discussed in further detail below and in Section IV.

A mixed methods approach is a common feature of all of the in-depth studies in the evaluation. For several of these studies, a process evaluation will be conducted to track the progress and process of a new initiative and/or to document program fidelity. In some cases, the first phase of the project involves a qualitative analysis, for example, to increase understanding of a process or to monitor project implementation. The second phase then involves a quantitative study using surveys or existing data and applying modeling techniques or multivariate data analysis. In other cases, the quantitative study occurs first, followed by a qualitative study to further clarify the information generated in the quantitative study.

Target and Comparison Populations

Many of the evaluation questions will involve analyzing outcomes for all Medicaid beneficiaries, e.g., assessing alternative payment methodologies or value-based purchasing reimbursement at the MCO or provider level. Most of the in-depth studies, however, target specific subgroups of beneficiaries, e.g., the homeless, nursing home residents, groups with chronic conditions, etc. Therefore, comparison populations chosen for each analysis may vary and are described in greater detail in Section IV.

Evaluation Period

The first year of the evaluation will focus primarily on designing, modifying, and refining the evaluation plan, working closely with MQD to ensure that the final plan is feasible yet sufficiently rigorous, and comprehensively addresses all of the Demonstration objectives. Additionally, a major part of our efforts will involve working with MQD to obtain the data required for the evaluation, when needed and in the required format. Preparing for primary data collection in the form of interviews, surveys, and focus groups will occur in years 2-3. Years 2-3 will also focus on preparing and accessing administrative data and conducting preliminary analyses or statistical modeling with small samples of data to determine whether the proposed models and analytic strategies can be accurately applied and tested. Year 4 will focus on drafting a renewal proposal and specifying and estimating models, testing hypotheses, and addressing all research questions. Year 5 will focus on finalizing the summative report.

Additionally, for the CIS project, rapid cycle assessments will be performed and reported on every 3 months throughout years two, three, and four of the evaluation. These preliminary assessments will be both formative and summative, focusing on early accomplishments as well as identifying areas of concern that should be addressed in the early stages to ensure that the CIS program has maximum impact on the targeted beneficiaries.

MQD intends to hold quarterly meetings of CIS stakeholders to discuss program implementation, quality, and opportunities for VBP; stakeholders included may encompass MCOs, hospitals engaged in efforts to address homelessness, and representation from homeless service providers. These quarterly meetings provide opportunities for gathering process measures, discussing challenges with implementation, sharing best practices and success stories, and presenting on findings of the RCAs. The evaluation team will attend, support, and participate in quarterly meetings, and use these meetings to engage with stakeholders to help contextualize the findings of RCAs, and support performance improvement initiatives.

Evaluation Measures

A variety of quantitative and qualitative measures will be used. Most of the quantitative data will be from existing databases, generated by existing tools and surveys; only a few instances of quantitative data collection by the evaluators is planned. Some of the quantitative measures include the Level of Care (LOC) assessment, measures of patient-reported health outcomes (PRO), utilization of LTSS, reporting tools, and demographic and medical background factors available in the administrative data set. Specifically, we intend to use data on age, health status, gender, and functional limitation measures (when available) from claims, encounter, or assessment sources for matching purposes.

Much of the data will be obtained through existing survey instruments and data sets. The SDOH in-depth study and a portion of the Primary Care study, for example, will involve detailed interviews with health plans, providers, community representatives, health partners, and other stakeholders. For the CIS initiative, several of the survey tools that include measures will be sourced from the Patient Reported Outcomes Measurement Information System (PROMIS; <https://commonfund.nih.gov/promis/index>) and the Centers for Disease Control and Prevention (Health Days Measure: https://www.cdc.gov/hrqol/hrqol14_measure.htm) to monitor homeless beneficiaries' health and well-being. These measurement sources are well-validated and many are in current use by the Centers for Medicaid and Medicare Services (e.g., the Medicare Health Outcomes Survey (MHOS); <https://www.hosonline.org/>).

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

Data Source

The evaluation may include assessment of quantitative or qualitative process and outcome measures using the following potential data sources:

- Administrative data (i.e., claims; encounters, enrollment in the Hawaii Prepaid Medical Management Information System (HPMMIS), health plan reports, etc.).
 - HPMMIS Claims and Encounter Data: MCOs in Hawaii are contractually required to submit complete, accurate, and timely encounter data to HPMMIS. Encounter data may be used to access information on diagnoses, utilization of services, and cost of care over time for a variety of analyses requiring these parameters. Encounter data is received up to twice per month from health plans, and subject to a comprehensive encounter data validation process. Encounters that do not meet validation criteria are either rejected or pended in the system. Health plans are required to review their pended encounters, make corrections and submit replacements as needed. Hawaii's encounter data continues to require quality improvement activities to enhance its completeness and accuracy. Additionally, encounter data may not fully capture

- services provided to beneficiaries that are not submitted via claims to managed care plans such as care and service coordination, and housing supports provided by health plan administrative staff; self-directed chore services; quality bonuses and other supplemental payments; and sub-capitation payments made to providers (although the corresponding encounters may be submitted). The Hawaii Medicaid program is actively engaged in a multi-pronged strategy to address these data quality and comprehensiveness issues. As data quality is enhanced, the completeness and accuracy of data is expected to improve; while this improvement is beneficial for evaluation, various analytic considerations may be needed to account for differences that arise from increases in cost and utilization attributed to improved data quality, as opposed to the interventions.
- HPMMIS Health Plan Enrollment Data: HPMMIS is the Hawaii Medicaid Program's enrollment system. As such, beneficiaries eligible for Medicaid are enrolled in a managed care plan and the managed care plan begins to receive capitation payments as of the date of enrollment. Data sent to health plans from HPMMIS, which includes member demographics extracted from the member's application (age, sex, race, geography, ethnicity, etc.), eligibility category (Aged, Blind, Disabled; Low Income Adult, etc.), enrollment in special programs (LTSS, "at risk", CIS, etc.) and capitation payment amounts, can be extracted and provided for analysis. Most data pertaining to health plan enrollment and capitation payment is heavily reviewed and checked for quality. As such, the data is expected to be clean, although missing data on optional fields (e.g. race/ethnicity) and outdated data (e.g. non-updated address fields) can limit the validity of the data.
 - Electronic Health Records (as needed/available): The specific need for EHR data in the evaluation design methodology has not yet been established. As program implementation efforts in new areas such as social determinants of health continue, and needs are identified, efforts will be made to access and assess the quality of such data.
 - MCO Reports (as dictated by MCO contract requirements): Clinical information to support the evaluation, such as a beneficiary's housing situation and functional limitations, are best gleaned through MCO reporting requirements, independent of administrative claims or encounter data. It is anticipated that needed information will be gleaned from EHRs, case management systems, etc., and reported by the health plans using MQD's standardized reporting format. MQD is in the process of revising reporting templates to obtain the appropriate data to support evaluation needs. Historical data on these contextual factors affecting beneficiary data are therefore not available. MQD expects to implement revised reporting requirements in alignment with its managed care contract re-procurement; revised requirements are expected to include a beneficiary level data file that collects contextual information at the beneficiary level from MCOs. Therefore, the greatest threat to the data remains MQD's inability to collect the appropriate data in time to support evaluation needs. Additionally, since data collection has not begun, data quality assessments are not feasible at this time.
 - Member and provider feedback sources (e.g. EQRO-conducted surveys, grievances, Ombudsman reports): MQD's EQRO administers CAHPS surveys annually to Medicaid beneficiaries, targeting children in odd years and adults in even years. CAHPS surveys are administered according to a standardized protocol for the CAHPS 5.0 survey specified by the National Committee for Quality Assurance (NCQA). Standard CAHPS indicators may therefore be trended across years and compared. Some key considerations are challenges associated with small sample sizes, which limit the ability to evaluate sub-populations using CAHPS; the frequency of survey administration, which limits the number of data points available during the

demonstration period; and the survey's limited ability for customization, which reduces the number of custom questions that may be included. MQD's EQRO also administers a provider survey, which may be used to gather provider-level feedback; this survey has historically been impacted by low response rates. MQD does not currently administer the HCBS CAHPS; should this survey be initiated, the data may be used for evaluation. Other data sources include grievances, and Ombudsman complaints, which may be used as needed for the evaluation.

- Healthcare Effectiveness Data and Information Set (HEDIS®) data: MQD has historically collected data on HEDIS quality measures, and other performance measures, from MCOs in an aggregate format. Beginning in 2021, MQD plans to implement a patient-level data file requirement that allows for more granular data collection. This file will include identifiers that allow for linking quality-based outcomes with other member-level information including demographics, utilization, cost of care, and other metrics. Given that this represents new reporting for MCOs, it is subject to timeline and other uncertainties; data quality issues may be present initially, taking 2-3 years to resolve completely. MQD may begin with a subset of measures for patient-level data reporting to phase implementation, therefore reducing the total amount of data available for evaluation. Also, no historic patient-level data will be available for comparison or analysis.
- External data sources holding information collected by MQD-contracted providers (e.g., HILOC database, HMIS data system)
 - HILOC Database: This database is maintained by the Health Services Advisory Group (HSAG), MQD's EQRO, and collects data on the level of care (LOC) assessments requested by MCOs and community providers for Medicaid members who require nursing facility level of care (NF LOC) or who are "at risk" of deteriorating to the NF LOC. The dataset includes comprehensive assessments of individuals' functional status during the initial request, annual review, or as changes occur. It also includes information about demographic characteristics and the availability of caregivers, which allows the evaluators to conduct matching and subgroup analyses. The data are collected primarily through a secure Web application developed by HSAG. Through this application, submission and review/approval of LOC requests are accessible to registered users from the State, Medicaid health plans, and service providers. Compared to paper-based methods, this automated data collection and processing method is more efficient and can provide faster reporting with more accuracy. HILOC interfaces with the State's prepaid medical management information system and can provide the necessary information to produce monthly, quarterly, annual, and ad hoc reports. Data timeliness and completeness may be impacted by the COVID-19 pandemic; through additional public health emergency related waiver authorities, individuals receiving LTSS services may begin or continue to receive services without an assessment during the public health emergency period.
 - HMIS. The Homeless Management Information System (HMIS) is a local information technology system that is used to collect and report client-level data for individuals who have experienced homelessness or at risk of homelessness and receiving support services. In Hawaii, MCOs work closely with the Continuums of Care responsible for managing the database. The evaluation team aims to leverage this data to account for ancillary services that complement services delivered via the CIS project. The database is limited by the quality and timelessness of the data entered by service organizations who provide direct care to clients experiencing homelessness. It is also relatively rigid regarding the types of data that can be entered. Moreover, it is not designed to be a research tool, instead a mechanism for accessing individual client records and histories. Therefore, extracting data can be labor intensive. Despite these limitations, the quality and

timeliness of data entry is monitored by the Continuums of Care (there are two CoCs for the state of Hawaii) to ensure that data files are appropriate for program evaluation and monitoring purposes.

- External databases allowing MQD data access for joint projects (e.g. HIR): Currently, MQD is not integrated with external datasets available through the health information exchange or the Hawaii Immunization Registry to facilitate evaluation. As these integrations are developed, data exchanges will allow for greater access to information in these external databases, and the resultant enriched data may be used for evaluation purposes. The integration with the immunization registry is key to evaluation priority area 5.
- Surveys and in-depth interviews developed by the evaluators explicitly for our purposes, such as in-depth interviews with providers, MCOs, patients and other stakeholders and conducted by the evaluators or qualified contractors
- Existing survey instruments that are appropriate for specific purposes will be used (e.g., BRFSS; MHOS) as a monitoring tool as well as provide a point of comparison. The BRFSS and MHOS are conducted annually and can provide state and national-level comparative data when within-state comparison groups are not possible.

Analytic Methods

In the absence of adequate control (and in some cases, comparison) groups, the evaluation will rely primarily on quasi-experimental methods, such as within group pre-post analyses and matching. A major initiative of several of the in-depth studies will focus on subgroup analyses to understand in greater depth how beneficiaries from different subgroups (e.g., age, ethnicity, type of disease) respond to the initiatives in the Demonstration.

The evaluation of trends in the utilization of Primary Care, for example, will involve subgroup analyses comparing those who did not use primary care in the prior demonstration period versus those who did, focusing on utilization, spending, and quality outcomes. In addressing time trends in utilization of Primary Care, regression analysis with matching and stratification will be used. The CIS project will conduct latent growth modeling to detect changes over time within the target population. A growth mixture model will also be tested, comparing the fit and appropriateness of a series of models to identify unique classes of beneficiaries over time. This analytical strategy will allow the evaluators to determine if there are subgroups of participants for whom the program is working well and for whom it is not. The HCBS evaluation will rely on latent class growth analysis and survival analysis to examine the subgroup differences in health outcomes and total cost of care among HCBS users who meet the institutional care criteria and the at-risk population. Latent class growth analysis allows the identification of specific numbers of unique classes of beneficiaries over time and subgroups of participants with better, worse, or no change in health outcomes and total cost of care during the period of analysis. The HCBS evaluation will also use a combination of matching and survival analysis to determine whether receipt of HCBS services slows the deterioration of health. The analysis will be based on the use of historic data since 2015 and the data collected during the demonstration period.

Across all programs, when possible, data from program participants will be compared to state and nationally normed data made available by federal agencies. We will explore and compare the performance measures of the demonstration to national benchmarks in the areas of primary care, emergency department visits, inpatient hospital and nursing home admissions through the AHRQ H-CUP data sources (NIS, NED, SEDD, SID), and CAHPS experience of care. Performance on Health Effectiveness Data and Information Set (HEDIS) quality measure data will be compared to national Medicaid HEDIS benchmarks, and the CMS Medicaid Score Card data where applicable to compare Hawaii's performance to other states. Such comparison may help to disentangle the effects of the demonstration from broader sectoral trends during the period. Possible data sources that enable the

comparison include, but not limited to, HEDIS, CMS Score Card, National Hospital Data Surveillance Network, Medical Expenditure Panel Survey, the CDC's BRFSS and MHOS.

Analytic Considerations

Our evaluation approaches will be continually informed by results from the rapid-cycle assessments. Further, interim evaluation report findings will directly contribute to the summative report and our long-term program planning. At each stage of the evaluation process, we will reexamine findings from previous reports to consider the interrelations among the Demonstration projects and the other aspects of the state's Medicaid program. We will also reexamine findings in relation to those from other Medicaid demonstrations and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This approach will allow us to consider system-wide impacts that affect service delivery, health outcomes, and cost of care, to make judgments about the Demonstration using evaluative reasoning, and inform Medicaid policymakers, advocates, and stakeholders at both the state and national levels.

Methodological Limitations

Our proposed evaluation design does not address all factors that contribute to health and cost outcomes. Theory of change has been considered for each of the in-depth studies but we recognize that we will be unable to evaluate all contributing factors. The proposed evaluation, however, will lay the groundwork for future evaluation efforts. For example, building on the findings from the proposed evaluation, we can further explore underlying drivers of the outcomes using qualitative approaches such as focus groups and interviews of beneficiaries and key informants in certain subgroups or quantitative analysis of survey data collected from subgroups.

Any well-designed evaluation requires a theory of change that explains why a given program may lead to changes in certain consequences. In this evaluation, we track both the changes in desired measures of, such as health outcomes as measured by standard mortality or morbidity measures, and what kinds of consequences might be plausibly expected as a result of the Demonstration, such as expanded primary care utilization or improved primary care quality. For instance, while this evaluation may be able to discern changes over time in the improvement in quality of diabetes care (RQ 1A.1), improvements in quality of diabetes care as a result of the Demonstration may not necessarily reduce diabetes prevalence. In fact, the Demonstration may actually increase diabetes prevalence because people with diabetes are able to live longer but with fewer complications. Thus, in the case of diabetes prevalence of beneficiaries, this may not be a suitable measure of health outcomes as a result of the Demonstration, whereas examining the percentage of diabetic patients with complications may be a suitable health measure. Similarly, the evaluation of this Demonstration may detect whether there are changes in the screening for enhanced primary care that were previously undiagnosed conditions. Yet such improved quality of care as measured by greater screening may again lead to ostensible increases in disease prevalence due to greater detection of previously underreported conditions.

For some questions, we propose to use archived administrative data as well as data that will be collected during this Demonstration. We assume the same "program" or "intervention" will be delivered during this Demonstration period is similar to what was delivered in the past since some of these programs were introduced in previous demonstrations. For HCBS, for example, changes in the delivery of services could occur at different levels (e.g., health plan providers and service coordinators) in relation to past demonstrations. These changes are not easily documented or observed and are not accounted for in our evaluation design. These challenges in defining precisely what the intervention was comprised of should be considered in the interpretation of results.

Several of the approaches in the evaluation design focus largely on within-group analysis, which is partly due to difficulties in identifying adequate comparison groups. For example, when we consider this question: does HCBS

slow the deterioration of LTSS needs among the at risk population? We face the challenge of identifying a good comparison group (e.g., members of the at-risk population who do not use HCBS) because at-risk status is assessed when individuals seek to use the services. Considering this limitation, it is best to use within-group comparisons, which can also yield informative findings for the evaluation.

Increases in immunization coverage may not lead to any detectable short-term health impacts due to low incidence of vaccine-preventable diseases. We are also limited to evaluating the impact of the immunization data that is entered into HIR. While we can make some direct comparisons between individuals with different demographic profiles within MCOs who consistently utilize the registry, we will need to be careful to not discriminate between data that was simply not entered, from data that suggests individuals are not being immunized.

Analytic Methods

Selection bias is a major threat to the validity of the evaluation. In the case of HCBS, for example, selection bias exists because LTSS-eligible members are provided the choices to use HCBS or institutional care. Beneficiaries with certain characteristics (e.g., having minor functional limitations and a home) are more likely to select HCBS than a nursing home. Service coordinators also encourage the use of HCBS. Therefore, assignment to the two treatment groups is not random. To address this issue, we propose to use propensity score matching methods. Although matching helps reduce the differences between the two groups, it does not eliminate selection bias. Another type of selection bias is survival bias/attrition. Beneficiaries may leave LTSS for reasons such as death or ineligibility. The exit from LTSS may not be random but is influenced by type of LTSS. For example, nursing home residents are likely to have a higher mortality rate due to a higher level of care needs compared to home care users. However, attrition might not be a big concern as data show that only about 6 percent of members left LTSS in 2017-2018 in Hawai'i.¹

For CIS, it is very likely that not all eligible beneficiaries will participate in services, and many of those who do may not follow-up with all elements of the program. Statistical adjustments and considerations will be necessary to account for attrition and selective participation. Advanced missing data techniques (e.g., multiple imputation and full information maximum likelihood) will account for some of these limitations.

Another potential threat is unobserved characteristics that can affect the randomization of the two treatments. For example, characteristics of health plans (e.g., qualification of health professionals) may affect beneficiaries' decisions. To mitigate the potential confounding bias, one possible solution is to include plan-and-year-specific fixed effects in the model. These fixed effects help control for a complete set of time-invariant, plan-specific effects and for factors that vary uniformly over time across plans. Admittedly, this does not eliminate the risk of unobserved characteristics that contribute to the differences, which is another limitation of the evaluation.

Other

One big challenge of the evaluation is to disentangle the effects of different components of the demonstration as they are implemented simultaneously and often targeted on large overlapping populations (e.g., population with social needs, homeless population, and LTSS beneficiaries). To meet the HOPE objectives, these components are designed to be cross cutting and mutually reinforcing. The program planning places challenges to the evaluation, however, the subgroup analyses we propose may help disentangle the effects to some extent.

¹If a beneficiary had no breaks of over 45 days, we counted him/her as staying in the LTSS program.

While most of the projects are new initiatives under this demonstration, LTSS, however, has existed for a long time, and HCBS were provided to the “at risk” population in prior demonstrations. It is, therefore, difficult to evaluate the impact of HCBS on the health outcomes of beneficiaries and the costs of the program during the current demonstration.

During the evaluation period, other policies and programs may also affect the outcomes of interest. We will consider these confounding factors wherever we can. However, we recognize that we may not have access to all the information that may impact beneficiaries or programs. For example, we do not have information about services from charitable organizations that beneficiaries may receive, which could have an impact on health outcomes. This is another limitation of the evaluation to keep in mind.

The COVID-19 pandemic and resulting public health emergency is also expected to have a profound impact on the evaluation. First, the pandemic is expected to have a broad-based impact on several outcome measures of interest, affecting several priority evaluation areas (e.g., service utilization and total cost of care). Next, MQD sought additional authorities/waivers of existing authorities related to the public health emergency that may impact eligibility requirements, payment models, and delivery of services in specific areas such as LTSS, therefore affecting specific priority evaluation areas. Finally, the economic impact of the pandemic may ultimately affect the interventions implemented by MQD; this evaluation design proposes to evaluate the impact of a multitude of new initiatives tied to MQD’s managed care re-procurement. Larger budgetary constraints may morph or dictate MQD’s decisions on how and when these interventions are implemented; similarly, the new immunization registry is led by the same Division within DOH that has led pandemic response efforts. Logistical and feasibility constraints may ultimately impact progress on this project. Substantive changes to project implementation scope and timelines will impact the evaluation timeline and design.

IV. Project-Level Detail

Demonstration Objective 1. Improve health outcomes for Medicaid beneficiaries covered under the Demonstration

Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes	
Component	Description
Demonstration Hypothesis 1.1	Increasing utilization for primary care, preventive services, and health promotion will reduce prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.
Target populations	<ul style="list-style-type: none"> • Populations with one or more chronic conditions such as diabetes, hypertension, and chronic kidney disease • Pregnant women • Infants and children eligible for well child visits • All adults
Research questions	<p>Research questions pertain to understanding:</p> <ol style="list-style-type: none"> (1) RQ 1A.1: What are time trends in utilization, spending (as a percentage of total spending), and quality of primary care for Demonstration populations? (2) RQ 1A.2: Are changes in primary care utilization and spending associated with plausibly relevant health outcomes? <p>Selection of health outcomes will be based on literature review and stakeholder (i.e. provider and beneficiary) consultation to identify and select health measures which are plausibly relevant to improvements in primary care utilization, spending, and quality, respectively (see Methodology and Limitations sections above).</p>
Data strategy, sources and collection frequency	<p>Administrative data.</p> <p>Potential administration data for analysis include encounter, claim, and beneficiary-level report data regarding primary care utilization, spending, and quality measures, as well as beneficiary sociodemographic characteristics. The administration data are housed in the data warehouse of State of Hawai'i Department of Human Services (DHS). Indicators that would be considered include HEDIS, state-defined health care quality and outcome measures, measures of total costs of care per beneficiary, as well as the measures of patient satisfaction and patient-reported outcomes e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS). Indicators chosen will depend on data availability and quality. Current indicators under consideration include HEDIS measures pertaining to Adult Access to Preventive/Ambulatory Health Services for distinct age groups, as well as other HEDIS measures and other quality measures as feasible.</p> <p>Examples of specific HEDIS measures that may be chosen for the evaluation include:</p> <ul style="list-style-type: none"> • Well-Child Visits in the First 15/30 Months of Life (W15/30-CH); • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH);

	<ul style="list-style-type: none"> • Prenatal and Postpartum Care (PPC-AD); • Adolescent Well-Care Visits (AWC-CH); • Adults' Access to Preventive/Ambulatory Health Services (AAP); and • Children and Adolescents' Access to Primary Care Practitioners (CAP-CH). <p>Examples of specific CAHPS measures that may be chosen for evaluation include:</p> <ul style="list-style-type: none"> • Getting Needed Care • Getting Care Quickly
Statistical framework for measuring impacts	<p>For all quantitative analyses, regression analysis using matching will be applied. Patient use of primary care is not random, and characteristics by plans, providers, and patients may systematically differ on observable characteristics. Propensity score matching will be used to assess whether use of primary care (as an endogenous treatment) is associated with changes in plausibly relevant health outcomes, based on a set of observable covariates. Time-series or longitudinal analysis will also be applied to examine time trends and discontinuities over time when data is available.</p> <p>(1) RQ 1A.1</p> <ol style="list-style-type: none"> a. Main Quantitative Analysis: Overall time trends in primary care utilization, spending, and quality will be examined, with a focus on geographic disparities and sociodemographic determinants and stratified by specific Medicaid Demonstration populations (pregnant women, infants, children, etc.) b. Subgroup Quantitative Analysis: Medicaid beneficiaries who did not seek primary care prior to the current Demonstration period will be identified. Changes in primary care measures of utilization, spending, and quality (using progressively broader primary care definitions) for these populations will be examined over time, with the expectation that primary care measures will increase over time. c. Qualitative analysis: In-depth interviews (n=25) will be conducted with plans, providers, and patients regarding patients who previously did not seek primary care to explore factors that led to changes in use of primary care and possible consequences or impacts of increased primary care utilization, spending, and quality. <p>(2) RQ 1A.2:</p> <ol style="list-style-type: none"> a. RQ 1A.2 is contingent upon seeing changes in RQ 1A.1. If there are no improvements in primary care observed, then this question is not relevant. b. Literature Review and Main Qualitative Analysis: This research question explores whether the changes in primary care as a result of this Demonstration also lead to improvements in health outcomes. It cannot be assumed that increased primary care utilization, spending and quality necessarily leads to improvements in health outcomes (see Methodological Limitations). As such, for this study component, we propose to carefully choose a measure of health outcomes through literature review and stakeholder consultation in order to identify and select one health outcome that is plausibly associated with improvements in primary care utilization, spending, and quality.

	c. Quantitative analysis of the chosen health outcome will depend on the literature review and qualitative analysis. This basic form of this analysis would regress the chosen health outcome on a chosen measure of primary care utilization, spending, or quality, respectively, and holding other factors constant; and examined in the four years prior to the start of the program and each quarter thereafter.
Subgroup analyses to assess disparities and differences	Individual subgroup populations will be explored and may include consideration of factors or groupings, such as selection of one's health plan versus automatic assignment, selection of one's own Primary Care Physician (PCP) vs auto-assignment, participation in a Patient-Centered Medical Home (PCMH) vs not, or populations with discontinuous coverage vs those with full coverage.

Project 1B: Care Coordination for Beneficiaries with Complex Conditions	
Component	Description
Demonstration Hypothesis 1.2	Improving care coordination (e.g. by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).
Target populations	Medicaid beneficiaries identified as those having complex health needs
Research questions	Research questions pertain to understanding: <ul style="list-style-type: none"> (1) RQ 1B.1: Will care coordination for individuals identified as having complex health needs result in improved health outcomes? (2) RQ 1B.2: Will care coordination for individuals identified as having complex health needs result in lowered utilization of the healthcare system, and a slower rate of expenditure growth?
Data strategy, sources and collection frequency	Administrative data will be used for analyses. Potential administration data for analysis include encounter, claim, and beneficiary-level report data regarding utilization, spending, and quality as well as beneficiary sociodemographic characteristics. The administration data are housed in the data warehouse of State of Hawai'i Department of Human Services (DHS).
Statistical framework for measuring impacts	For all quantitative analyses, regression analysis will be applied to assess whether individuals identified by MQD as having complex health needs experienced changes in plausibly relevant health outcomes and costs of care. MQD will provide information on the criteria for selection of individuals as having complex health needs. That criteria will be used to identify a plausible comparison group with similar or slightly lower levels of need and cost, which may lend itself to a regression discontinuity design. If a cutoff is not available (to enable regression discontinuity design), propensity score matching, using full optimal matching will be conducted. We will then pair the matching procedure with a time-series analysis to compare health outcomes, health utilization, can changes in expenditure growth in the four years prior to program evaluation and after the program was initiated on a quarterly basis for both the treatment and comparison groups.
Subgroup analyses to assess disparities and differences	Individual subgroup populations will be explored and may include consideration of factors or groupings, such as gender, age, and presence of multiple chronic conditions or behavioral health conditions.

Project 1C: Home- and Community-Based Services (HCBS)	
Component	Description
Demonstration Hypothesis 1.2	Improving care coordination (e.g. by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).
Target populations	<ul style="list-style-type: none"> For research question 1C.1, the target population is Medicaid beneficiaries who use long-term services and support (LTSS) in the home and community based setting or institutional setting among individuals meeting NF LOC criteria. For research question 1C.2, the target population is individuals meeting NF LOC and receiving HCBS services. For research question 1C.3, the target population is beneficiaries who do not meet institutional level of care but are at-risk of deteriorating to an institutional level of care (i.e. the at-risk population).
Research questions	<p>Research questions pertain to understanding:</p> <ol style="list-style-type: none"> (1) RQ 1C.1: Does HCBS slow the deterioration of health as reflected in the level of care among individuals meeting NF LOC criteria? (2) RQ 1C.2: Does length of time to enter a nursing home, patient-reported health outcomes (PROs), and total cost of care vary depending on a variety of client characteristics among individuals meeting NF LOC criteria and receiving HCBS services? (3) RQ 1C.3: Does length of time to enter a nursing home, PROs, and total cost of care vary depending on a variety of client characteristics among the at-risk population?
Data strategy, sources and collection frequency	<p>Administrative data. Potential administration data for analysis include encounters, claims, and beneficiary-level report data such as LTSS utilization, Hawaii's health and functional assessment used to assess the health status of LTSS beneficiaries, and sociodemographic characteristics. The administration data are housed in the data warehouse of State of Hawai'i Department of Human Services (DHS). Functional assessment (LOC assessment) data are managed by an External Quality Review Organization — Health Services Advisory Group (HSAG). The LOC assessments are collected annually and when changes occur or when requested by beneficiaries in between two annual assessments.</p> <p>Primary data collection. Primary data may include the collection of patient-reported health outcomes annually and when changes occur.</p>
Measures	<p>The outcome measures include</p> <ul style="list-style-type: none"> Length of time for the LOC to deteriorate to a certain level Length of time for beneficiaries to enter a nursing home Patient-reported health outcomes (e.g., beneficiaries' perception of health, quality of life, or satisfaction) TCOC <p>We will consult the HCBS staff at the State of Hawai'i Med-QUEST Division to determine a certain LOC level as the threshold, and measure the length of time from the baseline (prior to any LTSS use) to the time point when a LTSS qualifying</p>

	<p>beneficiary's LOC reaches the threshold. Potential questions for patient-reported health outcomes may be adapted from nationally recognized sources such as PROMIS, GLOBAL10, and the HCBS survey from Consumer Assessment of Health Care Providers and Systems (CAHPS).</p> <p>Other measures pertaining to LTSS and variables for matching or controlling in the analysis may include, but are not limited to:</p> <ul style="list-style-type: none"> • Utilization of LTSS (e.g., whether one uses HCBS/nursing home, types of HCBS used, intensity and duration of HCBS/nursing home used, health plan). • Factors that affect personal needs for care (e.g., health conditions and functional limitations). • Factors that may predispose, enable, or impede those who use services (e.g., age and sex).
Statistical framework for measuring impacts	<p>Quantitative impact analysis. For research question 1C.1, the evaluation will be based on a pre-post comparison of one period before the treatment (receiving HCBS or institutional care) and one or multiple periods after the treatment. Archived administrative data allow us to identify time points when Medicaid beneficiaries first started receiving LTSS and when they develop severe limitations in their functional status (as measured by the LOC and to be defined). The duration between the two time points is one measure of health outcome (i.e. length of time to duration). We plan to use a combination of matching methods and survival analysis. Matching methods are likely to create two balanced groups before beneficiaries receive the treatment. Matching variables may include, but not limited to, age, sex, health conditions, and the availability of caregivers.</p> <p>Research questions 1C.2 and 1C.3 will focus on identifying within-group comparisons. Specifically, we plan to examine subgroup differences in the patient-reported health outcomes, the deterioration to the institutional care, and the TCOC among individuals meeting NF LOC and receiving HCBS services and among the at-risk population using methods such as latent class growth analysis and survival analysis.</p>
Subgroup analyses to assess disparities and differences	<p>As described above, subgroup analyses are a major component of the HCBS evaluation. Specifically, we plan to examine subgroup differences in the patient-reported health outcomes, the deterioration to the institutional care, and the TCOC among HCBS users and the at-risk population using methods such as latent class growth analysis and survival analysis. Latent class growth analysis allows the evaluators to identify a specific number of unique classes, with each class containing a proportion of the overall sample who exhibit very similar trends over time. The class identification helps determine unique characteristics that are associated with program participants who are members of each class, some of which may have better, worse, or no change in the health outcomes and total cost of care. This analysis would inform further investigations about the reasons for the (lack of) change among subgroups in the future.</p>

Demonstration Objective 2. Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth

Project 2A: Value-based purchasing (VBP) reimbursed at the MCO and Provider levels

Component	Description
Demonstration Hypothesis 2	Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the MCO level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.
Target populations	Medicaid beneficiaries
Research questions	<p>Research questions pertain to understanding:</p> <ul style="list-style-type: none"> (1) RQ 2A.1: Will implementing VBP reimbursements at the MCO level result in improved health outcomes? (2) RQ 2A.2: Will implementing VBP reimbursements at the MCO level result in lowered utilization of the healthcare system and slower rate of expenditure growth? <p>The analyses will consider one or more VBP measures at the MCO level..</p>
Data strategy, sources and collection frequency	Administrative data. Potential administration data for analysis include encounters, claims, MCO-level quality data, and beneficiary-level report data (including beneficiary-level quality information). Health plan level VBP, and health plan data on provider-level VBP adoption and results, beneficiary-provider attribution data, and encounter data will be used in concert to identify beneficiaries served/services provided under different VBP structures.
Measures	The outcome measures may include one or more of the following: selected health outcome(s), total cost of care per beneficiary, and rate of expenditure growth in the managed care delivery system.
Statistical framework for measuring impacts	Quantitative impact analysis. To answer the first and second research questions, the evaluation will be based on data provided by MQD on beneficiaries' utilization of the health care system at the MCO and provider levels, and select MCO-level and beneficiary-level quality measure data as available (e.g. as reported to CMS in the Core Set of Health Care Quality Measures). The third question will be answered with administrative data (claims data), electronic records, and financial summaries submitted by health plans. We will use an interrupted time-series latent growth model to compare health outcomes, health utilization, can changes in expenditure growth in the four years prior to program evaluation and after the program was initiated on a quarterly basis.
Subgroup analyses to assess disparities and differences	As needed

Project 2B: Alternative Payment Models (APM) at the Provider level	
Component	Description
Demonstration Hypothesis 2	Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the MCO level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.
Target populations	Medicaid beneficiaries
Research questions	Research questions pertain to understanding:

	<p>(1) RQ 2B.1: Will implementing one or more APMs at the provider-level result in improved health outcomes?</p> <p>(2) RQ 2B.2: Will implementing one or more APMs at the provider-level result in lowered utilization of the healthcare system and slower rate of expenditure growth?</p>
Data strategy, sources and collection frequency	Administrative data. Potential administration data for analysis include encounters, claims, and beneficiary-level report data. Health plan tracking of providers' adoption of APM models, beneficiary-provider attribution data, and encounter data will be used in concert to identify beneficiaries served/services provided under different APM structures.
Measures	The outcome measures may include one or more of the following: selected health outcome(s), total cost of care per beneficiary, and rate of expenditure growth in the managed care delivery system.
Statistical framework for measuring impacts	Quantitative impact analysis. To answer the first and second research questions, the evaluation will be based on data provided by MQD on beneficiaries' utilization of the health care system, and select beneficiary-level quality measure data as available (e.g. as reported to CMS in the Core Set of Health Care Quality Measures) among one or more provider groups who have implemented an APM. The third question will be answered with administrative data (claims data), electronic records, and financial summaries submitted by health plans. We will use an interrupted time-series latent growth model to compare health outcomes, health utilization, and changes in expenditure growth in the four years prior to program evaluation and after the program was initiated on a quarterly basis.
Subgroup analyses to assess disparities and differences	As needed

Demonstration Objective 3. Support strategies and interventions targeting the social determinants of health

Project 3A: Community Integration Services (CIS)	
Component	Description
Demonstration Hypothesis 3	Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.
Target populations	Medicaid beneficiaries who are eligible for and consent to participate in CIS.
Research questions	<p>Research questions pertain to answering:</p> <ul style="list-style-type: none"> (1) RQ 3A.1: Do program participants who are stably housed decrease utilization of acute services (emergency and inpatient utilization)? (2) RQ 3A.2: Do program participants who are stably housed increase utilization of outpatient care services? (3) RQ 3A.3: Is total cost of care lower for participants who are stably housed?

	<p>(4) RQ 3A.4: Does individual health and wellbeing improve as participants' progress through the program?</p> <p>(5) RQ 3A.5: How does program effectiveness vary by client needs and experiences?</p>
Data strategy, sources and collection frequency	<p>Archival administrative data will be used to identify trends in program participants' health care utilization at least one year prior to starting the program (compiled quarterly) and made available to the evaluation team. We aim to have service staff administer a validated electronic survey quarterly with their clients and have results made available to the evaluation team.</p> <p>Administrative data. Potential administration data for analysis include encounters, claims, and beneficiary-level report data such as CIS utilization, functional assessment, and sociodemographic characteristics. The administration data are housed in the data warehouse of State of Hawai'i Department of Human Services (DHS).</p> <p>Primary data collection.</p> <p>Housing and Case Management Assessment Tool (obtained face to face with client)</p> <p>Potential secondary data sources:</p> <ul style="list-style-type: none"> • Homeless Management Information System (HMIS) • Contact hours and fidelity checklist <p>The HMIS tracks client-level service utilization data across all homeless services providers. This system can be used to acquire social service use data not captured in health utilization records. Specifically, shelter stays, case management (not managed by a Medicaid provider) substance use treatment, and housing support. These records will help account for whether program participants are receiving concurrent services through other agencies.</p> <p>Service delivery hours will be a measure of dosage. These are the billable units filed by the case managers. This information, in conjunction with a fidelity checklist submitted by the case managers on a quarterly basis will be used to determine the extent that the program is being implemented as intended.</p> <p>Note: DHS/MQD has not finalized the content of the eligibility screener, data collection forms used by health plans to support initial/ongoing assessment of CIS beneficiaries, and reporting requirements for the health plans. Evaluation methods will be adapted to the finalized tools as needed. The proposal submitted here assumes the use of certain tools for data collection. The evaluation team has offered its recommendations to MQD on the need for these instruments.</p>
Measures	<p><u>Initial client needs and progress</u> will be assessed using a validated survey tool. This tool was purposely designed to directly inform service providers of clients' needs and conditions while also providing a rich, empirically valid source of data for ongoing analysis. This tool will be administered quarterly to clients by the contracted providers. This tool will be used to track changes in self-reported access to healthcare, health outcomes, substance use, employment, income, service use/needs, and overall quality of life. The included measures were selected because they have shown adequate sensitivity to detect dynamic changes in wellness in a</p>

	<p>short time period and appropriate for the target population. <u>Potential</u> measures are outlined below:</p> <p><u>Access to Healthcare.</u> A potential measure will include four items from the Behavioral Risk Factor Surveillance System (BRFSS; Centers for Disease Control and Prevention, 2013) that represent access to healthcare (e.g. “Do you have one person you think of as your personal doctor or health care provider?” and “Was there a time in the past month when you needed to see a doctor but could not because of cost?”). Two additional items (“How long do you have to travel to get to your health care provider?” and “If I need to see a specialist, it is easy for me to find one.”) will be included to assess other domains of individual differences in participants’ access to health care and to more fully capture the construct.</p> <p><u>Health-related Quality of Life Outcomes.</u> Subjective perceptions of mental and physical health and stress will be measured. Overall perceived physical and mental health may be measured by the 9-item CDC Health-Related Quality-of-Life measure (HRQOL; the 4-item Core Module and 5-item Symptoms Module). The HRQOL is an empirically validated scale (Barile et al., 2013; Horner-Johnson et al., 2010) that consists of a 4-item physical health scale and a 4-item mental health scale that measures both anxiety and depression. Previous research using items from the HRQOL measure have demonstrated content, construct, and criterion validity with the Short-Form 36 (CDC 2000; Moriarty et al 2003; Moriarty et al 2005). Perceived stress will be measured by the Perceived Stress Scale-4 (Cohen, Kamarck, & Mermelstein, 1983; Cohen & Williamson, 1988). The Perceived Stress Scale also has been found to valid and reliable. This scale includes items such as, “In the last month, how often have you felt that you were unable to control the important things in your life?” Previous literature has found the measure to have a two-month test-retest reliability of .55 (Cohen, Kamarck, & Mermelstein, 1983) and to have construct and discriminant validity (Cohen & Williamson, 1988; Cohen, Tyrrell, & Smith, 1993).</p> <p><u>Substance Use.</u> Substance Use may be monitored by including items from the Patient-Reported Outcomes Information System (PROMIS) Alcohol Use – Short Form. This measure assesses individuals’ drinking behavior regarding the amount and impact by asking whether individuals drank heavily, had trouble controlling their drinking, or had difficulty getting the thought of drinking out of their head. This measure will be modified to assess any substance that a program participant has had a history of using.</p> <p>The measures chosen here are based on previous stakeholder feedback. However, the evaluation team may select additional or alternative measures based on literature review and stakeholder consultation to ensure that measures that are plausibly relevant to improvements in beneficiary health outcomes and total cost of care are considered comprehensively.</p>
<p>Statistical framework for measuring impacts</p>	<p>Quantitative impact analysis. Our primary evaluation questions will be assessed using multi-level sequential process growth mixture modeling (SPGMM), with adjustment for the nesting of participants within CIS case manager. We will answer secondary questions using latent class analyses and/or multinomial logistic regression. Latent growth modeling, more generally, is a method of estimating</p>

	<p>change over time that allows the researcher to test associations among time invariant (conditions that do not change) and time varying covariates (conditions that likely do change) and growth. Traditional latent growth curve modeling assumes that individuals within the sample likely change at similar rates over time. This level of homogeneity is unlikely, particularly with community-based samples. “Mixture” models allow the researcher to estimate heterogeneity in growth and identify naturally occurring “classes” or subsamples who follow similar trends. Multilevel modeling will be employed to account for the nesting of participants within case managers, as the outcomes for each participant are likely dependent upon how each case manager implements the program.</p> <p>To conduct a growth mixture model, the data analyst will systematically compare the fit and appropriateness of a series of models to the data with one or more “classes” – most commonly between 2 and 8. This approach aims to identify a specific number of unique classes, with each class containing a proportion of the overall sample who exhibit very similar trends over time.</p> <p>For our evaluation, we will employ sequential process growth mixture modeling because it will allow to identify unique classes before and after the start of the intervention, with class membership prior to start of the intervention likely predicting class membership after the start of the intervention. This process will allow us to determine what unique characteristics are associated with program participants who are members of each class, some of which may have excelled in the program while other deteriorated (or exhibited other unique trends over time).</p> <p>The first step in the analyses will be to identify growth trajectories based on longitudinal medical utilization records. The potential for two or more unique subgroups or classes that emerge from this data will then be examined, this is represented by Latent Class 1 in Figure 2. The second stage of the analyses identifies growth trajectories based on longitudinal data since starting the program (Latent Class 2). This will include medical utilization trends since starting the program (compiled quarterly) and predicted by covariates and moderators listed in Figure 2. Finally, associations between being a member of a specific class since starting the program and the patient reported outcomes, specifically the quality of life indices will be observed.</p> <p>This analytical approach will be used to assess the impact of the program on health care expenditures before and after the start of the program.</p> <p>RQ 3A.1 and 3A.2: Slopes (changes over time) identified prior to the start of the program using health care utilization records will be used to identify statistically significant changes in slopes identified after the start of the program. These analyses can be conducted after participating in the program one year, with four quarterly aggregated expenditures observed before and after the start of the program.</p> <p>RQ 3A.3 and 3A.4: Survey data assessing patient reported outcomes will be integrated into the health care expenditures model, with health care expenditure slopes being used to account for baseline needs when examining program outcomes, such as quality of life.</p> <p>Intermediate findings included in the rapid cycle assessments will focus on the</p>
--	--

	<p>program's implementation, fidelity, and adaptations. Dosage data, defined as the amount of face-to-face time that case managers spent with their client, and transitions from pre-tenancy to tenancy will be used to predict short-term outcomes. Depending on the number of case managers, multilevel modeling will be employed to account for the nesting of individuals with service providers (participants are nested within a case manager, and case manager are nested within their health care organization). Have multiple case managers will also allow us to examine the impact program implementation at the provider level. These intermediate, process-focused indicators will help inform providers of how implementation might be adapted to obtain the best results for their clients. The impact of dosage and other measures of fidelity will be used to predict classes or clusters of program participants demonstrated a range of success in the program as measured by the quality of life indicators and health expenditures in the previous six-months. These assessments will help identify necessary program adaptations and provide periodic updates on the health and well-being of participants.</p> <p>RQ 3A.5: Will be addressed by examining the unique classes and trajectories of program participants. It is very likely that the program will not be equally successful for all participants. Because of this, examining the subgroups defined by the classes will inform who might be the best candidate for the program. Potential predictors may include individuals' history of substance use, mental illness, trauma, or years experiencing homelessness.</p>
--	---

Project 3B: Assessing process of planning and implementing support strategies addressing social determinants of health	
Component	Description
Demonstration Hypothesis 3	Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.
Target populations	Medicaid Demonstration populations
Research questions	<p>This evaluation takes a realist evaluation approach to understanding how MQD has influenced the ecosystem of strategies and interventions that address the SDOH to ask the following contextual questions:</p> <ul style="list-style-type: none"> (1) RQ 3B.1: What kinds of support strategies and interventions addressing the social determinants are chosen by health plans and how do these strategies translate to provider and patient behaviors? (2) RQ 3B.2: In what ways did Health Plans develop and adopt a SDOH Work Plan within its Quality Assessment and Performance Improvement (QAPI) plan? (3) RQ 3B.3: In what ways did the State develop the SDOH statewide Transformation Plan?
Data Strategy, sources and collection frequency	<p>Qualitative interviews</p> <p>In-depth interviews with purposively chosen stakeholders from Health Plans, Regional Health Partnerships (if any), providers in regards to their SDOH strategies and interventions (n=25) with subsequent thematic analysis using grounded theory,</p>

	and review of MQD-provided documentation including meeting minutes, SDOH methodology, and capitation methodology.
Statistical framework for measuring impacts	Not applicable
Subgroup analyses to assess disparities and differences	Not applicable

Supplemental Evaluation Objective (Objective 4): Improve data quality for immunization-related performance measures

Project 4A: Improve Data Quality for Immunization-Related Performance Measures	
Component	Description
Goals and objectives	To measure progress in any area, including quality of care, that has been identified as needing improvement during the previous demonstration period. The selected area(s) for the in-depth analysis are immunization-related quality measures.
Target populations	Medicaid beneficiaries
Evaluation questions and testable hypotheses	<p>The joint MQD-Department of Health (DOH) Hawai'i Immunization Registry (HIR) project will increase the accuracy and completeness of childhood immunization data for Hawai'i Medicaid beneficiaries and increase childhood immunization coverage for Hawai'i Medicaid beneficiaries.</p> <p>(a) RQ 4A.1: Will the MQD-DOH HIR project increase the accuracy and completeness of childhood immunization data for Hawai'i Medicaid beneficiaries, as determined by comparison of coverage estimates from three sources: MQD beneficiary data system, DOH immunization data system, and linked MQD-DOH HIR data system?</p> <p>(b) RQ 4A.2: Will the MQD-DOH HIR project increase childhood immunization coverage for Hawai'i Medicaid beneficiaries, as determined by comparison of coverage estimates from prior years and quantification of increase in coverage estimates?</p>
Data strategy, sources and collection frequency	Various clinical and administrative data sources. Linked HIR and Administrative data, in combination with Health Plan data. Immunization data from a variety of sources (health plan records, HIR, and administrative data including claims, encounters, and beneficiary-level reports) will be used to track improvements in immunization rates for various childhood immunizations.
Measures	Immunization rates for various vaccines, and combination immunization rates as reported in quality measures reported in CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP.
Statistical framework for measuring impacts	Quantitative impact analysis. A single subject analysis design, time series analyses models will be used to evaluate changes in immunization rates across multiple immunizations included within the Childhood Immunization Status measure, comparing a time period prior to the re-build of the HIR to the period after the HIR has been built, and appropriate linkages and data exchange built to the health plans and MQD to assess the extent to which the investment in the HIR, and support for automated electronic data exchange, has improved the quality of immunization data for MQD beneficiaries.

Subgroup analyses to assess disparities and differences	As needed
---	-----------

V. Attachments

Independent Evaluator

In July 2019, MQD established the Health Analytics Office (HAO). Prior to HAO's establishment, encounter data quality validation, analytics, reporting, quality measurement, evaluation were dispersed throughout the division. The office now centralizes these functions, and maintains oversight of the required evaluation of the Demonstration. The independent evaluation of the project will be managed via a contract with the University of Hawai'i at Manoa.

The State of Hawai'i has developed a Memorandum of Agreement (MOA) with the University of Hawai'i at Manoa, College of Social Sciences. The MOA, approved in June 2019, provides a framework for the State to procure services and consultation from the University of Hawai'i College of Social Sciences via a "Work Task Letter" arrangement. The MOA names the Office for Evaluation and Needs Assessment Services (OENAS) in the Social Science Research Institute, College of Social Sciences, as the evaluator for the Demonstration.

The Director of OENAS, Dr. John Barile, is the lead evaluator on the Demonstration, and will serve as the Independent Evaluator. Dr. Barile has over 15 years of experience evaluating health-related programs and well published in the areas of social service delivery, quality of life, and program impact. Members of the evaluation team are also in tenured faculty positions at the University of Hawai'i and external to the State Department of Human Services. Their backgrounds are in health policy, health economics, quantitative research methods, and statistical modeling.

Evaluation Budget

The five-year evaluation budget totals \$2,452,500, which includes direct costs of \$1,962,000 and indirect costs of \$490,500 (25% indirect cost rate). A 4% increase is built in each year for salary and other cost-of-living increases. The year one budget (including indirect costs) is \$145,525, year two is \$556,435, year three is \$569,620, year four is \$583,330, and year five is \$597,590. After year one, which will be primarily devoted to planning and designing the evaluation, subsequent years include funds for two research associates and six graduate assistants. Summer overload (1 month) is included for four faculty evaluators over the five-year period. Funds to support travel to professional Medicaid-related conferences and to purchase software, hardware, and supplies are also included. These expenses are necessary to support all aspects of the evaluation, such as project administration, development of instruments to support primary data collection efforts, such as surveys and interviews, accessing administration data, data cleaning and analyses, and report generation.

Timeline and Major Milestones

The proposed timeline below is shown separately for administrative deliverables and project or research deadlines.

Administrative activities (evaluation)	Date
Draft evaluation design to CMS	November 8, 2019
Feedback and comments from DHS	November 15, 2019
Second Draft to DHS	December 17, 2019
Feedback and comments from DHS	January 10, 2020
Third draft to DHS	January 31, 2020
Leadership feedback from DHS	February 28, 2020
Final draft to DHS	March 15, 2020
Submission of Evaluation Design Draft to CMS	April 8, 2020
Feedback from CMS	June 10, 2020
Revised draft to DHS	July 10, 2020
Feedback and comments from DHS	July 17, 2020
Revised draft to DHS (2)	July 24, 2020
Any Final revisions	July 25-July 31, 2020
Final Evaluation Design to CMS	July 31, 2020
Evaluation activities	Date
Initial access to data/data preparation/cleaning	Year 2 (Aug. 2020-Aug. 2021)
Preparation of instruments for primary data collection (e.g., survey construction)	Year 2, 2 nd quarter
Pilot testing of instruments	Year 2, 3 rd quarter
Preliminary testing of statistical models and analytic approaches	Year 2, 4 th quarter
Administration of instruments for primary data collection	Final quarters of Years 2 and 3
Rapid cycle assessments (for CIS/CTS)	Every 3 months, from Y2 to Y4
Data analyses, modeling	Year 3-4
Report writing (including revisions to drafts)	Year 4
Renewal Submitted	July 31, 2023
Summative Report	January 31, 2025

VI. References

- Barile, J. P., Horner-Johnson, W., Krahn, G., Zack, M., Miranda, D., DeMichele, K., Ford, D., & Thompson, W. W. (2016). Measurement characteristics for two health-related quality of life measures in older adults: The SF-36 and the CDC Healthy Days items. *Disability and Health Journal*, 9, 567-574.
- Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 24, 385–396.
- Cohen, S., & Williamson, G. (Eds.). (1988). Perceived stress in a probability sample of the United States. Newbury Park, CA: Sage.
- Cohen, S., Tyrrell, D. A., & Smith, A. P. (1993). Negative life events, perceived stress, negative affect, and susceptibility to the common cold. *Journal of Personality and Social Psychology*, 64(1), 131-140.
- Centers for Disease Control and Prevention. (2000). Measuring Healthy Days. Unpublished manuscript, Atlanta, GA.
- Kushel, M. B., Gupta, R., Gee, L., & Haas, J. S. (2006). Housing Instability and Food Insecurity as Barriers to Health Care Among Low-Income Americans. *Journal of General Internal Medicine* 21(1),71-77.
- MedQUEST Division (2017). *Hawai'i Medicaid Ohana Nui Project Expansion (HOPE) Project*. Honolulu.State of Hawai'i Department of Human Services Med-Quest Division. (2018). *QUEST Integration 1115 Waiver Extension Application*. Honolulu.
- Moriarty, D. G., Kobau, R., Zack, M. M., & Zahran, H. S. (2005). Tracking Healthy Days – a window on the health of older adults. *Preventing Chronic Disease*, 2(3), A16.
- Moriarty, D. G., Zack, M. M., & Kobau, R. (2003). The Centers for Disease Control and Prevention's Healthy Days Measures - population tracking of perceived physical and mental health over time. *Health and Quality of Life Outcomes*, 1, 37.
-

Appendix 1: Overview of Objectives, Hypotheses, Projects and Research Questions

Demonstration Objectives	Demonstration Hypotheses	Key Evaluation Projects	Project Specific Research Questions
1. Improve health outcomes for Medicaid beneficiaries covered under the Demonstration	H1.1: Increasing utilization for primary care, preventive services, and health promotion will reduce prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.	Project 1A: Assessing Utilization, Spending, and Quality of Primary Care and its Association with Health Outcomes	<p>RQ 1A.1: What are time trends in utilization, spending (as a percentage of total spending), and quality of primary care for Demonstration populations?</p> <p>RQ 1A.2: Are changes in primary care utilization and spending associated with plausibly relevant health outcomes?</p>
	H1.2: Improving care coordination (e.g. by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for beneficiaries with complex conditions (i.e. high-needs, high-cost individuals).	Project 1B: Care Coordination for Beneficiaries with Complex Conditions	<p>RQ 1B.1: Will care coordination for individuals identified as having complex health needs result in improved health outcomes?</p> <p>RQ 1B.2: Will care coordination for individuals identified as having complex health needs result in lowered utilization of the healthcare system, and a slower rate of expenditure growth?</p>
		Project 1C: Home- and Community-Based Services (HCBS)	<p>RQ 1C.1: Does HCBS slow the deterioration of health as reflected in the level of care among individuals meeting NF LOC criteria?</p> <p>RQ 1C.2: Does length of time to enter a nursing home, patient-reported health outcomes (PROs), and total cost of care vary depending on a variety of client characteristics among individuals meeting NF LOC criteria and receiving HCBS services?</p> <p>RQ 1C.3: Does length of time to enter a nursing home, PROs, and total cost of care vary depending on a variety of client characteristics among the at-risk population?</p>

2. Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth	H2: Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the MCO level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.	Project 2A: Value-based purchasing (VBP) reimbursed at the MCO and Provider levels	<p>RQ 2A.1: Will implementing VBP reimbursements at the MCO level result in improved health outcomes?</p> <p>RQ 2A.2: Will implementing VBP reimbursements at the MCO level result in lowered utilization of the healthcare system and a slower rate of expenditure growth?</p>
		Project 2B: Alternative Payment Models (APM) at the Provider level	<p>RQ 2B.1: Will implementing one or more APMs at the provider-level result in improved health outcomes?</p> <p>RQ 2B.2: Will implementing one or more APMs at the provider-level result in lowered utilization of the healthcare system and a slower rate of expenditure growth?</p>
3. Support strategies and interventions targeting the social determinants of health	H3: Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.	Project 3A: Community Integration Services (CIS)	<p>RQ 3A.1: Do program participants who are stably housed decrease utilization of acute services (emergency and inpatient utilization)?</p> <p>RQ 3A.2: Do program participants who are stably housed increase utilization of outpatient care services?</p> <p>RQ 3A.3: Is total cost of care will be lower for participants who are stably housed?</p> <p>RQ 3A.4: Does individual health and wellbeing will improve as participants' progress through the program?</p> <p>RQ 3A.5: How does program effectiveness vary by client needs and experiences?</p>
		Project 3B: Assessing process of planning and implementing support strategies addressing social determinants of health	RQ 3B.1: What kinds of support strategies and interventions addressing the social determinants are chosen by health plans and how do these strategies translate to provider and patient behaviors?

			<p>RQ 3B.2: In what ways did Health Plans develop and adopt a SDOH Work Plan within its Quality Assessment and Performance Improvement (QAPI) plan?</p> <p>RQ 3B.3: In what ways did the State develop the SDOH statewide Transformation Plan?</p>
<p>4. (Supplemental Evaluation Objective) Improve data quality for immunization-related performance measures</p>		<p>Project 4A: Improve Data Quality for Immunization-Related Performance Measures</p>	<p>RQ 4A.1: Will the MQD-DOH HIR project increase the accuracy and completeness of childhood immunization data for Hawai'i Medicaid beneficiaries, as determined by comparison of coverage estimates from three sources: MQD beneficiary data system, DOH immunization data system, and linked MQD-DOH HIR data system?</p> <p>RQ 4A.2: Will the MQD-DOH HIR project increase childhood immunization coverage for Hawai'i Medicaid beneficiaries, as determined by comparison of coverage estimates from prior years and quantification of increase in coverage estimates?</p>

Attachment A

HAWAII MEDICAID OHANA NUI PROJECT EXPANSION (HOPE) PROJECT

MED-QUEST DIVISION

JUDY MOHR PETERSON, PHD

MED-QUEST ADMINISTRATOR



EXECUTIVE SUMMARY

Hawaii's Vision for Health Care Transformation: Hawai'i 'Ohana Nui Project Expansion (HOPE) Program

The Med-QUEST Division (MQD) is committed to laying the foundation for innovative programs that support and create healthy families and healthy communities. To accomplish this goal, MQD is building the Hawai'i 'Ohana Nui Project Expansion (HOPE) program, a five-year initiative to develop and implement a roadmap to achieve this vision of healthy families and healthy communities.

MQD's vision is that the people of Hawai'i embrace health and wellness. MQD's mission is to empower Hawai'i's residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha. The vision and mission will serve as the "North Star" and guide the work developed through HOPE.

The following guiding principles describe the overarching framework that will be used to develop a transformative healthcare system that focuses on healthy families and healthy communities.

- Assuring continued access to health insurance and health care.
- Emphasis on whole person and whole family care over their life course.
- Address the social determinants of health.
- Emphasis on health promotion, prevention and primary care.
- Emphasis on investing in system-wide changes.
- Leverage and support community initiatives.

In order to accomplish the vision and goals, HOPE activities are focused on four strategic areas.

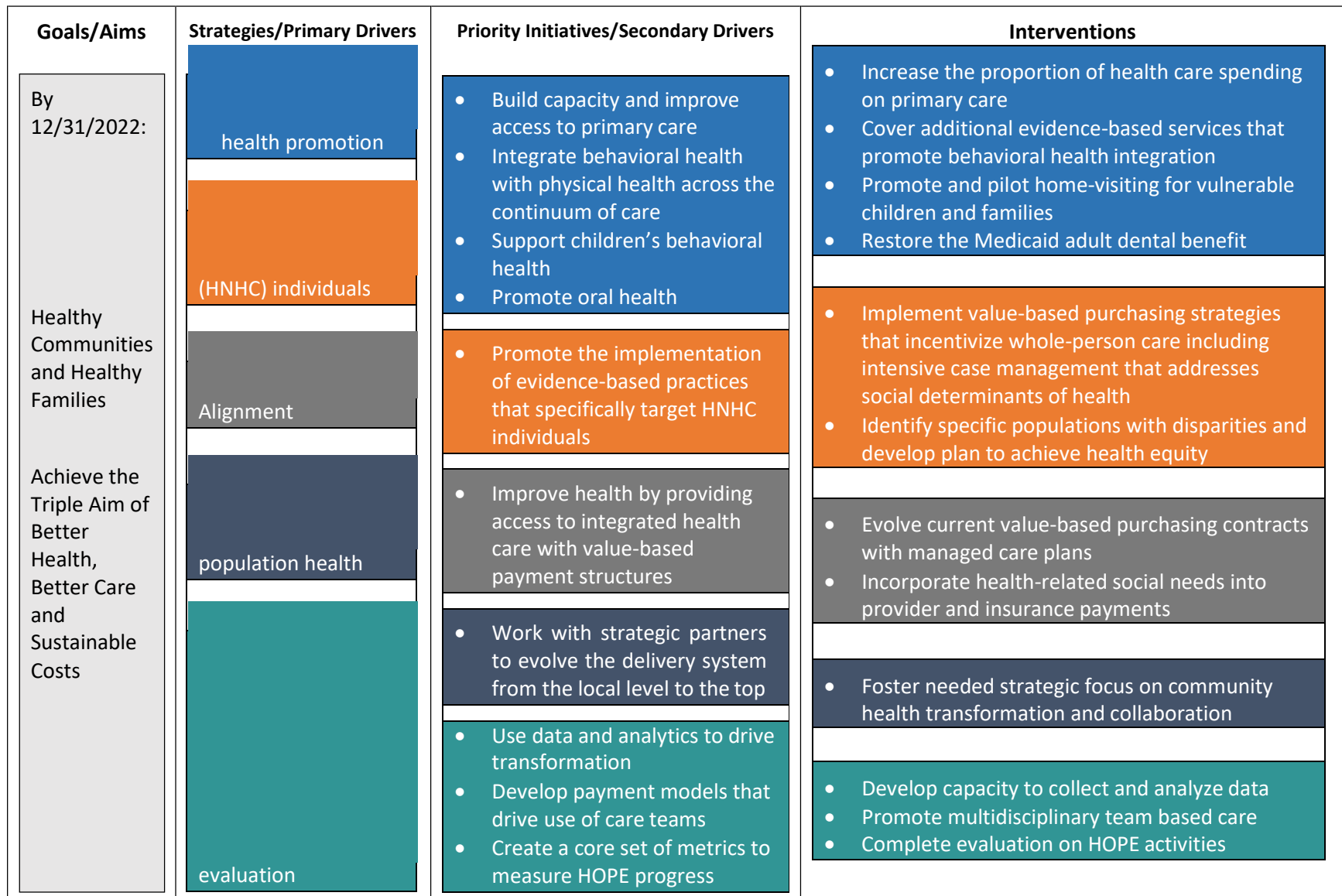
- Invest in primary care, prevention, and health promotion.
- Improve outcomes for high-need, high-cost individuals.
- Payment reform and alignment.
- Support community driven initiatives to improve population health.

In addition, HOPE activities are supported by initiatives that enhance three foundational building blocks.

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

MQD developed a driver diagram that depicts the relationships between the guiding principles, strategies and building blocks that enable MQD to achieve the vision of healthy families and healthy communities (see Figure 1).

Figure 1. Hope Driver Diagram



HAWAI'I MEDICAID 'OHANA NUI PROJECT EXPANSION (HOPE) PROJECT

The State of Hawaii's Vision for Healthy Families, Healthy Communities

The Hawai'i Department of Human Services (DHS) is committed to laying the foundation for innovative programs and models that support and create healthy families and healthy communities. To accomplish this overall goal it is necessary to align state programs and funding around a common framework: a multigenerational, culturally appropriate approach that **invests in children and families over the life-cycle to nurture well-being and improve individual and population health outcomes**. This is why the Med-QUEST Division (MQD) of DHS is building the Hawai'i 'Ohana Nui Project Expansion (HOPE) program, a five-year initiative to develop and implement a roadmap to achieve this vision of healthy families and healthy communities.

SECTION 1: VISION AND BACKGROUND

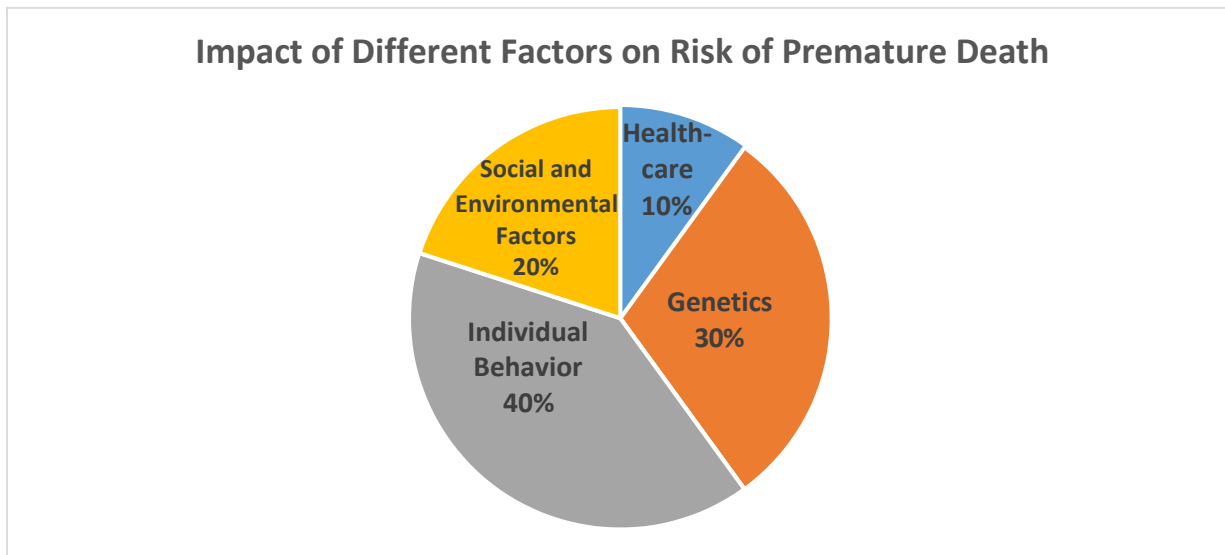
The Vision and Mission of Med-QUEST

MQD's vision is that the people of Hawai'i embrace health and wellness. MQD's mission is to empower Hawai'i's residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha. The vision and mission will serve as the "North Star" and guide the work developed through HOPE.

Drivers of Health and Well-Being

Efforts to improve health in the United States have almost exclusively focused on the health care system as the key driver of health and health outcomes. While reforms to the health care system are necessary and important, research has demonstrated that improving population health and achieving health equity also require broader approaches that address social, economic, and environmental factors that influence health.ⁱ Researchers have found that social factors, including education, social supports, and poverty accounted for over a third of total deaths in the United States.ⁱⁱ In addition, individual behaviors (i.e. smoking, diet and drinking) and genetics play a role in health and health outcomes. **It is estimated that health care only accounts for 10% of risk of premature death** (see Figure 1). For this reason, the focus of the HOPE efforts will include health care system redesign as well as strategies to address the health-related social needs and individual behaviors that influence health and well-being.

Figure 2ⁱⁱⁱ



The Goals of the HOPE Initiative

The goal of the plan is to achieve the Triple Aim of **better health, better care, and sustainable costs for our community**. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being, measurably lower prevalence of illness, and a more sustainable growth rate in healthcare spending. The goal is to bring the growth of health care spending more closely in line with the growth of our economy, so that we can invest a greater share of our productivity gains in education, housing and other priorities that have an even greater impact on health and well-being than the Medicaid delivery system.

More specifically, the goals include:

Improved Health	Better Health Care and Consumer Experience	Lower Costs
<p>Achieve or maintain top-quartile performance among states for adoption of best practices for outcomes in:</p> <ul style="list-style-type: none"> Health Wellness Health promotion Disease prevention Health improvement Health-related social needs. 	<p>Achieve high standards for quality and patient experience, including at least:</p> <ul style="list-style-type: none"> A X% (percent TBD) reduction in the risk factors associated with chronic conditions An increase in appropriate utilization of behavioral health services Decrease in preventable utilization for individuals with chronic conditions. 	<p>Generate \$X (number TBD) in cumulative savings by:</p> <ul style="list-style-type: none"> Reducing unnecessary care Shifting care to appropriate settings Curbing increases in unit prices for health care products and services that are not tied to quality.

The Need for Innovation and Change

Although Hawai'i is considered one of the healthiest states in the country in many areas, there is room for continued development.^{iv,v} Hawai'i, like all other states, is experiencing unsustainable increases in health costs, increasing morbidity from costly chronic diseases and behavioral health conditions, uneven access to care, and limited availability of health data and analytics. It is for this reason that MQD is pursuing this initiative to advance statewide innovation to strengthen population health, transform the health delivery system, and achieve the Triple Aim of better health, better care, and sustainable costs. MQD is a critical part of the health care system, and MQD will play a leadership role in health care transformation. **However, it is important to note that system transformation is only possible when patients, the community, health care providers, health plans, payers and other stakeholders work together to achieve transformation.**

Why We Need to Act Now

Despite being the healthiest state in the nation^{vi,vii}, the following information reflects the severity of the issues that individuals and families are experiencing and further demonstrating the need for action to bring about change and transform the health system now.

Table 1: Rationale for Transforming Health Care in Hawai'i

Prevalence of Chronic Diseases	<ul style="list-style-type: none">• There has been a 128% increase in the prevalence of diabetes in Hawai'i over the last 20 years (from 4.6% in 1997, to 7.6% in 2005, to 10.5% in 2017).^{viii}• There has been a 84% increase in the percentage of obese (Body Mass Index of 30 or higher) adults in the state over the past two decades (from 12.97% in 1997, to 20.6% in 2007, to 23.8% in 2017).^{ix}
Prevalence of Behavioral Health Conditions and Associated Costs	<ul style="list-style-type: none">• In 2013, results from the Hawai'i Behavioral Risk Factor Surveillance System (BRFSS) survey showed that prevalence for depression among adults increased by 12.7% from 2011 to 2013, with 11.4% (or 125,000 residents in the State) reporting a depressive disorder in 2013.^x• Suicide is the leading cause of death in young people ages 15 through 24, with the rate of suicide more than doubling between 2007 and 2011.^{xi}• More than one in ten (13%) of Native Hawai'i and Pacific Islander high school students attempted suicide one or more times in the previous year, the highest proportion among all racial groups.^{xii}

	<ul style="list-style-type: none"> • The average annual number of drug overdoses nearly doubled from the 1999-2003 period to the 2009-2017 period, and opioid pain relievers such as oxycodone or hydrocodone contributed to more than one third of drug overdose deaths.^{xiii} • Drug overdoses surpassed motor vehicle traffic crashes as the leading cause of fatal injuries.^{xiv} • A 2013 actuarial analysis in Hawai'i found that the average total health care costs for individuals with a behavioral health diagnosis was three times the average total health care cost for those without a behavioral health diagnosis. • Our 2017 actuarial analyses found that individuals facing homelessness had significantly higher costs due to co-morbidities of behavioral health, complex health conditions with intensive social needs. • An analysis by the Hawai'i Health Information Corporation (HHIC) of 2012 statewide data showed that 34% of hospitalizations and 36% of total costs were attributable to individuals with a comorbid behavioral health and physical diagnosis.
Pregnancy	<ul style="list-style-type: none"> • Substance use among pregnant women in Hawai'i is higher than national targets, which reflect there is essentially no acceptable rate of use of these substances. Hawai'i data shows that 5.9% of women reported drinking alcohol in the last trimester of their pregnancy, 8.6% reported cigarette smoking in the last trimester, and 3% reported using illicit drugs during their latest pregnancy.^{xv} • Although teen pregnancy rates have declined in recent decades, the United States rate is still one of the highest in the developed world. Hawai'i ranks 30th in teen pregnancy rates (rank of 1 is the lowest and 50th is the highest).^{xvi}
High Costs	<p><i>Hawai'i-Specific Data on High Costs</i></p> <ul style="list-style-type: none"> • Health care expenditures in Hawai'i increased by almost 40% between 2004 (\$6,391 million) and 2014 (\$10,338 million).^{xvii} • Health premiums in Hawai'i increased from \$1.2 billion in 1995 to \$6.3 billion in 2015, an average increase of 20% each year.^{xviii} Hawai'i health premiums are an increasing percentage of wages, growing from 2.8% in 1974 to 14.7% in 2015.^{xix} • From 2010 to 2015, the small group health premiums in Hawai'i increased each year on average of 6%, and increased 7.5% on average from 2013 through 2015.^{xx}

	<p><i>National Data on High Costs</i></p> <ul style="list-style-type: none"> • United States health care spending increased 4.3% to reach \$3.3 trillion, or \$10,348 per person in 2016.^{xxi} National health spending is projected to grow at an average rate of 5.6% per year for 2016-2025, and 4.7% per year on a per capita basis.^{xxii} • Between 2002 and 2012, U.S. health insurance premiums increased 97 percent, three times as fast as wages (33 percent) and inflation (28 percent).^{xxiii} • U.S. covered workers' average dollar contribution to family coverage has increased 74% since 2007 and 32% since 2012.^{xxiv} <p><i>Medicaid Cost Data – Hawai'i and National</i></p> <ul style="list-style-type: none"> • Medicaid makes up 16% of Hawaii's total state expenditures, and 11% of the state's general funds. • Hawai'i general fund expenditures for the state increased by 7.3% and 8.8% from fiscal years 2015-2016 and 2016-2017. Medicaid state fund expenditures increased by 6.3% and 12.3% during the same time period. While this is largely due to increase enrollment, increasing healthcare costs are also part of the increasing trends. • On a national level, Medicaid has grown from about 20% of total state spending to 29% of total state spending for 2017.^{xxv} Excluding federal funds, Medicaid was nearly 17% of state fund expenditures, or a 7.1% increase in state fund spending.^{xxvi} Combined federal and state expenditures for Medicaid accounted for about 16% of U.S. health care spending in calendar year 2014.^{xxvii}
--	--

SECTION II: FRAMEWORK FOR INNOVATION

MQD's Guiding Principles to Innovation

The following guiding principles describe the overarching framework that will be used to develop an innovative, transformative, healthcare system that focuses on healthy families and healthy communities. The framework's foundation is building multi-generational, culturally appropriate approaches that invest in children and families over their life course to nurture well-being and improve individual and population health outcomes.

1. Assuring Continued Access to Health Insurance and Health Care.

Hawai'i has a long history of prioritizing health coverage and quality healthcare for our residents. We expanded to low-income adults over twenty years ago, and welcomed the Affordable Care Act's further expansion. MQD will continue to support Hawaii's commitment to health care coverage for all our population through outreach efforts in the communities, partnering with communities and other agencies so that individuals and families continue to have health coverage when transitioning from one life circumstance to another, specifically targeting individuals with serious mental illness, economic vulnerabilities and behavioral health challenges.

2. Emphasize Whole Person and Whole Family Care over their Life Course. 'Ohana Nui –Focus on Young Children and their Families.

Whole person care is person-centered and person-engaged throughout the life cycle. Aligning with the social model, home and community-based services that emphasize choice, autonomy and living as independently as possible, it has been demonstrated that a person-centered approach that promotes person's engagement through mutual respect and responsibility leads to improved health outcomes and well-being. Patient engagement is the flip side of "compliance/adherence". Hawaii's Self-Advocacy Advisory Council's slogan succinctly captures this concept: "don't 'should' on me, ask me". HOPE will promote evidence-based practices that activate and engage individuals, families and communities in their own health and health care.

Whole person care also focuses on the person's over-all well-being, and does not silo one into a specific disease or body part. Thus, both the head and the body are one when considering one's health. The mental and oral health viewed in an integrated way with the rest of the body. Physical health and behavioral health need to be integrated in a whole-person perspective. Additionally, a person's larger context is also taken into consideration for one's well-being. Thus, the social determinants of health are essential.

Whole family care views individuals in the context of their family and/or social networks, which is a major driver of health. In Hawai'i, using *'Ohana Nui*, or investing in young children and their families, is imperative to community health and well-being. Investing in children helps children to develop to their full potential, and taking care of the health needs of children yields positive benefits to economies and societies. It is especially important to invest in young children during their most critical period of development and growth (ages 0 to 5). Using a multi-generational life-cycle approach to service delivery is more effective than one that separately addresses individuals' needs. This includes the five pillars that create an intergenerational cycle of opportunity (social capital, early childhood education, postsecondary and employment pathways, health and well-being, and economic assets). As with a whole-person perspective, these pillars are also integral social determinants of health.

3. Address the Social Determinants of Health (SDOH).

There is a growing body of research that shows a broad range of social, economic, and environmental factors shape individuals' opportunities and barriers to engage in health behaviors. Social determinants of health, also known as health-related services, are the structural determinants and conditions in which people are born, grow, live, work and age (see Figure 3).^{xxviii} **MQD's approach to addressing these broader determinants of health is to develop integrated solutions within the context of the health care delivery system.** More specifically, MQD will develop initiatives that link health care to broader social needs, and promote and incentivize health systems and providers to coordinate and integrate the delivery system with community services, education, social services, and public health so individuals and families can receive the services that improve their health and well-being.

4. Emphasis on Health Promotion, Prevention and Primary Care

According to the World Health Organization, 80% of chronic diseases are preventable.^{xxix} The major contributors to chronic disease are an unhealthy diet, lack of physical activity, and tobacco use. Lifestyle choices have more impact on health and longevity than any other factor. Prevention and health promotion should be woven into all aspects of our lives, including where and how we live, learn, work, play and pray. Everyone, including government, health care institutions, and individuals have a role in creating healthier families and communities. **In other words, health is everyone's "kuleana", or responsibility.** Initiatives included in HOPE emphasizes the importance of health promotion, prevention, and early detection of disease by encouraging and incentivizing providers to screen and educate individuals and families on the impact of lifestyle choices on health. MQD will promote best practice models of care that emphasize care coordination across providers and have robust primary care capabilities at their center. Additionally, focus on more convenient access to routine primary and preventive services.

5. Emphasis on Investing in System-Wide Changes.

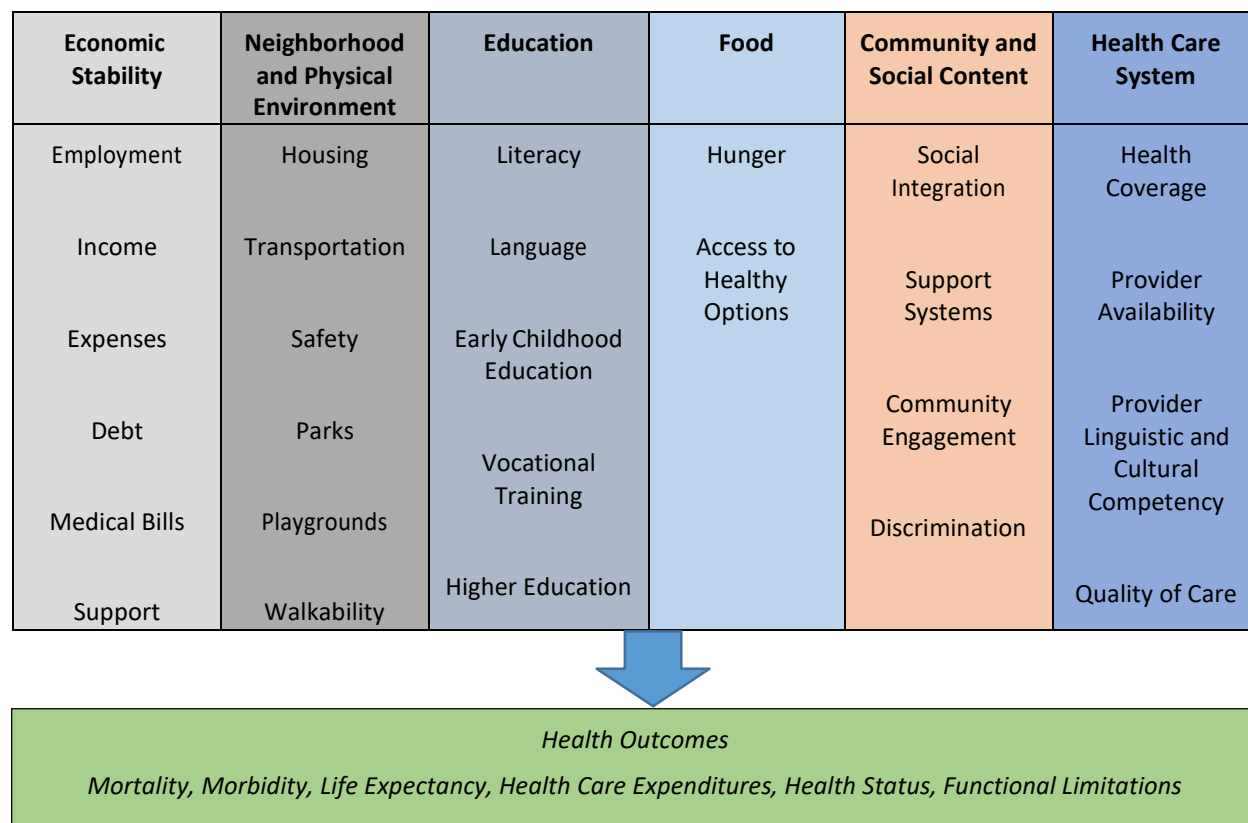
There is great potential for improving outcomes and saving money in healthcare reform, but efforts will not fully achieve the Triple Aim if they are not well targeted or if they are included as incremental or "add-on" steps in the context of a fragmented health care system with perverse financial incentives. The system-wide initiatives that are chosen to be a part of HOPE will integrate the system and focus on adaptive solutions rather than technical fixes. From a systemic, transformative lens, we will address quality of care, improve collaboration and coordination, and reform how services are paid for, resulting in achieving the Triple Aim goals of improved health outcomes, improved care and sustainable costs. This will require strong partnerships across agencies, the delivery system, payers and social/human service providers. Additionally, HOPE initiatives will help lay the foundation for potential future comprehensive multi-payer initiatives (e.g. Medicare/Medicaid). In order for comprehensive healthcare delivery system transformations to occur, it is imperative that multiple payers and delivery systems work together to accomplish the goals.

6. Leverage and Support Community Initiatives.

While taking a systemic, transformative approach is necessary for innovation, those changes are rooted in local, community efforts. Community care includes viewing the community in context of the environment, local initiatives and engagement with the community, and a recognition that where we live, work, play and pray has an impact on health and well-being. The island geography of our state has given rise to great diversity at the local community level of social capital and health assets as well as unique needs. It is essential that HOPE build on and support culturally appropriate and effective initiatives, improve health equity, and reduce health and geographic disparities.

Hawai'i has a long tradition of developing innovative health programs and policies at the local level. Many health plans, providers and community organizations are developing innovative programs and initiatives, and MQD will leverage these initiatives in HOPE in order to advance innovation and avoid duplication of effort. Examples of some of the community initiatives that support HOPE goals includes the Blue Zones project,^{xxx} MAHIE 2020,^{xxxi} Community First,^{xxxii} and the United Health Care Services' Accountable Health Communities Model.^{xxxiii} Additionally, many community health centers in Hawai'i have invested in serving their communities in new and innovative ways such as supporting local job skills development and facilitating access to culturally relevant fresh food and meals.

Figure 3. Social Determinants of Health/Health-Related Services^{xxxiv}



Strategies and Foundational Building Blocks

In order to accomplish the vision and goals, HOPE activities are organized along two major axes: (1) four strategic focus areas, which include multiple targeted initiatives to promote integrated health systems and payment reforms, and (2) three foundational building blocks, which directly support the four strategies and also enhance overall system performance.

The first two strategies reflect the short and long term investments needed to accomplish the Triple Aim. The first strategy is focused on investing in primary care, health promotion, and prevention early in one's life and over one's life. The second strategy is focused on people with the highest, most complex health and social needs because they use a majority of health care resources, and there is potential for a strong return on investment. The health and well-being of individuals with complex needs must be addressed in order to begin to bend the cost curve, and the savings accrued will be used to support the sustainability of HOPE initiatives including investments in primary care, children, and health-related services.

The third strategy reflects the need to pay for care differently. The focus is to move away from rewarding volume toward accountability for overall cost and quality that is essential for supporting the integrated delivery system reforms identified in the first two strategies. The fourth strategy reflects MQD's commitment to invest in community care, support community initiatives, and develop initiatives that link integrated health systems with community resources in order to improve population health.

The foundational building blocks of health information technology, workforce development and performance management and evaluation are critical to the success of the four strategies. Each strategy requires development to enhance system performance in each of the foundational building blocks on the provider level, MCO level, and at the Med-QUEST administrative level.

Figure 4: HOPE Project Summary

HOPE PROJECT SUMMARY				
Goals	Healthy Families and Healthy Communities and Achieving the Triple Aim – Better Health, Better Care, Sustainable Costs			
Strategies	1. Invest in primary care, prevention, and health promotion	2. Improve outcomes for High-Need, High-Cost Individuals	3. Payment Reform and Alignment	4. Support locally driven initiatives to improve population health
Foundational Building Blocks	1. Use health information technology to drive transformation			
	2. Increase workforce capacity			
	3. Performance measurement and evaluation			

STRATEGY #1: INVEST IN PRIMARY CARE, PREVENTION AND HEALTH PROMOTION

In order to achieve HOPE goals, Hawai'i needs to close the gaps between prevention, primary care, and physical and behavioral health care. The goal is to improve health overall by building healthy communities and individuals through prevention, health promotion, and early mitigation of disease throughout the life course. MQD plans to achieve this with four priority initiatives: (1) Invest in Primary Care, (2) Promote Behavioral Health Integration, (3) Support Children's Behavioral Health, and (4) Promote Oral Health and Dental Care.

PRIORITY INITIATIVE: INVEST IN PRIMARY CARE

Primary care is in a critically important position in the health care delivery system because of its focus on prevention and early mitigation of diseases throughout the life course. Primary care teams are often patients' first point of contact with the health delivery system, and make decisions that have a major impact on quality of care and total health care spending. Greater use of primary care has been associated with lower costs, higher patient satisfaction, fewer hospitalizations and emergency departments visit, and lower mortality.^{xxxv} Further, underinvestment in primary care is one of four fundamental reasons that the U.S. health system ranks last among high-income countries.^{xxxvi}

Despite the strong evidence that primary care is critical to achieving the Triple Aim, primary care faces many challenges. Fragmented systems and policies make it difficult to coordinate care with specialists and social service organizations, burdensome administrative requirements result in primary care providers not spending enough time with patients, and reimbursement encourages primary care practices to adopt volume-based (as opposed to outcome-based) business and care models. These and other factors contribute to low job satisfaction and burnout, patients not getting the care they need, unsustainable increases in health expenditures, and consequently, is stifling the development of innovative approaches to primary care delivery.

MQD is committed to investing in primary care and is exploring the following innovations:

- Increase the proportion of health care spending on primary care in order to promote the health system's orientation toward high-value care. The spending rate includes clinician incomes, performance payments, case-management activities, and health information technologies.
- Promote primary care and pay for value. Hawai'i will request to advance the use of value-based payments to MCOs. MQD will request to provide new performance incentive payments to primary care providers.
- Continue to maintain an increase in reimbursement to primary care providers and obstetricians (aka the "PCP bump"), even though the enhanced match rate that initially supported the increase are no longer available.
- Cover additional evidence-based practices that further integrate physical and behavioral health services such as the Collaborative Care Model.

- Promote best practices that address the needs of High-Need, High-Cost individuals (i.e. care coordination, palliative care, Dr. Ornish’s Program for Reversing Heart Disease).
- Promote education opportunities for primary care teams such as Project Extension for Community Healthcare Outcomes (ECHO) and care collaboratives.
- Work with stakeholders to identify and facilitate shared workforce resources, including but not limited to, community health workers, care managers, and care coordinators, especially for neighbor islands.
- Promote increased investments in health related and flexible services.
- MCOs will be encouraged to invest in health-related social needs and services that improve quality and outcomes, and MCOs that reduce costs through the use of these services can receive financial incentives to offset those cost reductions.

PRIORITY INITIATIVE: PROMOTE BEHAVIORAL HEALTH INTEGRATION ACROSS THE CONTINUUM

Behavioral health integration has been a priority for MQD for the past few years and will continue to be a top priority. The rationale for this includes:

- Medicaid pays for 26% of all spending on behavioral health in the country.^{xxxvii}
- Individuals with a behavioral health conditions cost nearly four times more than individuals without behavioral health conditions.^{xxxviii}
- One in five Medicaid enrollees have a behavioral health condition, but account for almost half of total Medicaid expenditures.^{xxxix}
- Disparities: Those with serious mental illness die on average 25 years earlier than those without, largely because of preventable chronic physical illness.^{xi}
- There is a large body of evidence showing that patients fare best when their physical and behavioral health needs are addressed in tandem.^{xii}
- Integrated care better aligns system incentives and increases health plan or provider accountability for managing a more complete range of services, which is important for a population with high comorbidity rates.^{xiii}

The overarching goals are to integrate behavioral health (mental health and substance use) with physical health at the primary care level, through the continuum to the most intensive level for individuals with complex conditions and health-related social needs (the later will be addressed in strategy #2). Other goals include integrating care with value-based payment structures, and screening, diagnosing, and treating conditions as early as possible. To achieve these goals, MQD is exploring the

following options:

- Identification of activities and processes necessary to achieve a foundational level of behavioral health integration emphasizing best practices that are scalable.
- Payment to primary care providers and members of the multidisciplinary team for providing integrated services using the Collaborative Care Model and other evidence-based integration models.
- Address gaps in provider education and curriculum by promoting psychiatric hotline services (aka “curbside consults”), and continuing education opportunities such as Project ECHO.
- Development of health homes that integrate behavioral health with primary care for children and families, adults, and aged individuals.
- Developing payment models that reward health plans and providers for integrating care at the most intensive level for individuals with complex conditions and health-related social needs.
- Identify specific populations (i.e. racial/ethnic, geographic, etc.) that have experienced disproportionately poor health outcomes and develop a plan to improve outcomes and achieve health equity.
- Continue to promote Screening, Brief Intervention, and Referral to Treatment (SBIRT) at the primary care level to address substance misuse and abuse, motivational interviewing, Housing First for the chronic homeless, and transitions of care models.
- Expand behavioral health services integration through partnerships with primary care providers, corrections, and other community-based organizations.

PRIORITY INITIATIVE: SUPPORT CHILDREN’S BEHAVIORAL HEALTH

Children’s Behavioral Health will include all of the activities listed in the behavioral health integration project, and will include additional activities:

- Promotion of the importance of screening young children for developmental and behavioral health conditions, including social-emotional development.
- Promoting and piloting home-visiting for vulnerable families and children who experienced multiple adverse childhood experiences (ACE).
- Continue to work with the Department of Education and the DOH including the Early Intervention Section, Children with Special Health Care Needs Branch, the Communicable Disease and Public Health Nursing Division, and the Child and Adolescent Mental Health Division to coordinate services with the health care delivery system.

PRIORITY INITIATIVE: PROMOTE ORAL HEALTH AND DENTAL CARE

Improving oral health is an important step in achieving whole-person health, with research increasingly identifying links between poor oral health and physical health. These include premature birth and multiple chronic health conditions where recent studies found that treating gum disease can lead to

lower health care costs and fewer hospitalizations for pregnant women and people with type 2 diabetes, coronary heart disease, and cerebral vascular disease.^{xliii} Unfortunately, Hawai'i has received a failing grade in three recent oral health report cards for children, and some of the factors that contribute to Hawaii's oral health challenges include that the State has no public water fluoridation and that dental benefits have not been covered for adults in the Medicaid program (other than emergency care) since 2009.^{xliv} The goals are to improve oral health for pregnant women, children, and individuals with chronic conditions, and in order to achieve this, MQD is exploring the following:

- Restore the Medicaid adult dental benefit;
- Promoting good oral health to pregnant women and individuals with chronic conditions;
- Continue to promote access to children's early dental care; and
- Continue to explore and maximize oral health options using available community resources such as dental hygiene schools.

STRATEGY #2: IMPROVE OUTCOMES FOR INDIVIDUALS WITH HIGH-NEEDS AND HIGH-COSTS

The top one percent of patients account for more than 20 percent of health care expenditures, and the top five percent account for nearly half of the nation's spending on health care.^{xlv} These trends are also evident in Hawai'i. Improving care management for this population while balancing quality and associated costs will require engagement from payers, providers, patients, community leaders, and other stakeholders. This is a priority because this is a vulnerable population with complex medical, behavioral, and social needs, and there is a potential for a return on investment that may help offset upfront costs of new interventions that improve outcomes.

Recent research on High-Need, High-Cost (HNHC) individuals has identified key characteristics and care recommendations that may improve outcomes. They include^{xlvi}:

- **HNHC individuals have higher medical, social and behavioral health needs, and addressing their medical needs alone will not improve outcomes.** Therefore, it is critical that care models address the medical, social, and behavioral factors in play for a given patient.
- The HNHC population is diverse and segmenting patients based on factors that drive health care need is essential for targeting care, improving outcomes, and lowering costs.
- Policy action and care models should focus on accelerating three program attributes:
 - Managing transitions of care (i.e. from hospital to home) that are commonly risky for patients with complex conditions.
 - Extend primary care teams by integrating social services with primary care.
 - Attributes of successful interdisciplinary, person-centered primary care include careful segmentation and targeting of interventions to persons most likely to benefit, close communication and coordination among members of the interdisciplinary care team,

strong information technology support, and promotion of patient and caregiver engagement in the process.

- Policy action should also focus on addressing the existing constraints and complexities preventing the integration of medical, behavioral, and social services and the way the MQD finances this model.

The goals are to improve outcomes and decrease costs, and in order to achieve this, MQD is exploring the following:

- Work with the MCOs to develop a taxonomy that aligns HNHC individuals with care models that target their specific needs.
- Modify MCO contracts to better enable MCOs to assess behavioral health factors, social risk factors, and the functional limitations of HNHC individuals using evidence-based surveys and tools. This builds on the supportive housing for chronically homeless population 1115 waiver amendment that is currently under consideration with CMS.
- Promote and accelerate the implementation of evidence-based practices *at the point of care* that specifically targets HNHC individuals, including but not limited to, the Chronic Care Model, Collaborative Care Model, Dr. Ornish's Program for Reversing Heart Disease, coordinated care models, and other evidence-based practices that improve outcomes and decrease costs.
- Identify specific populations (i.e. racial/ethnic, geographic, etc.) that have experienced disproportionately poor health outcomes and develop a plan to improve health outcomes and achieve health equity.
- Implement value-based purchasing strategies that incentivize quality, whole-person care, including intensive care management that addresses health-related social needs.
- Implement health homes and value-based purchasing strategies for health homes that aligns with federal initiatives such as the Comprehensive Primary Care Initiative.
- Establish a small set of proven quality measures appropriate for assessing outcomes, including return on investment, and continuously improving programs for HNHC individuals at the provider level and health plan level.
- Further develop the Managed Long Term Services and Supports (MLTSS) program including identifying specific metrics and outcomes in managed care contracts.
- Explore “default enrollment” of dually eligible Medicare/Medicaid members and align Dual Eligible Special Needs Plans (D-SNP) to support continuity and alignment of care.
- Explore paramedicine programs that target HNHC individuals.
- Implementing programs that support palliative care and quality of life at the end of life. In addition, promote the utilization of Physician Orders for Life-Sustaining Treatment Paradigm Forms (POLST), which is an approach to end-of-life planning that elicits, documents and honors patient treatment wishes.

STRATEGY #3: PAYMENT REFORM AND ALIGNMENT

The Way Health Care is Delivered and Paid for Today is Unsustainable

The United States has the most expensive health system in the world. Health spending constitutes more than 18% of the economy, compared with 10% in the average industrialized nation. One of the reason the United States spends so much on health care is because of higher prices compared to other countries. The high cost would be justified if Americans received the highest-quality care and achieved the best health care outcomes. However, evidence suggests that the health care system doesn't produce higher quality care, and even lags in basic population health metrics such as infant mortality, care coordination, patient safety, and access.^{xlvii}

The Problem with the Way Health Care is Financed

There is emerging consensus among providers, payers, patients, purchasers, and other stakeholders that efforts to deliver affordable quality health care in the United States have been stymied to a large extent by a payment system that rewards providers for volume as opposed to quality.^{xlviii} Health care reform efforts that attempt to reconfigure payments to incentivize value, and ensure that valuable activities such as preventive health services and care coordination are compensated appropriately, will better enable providers to invest in care delivery systems that are more focused on patient needs and goals. **Although changes in the payment system are necessary, they are insufficient on their own unless they are aligned with delivery system transformations** which ensure the delivery of high quality care, and that health care costs reflect appropriate and necessary spending for individuals, government, employers, and other stakeholders.

Financial and Quality Alignment across Payers is Critical

New payment models require providers to make fundamental changes in the way care is provided, and the transition to new way of providing care may be costly and administratively difficult even though new payment models are more efficient over time. In order to accelerate this transition, a critical mass of public and private payers must adopt aligned approaches and send a clear and consistent message that payers are committed to a person-centered health system that delivers the best health care possible. **Aligned payment approaches and performance metrics from a critical mass of payers would enable providers to establish an infrastructure that would increase the likelihood of success for innovative delivery systems over the long run.**

Key Definitions

Value-based purchasing (VBP) is generally considered any activity MQD undertakes to hold a provider or a managed care organization accountable for both the costs and quality of care they provide or pay for.

Alternative payment models (APM) or methodologies often define a strategy that changes the way MQD providers are paid, moving away from fee-for-service payment which rewards volume, to methods of payment that incentivize value.

Population-based payment models target expenditures that are established for a population (Total Cost of Care) and a provider or groups of providers are held responsible for quality and cost based on that targeted expenditure.

MQD's Road Map to Payment Reform

MQD's Value-Based Purchasing (VBP) Road Map lays out the way MQD will fundamentally change how health care is provided by implementing new models of care that drive toward population-based care. The goal is to improve the health of Medicaid beneficiaries by providing access to integrated physical and behavioral health care services in coordinated systems, with value-based payment structures. To achieve this, MQD needs to pay for care differently and is exploring the initiatives listed below.

PRIORITY INITIATIVE: VALUE-BASED PURCHASING

The collaborative effort to reshape the health delivery system in Hawai'i over the last four years has led to important gains and laid the groundwork for the next level of reform, and MQD is taking this effort to the next level by exploring these activities:

- Evolve current MCO value-based purchasing requirements to reflect the Health Care Payment Learning and Action Network APM Framework (see Table 2), and require the MCOs to move toward more sophisticated VBP purchasing over the life of the contract with primary care providers, hospitals, specialist, LTSS providers, and other provider types.
- Evolve pay-for-performance model to reward MCOs for providing high quality care and access to services and move it towards more outcome-based performance and population metrics. Use funds that are not awarded to support innovations identified in HOPE.
- Research other managed care VBP models such as accountable care organizations, global payments, and other health models.
- Partner and engage with stakeholders to design and develop multi-payer models for services such as acute and outpatient care.
- Incorporate health-related social needs into provider and insurance payments.
- Develop APMs for Federally Qualified Health Centers and promising practices in primary care.
- Development payment models that decrease cost variation by including total cost of care.
- Enhance rate setting methodology and new contracting strategies by allowing MCOs and providers the use of health-related services, including flexible services^{xlix} and community benefit initiatives aimed at addressing the social determinants of health.
- Develop a plan to decrease unnecessary care, meaning patient care was received with no benefit in specific clinical scenarios. In 2014, more than \$500 million was spent in 2014 on 44 "low-value" health services.^l

Table 2: HCP LAN Updated APM Framework^{li}

Category 1	Category 2 Fee-for-Service – Link to Quality and Value	Category 3 APMs Built on Fee-for-Service Architecture	Category 4 Population-Based Payment
Fee-for-Service – No link to Quality and Value	A	A	A
	Foundational Payments for Infrastructure & Operations (e.g. care coordination fees and payments for HIT investments)	APMs with Shared Savings (e.g. shared savings with upside risk only)	Condition-Specific Population-Based Payment (e.g. per member per month payments, payments for specialty services, such as oncology or mental health)
	B	B	B
	Pay for Reporting (e.g. bonuses for reporting data or penalties for not reporting data)	APMs with Shared Savings and Downside Risk (e.g. episode-based payments for procedures and comprehensive payments with upside and downside risk)	Comprehensive Population-Based Payment (e.g. global budgets or full/percent of premium payments)
	C		C
	Pay-for-Performance (e.g. bonuses for quality performance)		Integrated Finance & Delivery System (e.g. global budgets or full/percent of premium payments integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

STRATEGY #4: SUPPORT COMMUNITY DRIVEN INITIATIVES TO IMPROVE POPULATION HEALTH

The fourth strategy reflects MQD's commitment to invest in communities by supporting community initiatives, and develop initiatives that link integrated health systems with community resources in order to improve population health. MQD embraces the paradigm shift that emphasizes the role and influence of local initiatives and community partners in shaping a health system responsive to local population health and health care delivery needs while addressing health-related social needs. As noted in our framework principles, while taking on systemic change, the actual innovations are implemented at the local level, meeting local community needs. Taken together population health outcomes improve.

As a part of HOPE, MQD will work with various strategic partners across the spectrum to evolve the health care delivery system from the local level to the top. Improvements in population health at the local and regional levels require aligned state policies, alignment at the health plan level and a collaborative and supportive approach to local initiatives, actionable data, transformation support and investment funding. The goal is to support and/or develop partnerships that will design new models to increase integration, collaboration and alignment among MCOs, local hospitals, community-based organizations, housing authorities, county government and public health agencies, affordable housing providers, corrections, behavioral health and substance use disorder providers.

Hawai'i has a long tradition of developing innovative health programs and policies at the local level, and MQD will leverage these initiatives in HOPE in order to advance innovation and avoid duplication. More specifically, MQD is exploring the following activities:

- Work with the relevant entities that currently have responsibility for regional/community health assessments to develop a regional health assessment that identifies and aligns community health improvement priorities and key strategies. The assessment will likely satisfy non-profit community benefit needs assessment requirements.
- Convene and participate in forums that foster needed strategic focus on community health transformation and collaborations across sectors including health care delivery, public health, behavioral health, education, human services, and community-based organizations.
- Support community and local initiatives by streamlining administrative functions and reducing waste and duplicative services. Some of the current administrative complexities are due to misalignment of health plans and local community efforts/providers.
- Develop strategies to evolve health plan and community relationships.
- Seek opportunities and venues that will allow communities to:
 - Act as a forum for harmonizing payment models, performance measures and investments.
 - Act as a forum to identify and develop cross sector investments that may yield created saving or efficiencies for other sectors.
 - Accelerate implementation of new integrated delivery and payment models.

Foundational Building Blocks

The building blocks listed below address fundamental capabilities and supports that must be in place to

realize the Triple Aim, and for reform to succeed on a system-wide basis.

FOUNDATIONAL BUILDING BLOCK #1: HEALTH INFORMATION TECHNOLOGY

USE DATA AND ANALYTICS TO DRIVE TRANSFORMATION AND IMPROVE CARE

Access to data and analytics is critical to providing and measuring quality care, and implementing payment reform. MQD is exploring the following:

- Continue to support health information exchange so providers have secured access to appropriate clinical patient information to improve the speed, quality, safety and cost of care;
- Work to increase access to a person's own health record, as well as their health data to encourage personal responsibility and engagement in their own care.
- Increase the number of LTSS and behavioral health providers utilizing electronic records and information exchange.
- Develop capacity to collect, analyze and use clinical and cost data to support patient-centered system development and to track trends;
- Develop capacity to collect, analyze, and integrate claims data, clinical data, and data on social determinants, and provide timely, actionable information to health plans, providers, and consumers. Increase interconnectivity between electronic health records, disease registries, public health registries, actionable reports for providers, and data repositories for analytics;
- Address the governance, legal, policy and technical issues that impede the adoption of exchanging health information among providers;
- Promote common performance measurement reporting among health plans and providers;
- Support data integration across homeless systems as well as health surveillance, personal health records, social determinants and vital records; and
- Support DHS' Enterprise and Integrated eligibility system and DHS programs.
- Reduce administrative burden.
- Develop payment models for total cost of care based on data and analytics listed above.

FOUNDATIONAL BUILDING BLOCK #2: INCREASE WORKFORCE CAPACITY AND FLEXIBILITY

Hawai'i faces significant shortages and distribution challenges in its health care workforce which impact access to care, delivery of care, and ultimately health outcomes. Additionally, the healthcare industry is transitioning from acute care to ambulatory care and including community health workers and behavioral health peers as a part of multidisciplinary teams. The goal is to develop delivery and payment models that drive the ability to use clinical and other personnel in the most efficient and effective manner to ensure broad access to high-quality services. MQD is exploring the following activities:

- Promoting the inclusion of community health workers and peer-support specialists in

multidisciplinary team based care.

- Encourage and incentivize behavioral health integration into primary care.
- Promote and support residency programs that train new generations of health professionals in whole person, whole family care, team based models, and behavioral health.
- Help promote and build primary care capacity for behavioral health by supporting the Collaborative Care Model, Project ECHO, and other care/capacity building models.
- Promote evidence-based, best practices for recruiting and retaining workforce.

FOUNDATIONAL BUILDING BLOCK #3: PERFORMANCE MEASUREMENT AND EVALUATION

MQD will work with stakeholders to develop a standardized, statewide approach to measure and evaluate the quality and efficiency of care delivered through HOPE. The goal is to create a core set of industry-standard metrics that will serve as a common basis for measuring progress and impact of HOPE and facilitate continuous improvement throughout the initiative. MQD is exploring the following possibilities:

- MQD will develop a proposed dashboard that will include a set of metrics that measure the impact of HOPE.
- MQD will have an evaluation completed on all activities included in HOPE.
- MQD will work with stakeholders to develop a standardized, statewide approach to measure and evaluate the quality and efficiency of care delivered through HOPE.

SECTION IV: THE WAY FORWARD - A VISION FOR SUSTAINABILITY

As health care reform initiatives are taking place in Hawai'i as well as the nation, there are increasing concerns about the price tag and the sustainability of the innovations. That is why the initiatives outlined in HOPE have been carefully chosen and meet the following criteria:

- Build on successes of previous reform efforts;
- Leverage community initiatives and resources;
- Have a strong return on investment;
- Have the potential for federal matching dollars; and
- Have broad community support beyond Medicaid.

MQD is working with federal and local stakeholders to identify sustainable financing mechanisms. MQD will request approval from CMS for the 1115 demonstration waiver renewal which if approved will cover some of the initiatives outlined in HOPE (see below). However, not all HOPE initiatives are covered by the 1115 waiver demonstration, so MQD will work with CMS to identify other potential federal authorities and financing mechanisms such as state plan amendments and multi-payer waivers. In

addition, MQD may also look into other potential funding opportunities and collaborate with community leaders and providers to seek other funding sources.

WORKING WITH CMS: 1115 DEMONSTRATION WAIVER RENEWAL

In 2018, MQD will request a renewal of the QUEST 1115 Demonstration under the Section 1115(a) of the Social Security Act for a five-year period effective January 1, 2019 through December 31, 2023. The 1115 Demonstration renewal is a vehicle that states use to test new delivery and payment models. The waiver is a contract with the federal government and allows Hawai'i to receive a federal match for covered services and populations included in the waiver. It is important to note that waivers have to be budget neutral. This means that MQD cannot spend more than what would be spent without the waiver.

Building on the Success of QUEST and Previous Waiver Requests

MQD is committed to building on the gains it has made in partnership with CMS, and to renewing this demonstration so Hawai'i can take health system transformation to the next level through targeted modifications made when renewing the current Section 1115 demonstration waiver.

The waiver renewal will **preserve QUEST's core tenets**:

- Maintain the current populations covered by QUEST;
- Maintain the current comprehensive benefit package;
- Continue to deliver services through a managed care delivery system;
- Continue to integrate physical, behavioral and LTSS into one program;
- Maintain the Community Care Service (CCS) program, a specialized mental health plan; although seek to modify and broaden scope.
- Continue to not require premiums or other cost-sharing; and
- Continue to hold down costs to a sustainable rate of growth.

The waiver renewal goals and strategies will be the same as the goals and strategies identified in this document. Hawai'i will request additional flexibility to make the following **targeted changes** in the waiver renewal:

- Increase the proportion of health care spending on primary care in order to promote the health system's orientation toward high-value care.
- Continue to promote further developments in value-based purchasing and alternative payment methodologies.
- Promote best practices that address the needs of HNHC individuals (i.e. care coordination, palliative care, Dr. Ornish's Program for Reversing Health Disease).
- Promote primary care and pay for value. Hawai'i will request to advance the use of value-based payments to MCOs. MQD will request to provide new performance incentive payments to primary care providers.

- Cover additional evidence-based services that further integrate physical and behavioral health services such as the Collaborative Care Model.
- Promote increased investments in health related and flexible services.
- MCOs will be encouraged to invest in services that improve quality and outcomes, and MCOs that reduce costs through the use of these services can receive financial incentives to offset those cost reductions.
- Support workforce development efforts such as Project ECHO, a teaching program for providers
- Restore the adult dental benefit.

Waiver Renewal Hypotheses

The waiver is a vehicle to test new delivery and payment innovations, and MQD will continue to test two overarching hypotheses about its demonstration. (Note that these hypotheses are preliminary and may change during the waiver renewal process.)

- Capitated managed care delivers high quality care, while also slowing the rate of health care expenditure growth; and
- Capitated managed care provides access to HCBS and facilitates rebalancing of provided LTSS.

In addition, MQD will test the following overarching hypotheses about the proposed changes:

- Further integration of physical, behavioral, and oral health care will result in reduced growth of encounter-based spending and improved quality of care, access to care, and health outcomes for QUEST members.
- Increased focus on social determinants of health will result in improved population health outcomes as evidenced by a variety of health indicators.
- A focus on health equity improvements for specific populations that have experienced disproportionately poor health outcomes will result in improved health outcomes, increased access to care, and a reduction in the gap between outcomes for populations of focus and those that historically experienced favorable health outcomes.
- Screening for health-related social needs and making referrals/connections to resources such as housing supports.
- Expansion and increased use of health-related social services will result in improved care delivery and member health and community-level health care quality improvements.
- Adoption and use of value-based payment arrangements will align MCO and their providers with health system transformation objectives and lead to improvements in quality, outcomes, and lowered expenditures.
- A move towards more outcomes-based measures that are tied to incentive programs will improve quality of care, advance state and MCO priorities (e.g. behavioral health and oral health integration, health equity), increased regional collaboration, and improve coordination with other systems (e.g. hospitals, early learning hubs).
- Emphasis on homeless prevention, care coordination and supportive housing services for vulnerable and at-risk adults and families will result in reduction in avoidable hospitalizations

and unnecessary medical utilization (e.g. lower emergency department utilization), transitions to more appropriate community-based settings, increased access to social services, reduction in overall Medicaid costs, and improved regional infrastructure and multi-sector collaboration.

These hypothesis collectively are focused on improving the Triple Aim of better health, better care and sustainable costs – the primary focus of the demonstration renewal.

Next Steps for the Waiver Process

Med-QUEST plans to hire consultants to help with the waiver renewal process. The process will begin in the fourth quarter of 2017 and is expected to be completed by January 2019. The implementation phase is expected to begin in July 2019 and should be completed by 2022.

Figure 5. Waiver Renewal Timeline

ⁱ The Kaiser Commission on Medicaid and the Uninsured. “Issue Brief - Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.” November 2015.

ⁱⁱ The Kaiser Commission on Medicaid and the Uninsured. “Issue Brief - Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.” November 2015.

ⁱⁱⁱ The Kaiser Commission on Medicaid and the Uninsured. “Issue Brief - Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.” November 2015.

^{iv} America’s Health Rankings. (2016) State Data: Hawaii. <http://www.americashealthrankings.org/explore/2015-annual-report/measure/Overall/state/HI>

- ^v Leins, Casey. The 10 Healthiest States. US News and World Report, June 14, 2017. <https://www.usnews.com/news/best-states/rankings/health-care/public-health>
- ^{vi} America's Health Rankings. (2016) State Data: Hawaii. <http://www.americashealthrankings.org/explore/2015-annual-report/measure/Overall/state/HI>
- ^{vii} Leins, Casey. The 10 Healthiest States. US News and World Report, June 14, 2017. <https://www.usnews.com/news/best-states/rankings/health-care/public-health>
- ^{viii} United Health Foundation. (2017). Hawaii. <http://www.americashealthrankings.org/HI>
- ^{ix} United Health Foundation. (2017). Hawaii. <http://www.americashealthrankings.org/HI>
- ^x Hawaii Health Data Warehouse. (2015). Behavioral risk factor surveillance survey (BRFSS). https://hhdw.org/wp-content/uploads/BRFSS_Depression_IND_00002_20111.pdf
- ^{xi} Eagle, N. 2012. "Hawai'i Youth Suicide Rate Doubles in 5 Years." *Hawai'i Civil Beat*. <http://www.civilbeat.com/2012/10/17476-hawaii-youth-suicide-rate-doubles-in-5-years/>
- ^{xii} Asian & Pacific Islander American Health Forum. 2010. "Native Hawaiian and Pacific Islander Health Disparities." http://www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf.
- ^{xiii} The Hawaii Department of Health. http://www.hawaiihealthmatters.org/content/sites/hawaii/2015_Hawaii_Drug_Overdose_Death_Special_Emphasis_Report_2015.pdf
- ^{xiv} The Hawaii Department of Health. http://www.hawaiihealthmatters.org/content/sites/hawaii/2015_Hawaii_Drug_Overdose_Death_Special_Emphasis_Report_2015.pdf
- ^{xv} Delafield, R., & Wright, T. E. (2016). Insights in Public Health: Substance Use in Pregnant Women in Hawai'i: Extending Our Capacity and Compassion. *Hawai'i Journal of Medicine & Public Health*, 75(11), 348–352.
- ^{xvi} The National Campaign to Prevent Teen Pregnancy and Unplanned Pregnancy. "Teen Pregnancy Comparison, 2013." <https://thenationalcampaign.org/data/compare/1678> [Accessed 10/25/17]
- ^{xvii} Kaiser Family Foundation. State Health Facts. <https://www.kff.org/other/state-indicator/health-care-expendituresbystateofresidenceinmillions/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22hawaii%22:%7B%22%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7Dv>
- ^{xviii} According to the Hawaii Department of Commerce and Consumer Affairs Insurance Division.
- ^{xix} According to the Hawaii Department of Commerce and Consumer Affairs Insurance Division.
- ^{xx} According to the Hawaii Department of Commerce and Consumer Affairs Insurance Division.
- ^{xxi} The Centers for Medicare and Medicaid. 2016 National Health Expenditure Data. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>
- ^{xxii} The Centers for Medicare and Medicaid Services. NHE Fact Sheet. <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>
- ^{xxiii} The Kaiser Family Foundation. "Family Health Premiums Rise 4 Percent to Average of \$15,745 in 2012, National Benchmark Employer Survey Finds." <https://www.kff.org/private-insurance/press-release/family-health-premiums-rise-4-percent-to/>
- ^{xxiv} The Kaiser Family Foundation. "2017 Employer Health Benefits Survey." <https://www.kff.org/report-section/ehbs-2017-summary-of-findings/>
- ^{xxv} The National State Budget Officers November 2017 Expenditure Report. <https://www.nasbo.org/mainsite/reports-data/state-expenditure-report>
- ^{xxvi} The National State Budget Officers November 2017 Expenditure Report. <https://www.nasbo.org/mainsite/reports-data/state-expenditure-report>
- ^{xxvii} <https://www.macpac.gov/medicaid-101/spending/>
- ^{xxviii} The Kaiser Commission on Medicaid and the Uninsured. "Issue Brief - Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity." November 2015.
- ^{xxix} World Health Organization. 2005. "Preventing Chronic Diseases: A Vital Investment."

xxx <https://hawaii.bluezonesproject.com/>

xxxi <https://hmsa.com/Media/Default/documents/annual-reports/annual-report-2015.pdf>

xxxii <http://www.communityfirsthawaii.org/>

xxxiii <https://innovation.cms.gov/initiatives/ahcm>

xxxiv The Kaiser Commission on Medicaid and the Uninsured. "Issue Brief - Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity." November 2015.

xxxv Christopher K. Koller, M.P.P.M., M.A.R., and Dhruv Khullar, M.D., M.P.P. N Engl J Med 2017; 377:1709-1711 November 2, 2017 DOI: 10.1045/NEJMp1709538

xxxvi Christopher F. Koller, M.P.P.M., M.A.R., and Dhruv Khullar, M.D., M.P.P. N Engl J Med 2017; 377:1709-1711 November 2, 2017 DOI: 10.1056/NEJMp1709538

xxxvii The Center for Health Care Strategies, Inc. "Moving Toward Value-Based Payment for Medicaid Behavioral Health Services." June 2017.

xxxviii The Center for Health Care Strategies, Inc. "Moving Toward Value-Based Payment for Medicaid Behavioral Health Services." June 2017.

xxxix MACPAC. Report to Congress on Medicaid and CHIP. "Chapter 4: Integration of Behavioral and Physical Health Services in Medicaid." March 2016.

xl MACPAC. Report to Congress on Medicaid and CHIP. "Chapter 4: Integration of Behavioral and Physical Health Services in Medicaid." March 2016.

xli The Commonwealth Fund. "State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment." August 2014.

xlii The Commonwealth Fund. "State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment." August 2014.

xliii Jeffcoat M. et. al. Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systematic Conditions. (2014). American Journal of Preventive Medicine. 47(2).

xliv The Pew Center on the States, a division of the Pew Charitable Trusts. <http://www.pewtrusts.org/en/research-and-analysis/reports/0001/01/01/the-state-of-childrens-dental-health> [Accessed 11/07/17]

xliv The National Academy of Medicine. "Effective Care for High-Need Patients: Opportunities for improving Outcome, Value, and Health." 2017. <https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients-Executive-Summary.pdf> [Accessed 11/20/17]

xlvi The National Academy of Medicine. "Effective Care for High-Need Patients: Opportunities for improving Outcome, Value, and Health." 2017. <https://nam.edu/wp-content/uploads/2017/06/Effective-Care-for-High-Need-Patients-Executive-Summary.pdf> [Accessed 11/20/17]

xlvi The Commonwealth Fund. "The Road Not Taken: The Cost of 30 Years of Unsustainable health Spending Growth in the United States. March 2013.

xlvi Health Care Payment Learning and Action Network. "Alternative Payment Model (APM) Framework: Refreshed for 2017."

xlvi Flexible services are cost-effective services offered instead of or as an adjunct to covered benefits (e.g. home modifications and healthy cooking classes). Community benefit initiatives are community-level – as opposed to member-specific – interventions, such as investments in provider capacity and care management capabilities. Both flexible services and community benefit initiatives (collectively referred to as "health related services") aim to address the social determinants of health.

^l Health Affairs Blog. "Tackling Low-Value Care: A New "Top Five" For Purchaser Action." <https://www.healthaffairs.org/do/10.1377/hblog20171117.664355/full/> [Accessed 11/22/2017]

^{li} Health Care Payment Learning and Action Network (HCP LAN). "Alternative Payment Model Framework: Refreshed for 2017."

The following are the provider guidelines and service definitions for HCBS provided by section 1915(c) waivers, as well as the QUEST integration program.

Service/Provider Term	Service Definition
Adult Day Care Center	<p>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.</p> <p>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.</p> <p>Adult Day Care Centers are licensed by the Department of Human Services and maintained and operated by an individual, organization, or agency.</p> <p>Included in the sub-set of services for the “At Risk” population.</p>
Adult Day Health Center	<p>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.</p> <p>Each program must have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services must be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse.</p> <p>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.</p> <p>Adult Day Health Centers are licensed by the Department of Health.</p> <p>Included in the sub-set of services for the “At Risk” population.</p>
Assisted Living Facility	<p>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.</p> <p>Section 30.200 describes Assisted Living Facilities as a facility, as defined in HRS 321-15.1, that is licensed by the Department of Health. This facility must consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility must be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.</p>
Community Care Management Agency (CCMA)	<p>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,</p>

Service/Provider Term	Service Definition
	<p>supplies, and equipment needs of members; ongoing face-to-face monitoring and implementation of the member's care plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. CCMA's shall (1) communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders, (2) work with families regarding service needs of member and serve as an advocate for their members, and (3) be accessible to the member's caregiver twenty-four (24) hours a day, seven (7) days a week.</p> <p>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.</p>
Community Care Foster Family Home (CCFFH)	<p>CCFFH services is personal care and supportive services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted under state law) provided in a <u>certified</u> private home by a principal care provider who lives in the home. The number of adults receiving services in CCFFH is determined by HAR, Title 17, Department of Human Services, SubTitle 9, Chapter 1454-43. CCFFH services are currently furnished to up to three (3) adults who receive these services in conjunction with residing in the home. All providers must provide individuals with their own bedroom. Each individual bedroom shall be limited to two (2) residents. Both occupants must consent to the arrangement. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four(4).</p> <p>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.</p> <p>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.</p>
Counseling and Training	<p>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.</p> <p>Counseling and training is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member.</p>
Environmental Accessibility Adaptations	<p>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.</p> <p>Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be provided in accordance with applicable state or local building codes.</p>
Expanded Adult	Residential care services are personal care services, homemaker, chore, attendant care and

Service/Provider Term	Service Definition
Residential Care Home (E-ARCH) or Residential Care Services	<p>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.</p> <p>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.</p> <p>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.</p>
Home Delivered Meals	<p>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.</p> <p>Included in the sub-set of services for the "At Risk" population</p>
Home Maintenance	<p>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.</p>
Moving Assistance	<p>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.</p>
Non-Medical Transportation	<p>Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.</p>
Personal Assistance Services (Level I)	<p>Personal assistance services Level I are provided to individuals requiring assistance with instrumental activities of daily living (IADLs) in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I may be self-directed and consist of companion services and homemaker services. Homemaker services include:</p>

Service/Provider Term	Service Definition
	<ul style="list-style-type: none"> • 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. <p>Included in the sub-set of services for the "At Risk" population</p>
Personal Assistance Services (Level II)	<p>Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform activities of daily living (ADLs) and health maintenance activities. Personal assistance services Level II must be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. The following activities may be included as a part of personal assistance services Level II:</p> <ul style="list-style-type: none"> • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing; • Assistance with bowel and bladder care; • Assistance with ambulation and mobility; • Assistance with transfers; • Assistance with medications, which are ordinarily self-administered when ordered by member's physician; • Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician; • Assistance with feeding, nutrition, meal preparation and other dietary activities; • Assistance with exercise, positioning, and range of motion; • Taking and recording vital signs, including blood pressure; • Measuring and recording intake and output, when ordered; • Collecting and testing specimens as directed; • Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, Hawaii Administrative Rules; • Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished; • Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and • Maintaining documentation of observations and services provided.

Service/Provider Term	Service Definition
	<p>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.</p> <p>Personal assistance services Level II may be self-directed.</p> <p>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.</p> <p>Included in the sub-set of services for the "At Risk" population</p>
Personal Emergency Response Systems	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>All types of PERS, described above, must meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible.</p> <p>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.</p> <p>Included in the sub-set of services for the "At Risk" population</p>
Private Duty Nursing	<p>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.</p> <p>Included in the sub-set of services for the "At Risk" population</p>
Respite Care	<p>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</p>

Service/Provider Term	Service Definition
	<p>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.</p>
Specialized Medical Equipment and Supplies	<p>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.</p> <p>This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items must meet applicable standards of manufacture, design and installation and may include:</p> <ul style="list-style-type: none"> • Specialized infant car seats; • Modification of parent-owned motor vehicle to accommodate the child (i.e., wheelchairlifts); • Intercoms for monitoring the child's room; • Shower seat; • Portable humidifiers; • Electric bills specific to electrical life support devices (ventilator, oxygenconcentrator); • 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. <p>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.</p> <p>Specialized medical equipment and supplies shall be recommended by the member's PCP.</p>

Attachment E: Behavioral Health Services Protocol

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 disorder (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 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 substance use disorder (SUD) 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 ≥18), SMI/SPMI services are provided through the DOH Adult Mental Health Division (AMHD) if the beneficiary is legally encumbered, 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 (including clubhouse), peer specialist, financial management services, supported employment, Community Integration Services (CIS), partial or intensive outpatient hospitalization, and therapeutic living supports.

See Exhibit 1 for an overview of the behavioral health services delivery systems for individuals

with SMI, SPMI, or SEBD; and see Exhibit 2 for a detailed description of the services provided by CAMHD, AMHD, CCS, and the managed care health plans.

I. 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. 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 standard and specialized 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.

II. RECEIPT OF SPECIALIZED BEHAVIORAL HEALTH SERVICES BY ADULTS (INDIVIDUALS \geq 18 YEARS)

A. Clinical Criteria

For the beneficiaries \geq 18 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 (1) of the criteria below demonstrating instability and/or functional impairment:
 - Clinical records demonstrate that the beneficiary is currently unstable under current treatment or plan of care. (Examples include, but are not limited to:
 - multiple hospitalizations in the last year and currently unstable;
 - substantial history of crises and currently unstable; 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 member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

B. Service Delivery

AMHD provides coverage of behavioral health services for QI beneficiaries that are legally encumbered. Currently, CCS provides coverage of behavioral health services to approximately 5,000 adult members. If a beneficiary is enrolled in CCS, they receive both their standard and specialized behavioral health services through CCS. MQD awards the CCS contract through a Request for Proposal (RFP) for a capitated payment. Certain new services may be reimbursed through a fee-for-service (FFS) basis until able to be incorporated in the capitated payment.

All referrals are submitted to MQD for eligibility determination. CCS referrals may be submitted to the MQD by the following agencies:

- QI Health Plan
- Hawaii State Hospital (HSH)
- Department of Health: AMHD, CAMHD or Developmental Disabilities Division (DDD)
- Department of Public Safety correctional facilities
- Hawaii Youth Correctional Facilities
- Medicaid individuals self-referring directly to CCS or first contact with CCS through crisis services

The MQD physician reviews the referrals and determines CCS eligibility based on the Clinical Criteria in the RFP. Once the member has been determined to meet the criteria, the member will be enrolled into CCS five (5) working days after the date of approval.

Upon enrollment, the member can choose from the CCS contracted, community-based case management (CBCM) agencies. Once chosen, the agency will assign a case manager to conduct an assessment and develop an Individualized Treatment Plan. If an agency is not chosen, CCS will assign a CBCM agency.

III. 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 in subparagraph (C) below, and these services are not available through the health plans. The delivery system for these services are further clarified in exhibit 2. 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 (including SUD treatment)

1. Acute Psychiatric Hospitalization
2. Diagnostic/Laboratory Services
3. Electroconvulsive Therapy
4. Evaluation and Management
5. Methadone Treatment
6. Prescription Medications
7. SUD Treatment
8. Transportation

B. State Plan Specialized Behavioral Health Services

1. 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)
9. Peer Support and Peer Specialist

C. 1115 Demonstration Specialized Behavioral Health Services

1. Financial management services

- a. Services provided by an individual or organization for a beneficiary that cannot manage his or her money. This benefit is only for those without access to the social security representative payee program.
- b. The financial manager shall direct the use of 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. The individual or organization must also keep records of expenses. Reports shall be provided quarterly to the beneficiary (if appropriate), and the beneficiary's legal guardian (or other designated responsible individuals).

2. Supported 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.

3. Community Integration Services

- a) Community Integration Services will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual. The CIS benefit package is

described in STCs 22-23.

Exhibit 1 to Behavioral Health Protocol

Overview of Behavioral Health Services Delivery

	Basic BH Services	Adults with SMI/SPMI Enrolled in AMHD	Adults with SMI/SPMI Enrolled in CCS	Children with SEBD Enrolled in CAMHD
Acute Psychiatric Hospitalization	HP	HP	CCS	HP
Diagnostic/laboratory Services	HP	HP	CCS	HP
Electroconvulsive Therapy	HP	HP	CCS	HP
Evaluation and Management	HP	HP	CCS	CAMHD/ HP
Methadone Treatment	HP	HP	CCS	HP
Prescription Medications	HP	HP	CCS	HP
SUD Treatment	HP	HP	CCS	HP
Transportation	HP	HP	CCS	HP
Biopsychosocial Rehabilitation	n/a	AMHD	CCS	n/a
Community Based Residential Programs	n/a	AMHD	n/a	CAMHD
Crisis Management	n/a	AMHD	CCS	CAMHD
Crisis Residential Services	n/a	AMHD	CCS	CAMHD
Hospital-based Residential Services	n/a	n/a	n/a	CAMHD
Intensive Case Management	n/a	AMHD	CCS	CAMHD
Intensive Family Intervention	n/a	n/a	n/a	CAMHD
Intensive Outpatient Hospital Services	n/a	AMHD	CCS	CAMHD
Therapeutic Living Supports and Therapeutic Foster Care Supports	n/a	AMHD	CCS	CAMHD
Financial management services	n/a	AMHD	CCS	n/a
Supportive Employment	n/a	AMHD	CCS	n/a
Community Integration Services	n/a	AMHD	CCS	n/a

Legend:

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

Exhibit 2 to Behavioral Health Protocol

Behavioral Health Services in the QUEST Integration Program

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 ¹ licensed to provide psychiatric services	Twenty-four (24) hour care for acute psychiatric illnesses including: <ul style="list-style-type: none"> ○ Room and board ○ Nursing care ○ Medical supplies and equipment ○ Diagnostic services ○ Physician services ○ Other practitioner services as needed 	Provided by health plan	Twenty-four hour acute psychiatric illnesses including: <ul style="list-style-type: none"> ○ Room and board ○ Nursing care ○ Medical supplies and equipment ○ Diagnostic services ○ Physician services ○ Other practitioner services, as needed ○ Other medically necessary services 	Provided by health plan

¹ Excludes Institutions of Mental Disease (IMDs) as defined at 42 CFR 435.1010

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		<ul style="list-style-type: none"> ○ Other medically necessary services ○ Pharmaceuticals ○ Rehabilitation services, as needed 		<ul style="list-style-type: none"> ○ Pharmaceuticals ○ Rehabilitation services, as needed 	
Diagnostic/ laboratory services	Laboratories	Diagnostic/laboratory services including: <ul style="list-style-type: none"> ○ Psychological testing ○ Screening for drug and alcohol problems Other medically necessary diagnostic services	Provided by health plan	Diagnostic/laboratory services including: <ul style="list-style-type: none"> ○ Psychological testing ○ Screening for drug and alcohol Other medically necessary diagnostic services	Provided by health plan
Electroconvulsive Therapy (ECT)	Acute Psychiatric Hospital Outpatient facility	ECT <ul style="list-style-type: none"> ○ Medically necessary, may do more than one/day Inclusive of anesthesia	Provided by health plan	ECT <ul style="list-style-type: none"> ○ Medically necessary, may do more than one/day Inclusive of anesthesia	Provided by health plan
Evaluation and Management	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice	Psychiatric or psychological evaluation Individual and group counseling and monitoring	Psychiatric or psychological evaluation for SMI/SPMI Individual and group counseling and	Psychiatric, psychological or neuropsychological evaluation for SMI/SPMI Individual and group	Psychiatric, psychological or neuropsychological evaluation for SEBD Individual and group counseling and

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists		monitoring for SMI/SPMI HP provides individual and group counseling and monitoring for non-SMI/SPMI	counseling and monitoring for SMI/SPMI HP provides individual and group counseling and monitoring for non-SMI/SPMI	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
SUD	Licensed providers and certified substance abuse counselors*	SUD- Residential ○ Medically necessary services based on	Provided by health plan	SUD- Residential ○ Medically necessary services based on	Provided by health plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	<p>Specialized residential treatment facilities</p> <p>Facilities licensed to perform substance abuse treatment</p>	<p>American Society of Addiction Medicine (ASAM)</p> <p>SUD – Out-patient</p> <ul style="list-style-type: none"> ○ Screening ○ Treatment and treatment planning ○ Therapy/counseling ○ Therapeutic support & education ○ Homebound services ○ Continuous treatment teams ○ Other medically necessary ○ SUD screening 		<p>American Society of Addiction Medicine (ASAM)</p> <p>SUD – Out-patient</p> <ul style="list-style-type: none"> ○ Screening ○ Treatment and treatment planning ○ Therapy/counseling ○ Therapeutic support & education ○ Homebound services ○ Continuous treatment teams ○ Other medically necessary ○ SUD screening. 	
Community Integrated Services (CIS)	As described in STCs 22-23.	As described in STCs 22-23.	NA	As described in STCs 22-23.	NA
Transportation	Approved transportation providers to include medical vans, taxi cabs, bus	<p>Transportation</p> <ul style="list-style-type: none"> ○ Air ○ Ground for medically necessary services 	Provided by health plan	<p>Transportation</p> <ul style="list-style-type: none"> ○ Air ○ Ground for medically necessary services 	Provided by health plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	services, and handicap bus services.				
Specialized Behavioral Health Services					
Biopsychosocial Rehabilitative Programs (including Clubhouse services)	AMHD Qualified Mental Health Provider**	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Not provided
Community Based Residential Programs ²	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 a. 24-hour crisis telephone consultation	Crisis Management c. 24-hour crisis telephone consultation	Crisis Management a. 24/7 Crisis hotline (through 800#)	Crisis Management a. 24/7 Crisis hotline (through 800#)

² Meet inpatient psych under 21 requirements under 42 CFR 440.160

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		b. Mobile outreach services Crisis intervention/stabilization services	d. Mobile outreach services e. Crisis intervention/stabilization services	b. Mobile crisis response/outreach c. Crisis intervention/stabilization	b. Mobile crisis response/outreach c. Crisis intervention/stabilization d.
Crisis Residential Services	Qualified Mental Health Provider**	Not provided	Crisis Residential Services	Crisis Residential Services	Crisis Residential Services
Hospital based residential treatment ³	Acute psychiatric hospital	Not provided	Not provided	Not provided	Hospital based residential treatment
Intensive Case Management	Qualified Mental Health Provider**	Care Coordination/Service Coordination	Intensive Case Management/ community-based case management Targeted Case Management	Intensive Case Management/community-based case management ○ Assessment ○ Individualized care planning ○ Outreach ○ Ongoing monitoring	Intensive Case Management/ community-based care management Targeted Case Management
Intensive family intervention	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with	Not provided	Not provided	Not provided	Intensive family intervention

³ Excludes services in IMD as defined at 42 CFR 435.1010.

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists				
Intensive Outpatient Hospital Services	Acute psychiatric Hospitals Qualified Mental Health Provider**	Intensive Outpatient Hospital Services <ul style="list-style-type: none"> ○ Medication management ○ Pharmaceuticals ○ Medical supplies ○ Diagnostic testing ○ Therapeutic services including individual, family, and group therapy and aftercare ○ Other medically necessary services 	Intensive Outpatient Hospital Services <ul style="list-style-type: none"> ○ Medication management ○ Pharmaceuticals ○ Medical supplies ○ Diagnostic testing ○ Therapeutic services including individual, family, and group therapy and aftercare ○ Other medically necessary services 	Intensive Outpatient Hospital Services: <ul style="list-style-type: none"> ○ Medication management ○ Pharmaceuticals ○ Medical supplies ○ Diagnostic testing ○ Therapeutic services including individual, family, and group therapy and aftercare ○ Other medically necessary services 	Intensive Outpatient Hospital Services: <ul style="list-style-type: none"> ○ Medication management ○ Pharmaceuticals ○ Medical supplies ○ Diagnostic testing ○ Therapeutic services including individual, family, and group therapy and aftercare ○ Other medically necessary services
Peer Specialist	Certified peer specialist	Structured activities within a peer support center that promotes socialization, recovery,	Structured activities within a peer support center that promotes socialization, recovery,	Structured activities within a peer support center that promotes socialization, recovery,	Not provided

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		wellness, self advocacy, development of natural supports, and maintenance of community skills.	wellness, self advocacy, development of natural supports, and maintenance of community skills.	wellness, self advocacy, development of natural supports, and maintenance of community skills.	
Financial management services*	Licensed Organization or Individual	Not provided	Assist beneficiary in managing their financial status.	Assist beneficiary in managing their financial status.	Not provided
Supported 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
Therapeutic Living Supports and Therapeutic Foster Care Supports	Specialized residential treatment facility	Specialized residential treatment facility	Specialized residential treatment facility	Specialized residential treatment facility	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.

Exhibit 3 to Behavioral Health Protocol

Eligibility Diagnoses for Specialized Behavioral Health Services

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:

- Substance Induced Psychosis:
 - Alcohol Induced Psychosis (F10.15x, F10.25x, F10.95)
 - Opioid Induced Psychosis (F11.15x, F11.25x, F11.95x)
 - Cannabis Induced Psychosis (F12.15x, F12.25x, F12.95x)
 - Sedative Induced Psychosis (F13.15x, F13.25x, F13.95x)
 - Cocaine Induced Psychosis (F14.15x, F14.25x, F14.95x)
 - Other Stimulant Induced Psychosis (F15.15x, F15.25x, F15.95x)
 - Hallucinogen Induced Psychosis (F16.15x, F16.25x, F16.95x)

- Inhalant Induced Psychosis (F18.15x, F18.25x, F18.95x)
- Other Substance Induced Psychosis (F19.15x, F19.25x, F19.95x)
- PTSD (F43.1x)
- Schizophrenia (F20.x, includes Schizophreniform disorder F20.81)
- Schizoaffective Disorder (F25.x)
- Delusional Disorder (F22)
- Bipolar Disorder (F30.xx, F31.xx)
- Major Depressive Disorder, Severe: (F32.3, F33.2, F33.3)

Attachment K: Emergency Preparedness and Response

APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.ⁱ This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: Hawaii

B. Waiver Title: 1115 QUEST Integration- Home and Community Based Services

C. Control Number:

QUEST Integration Medicaid Section 1115 Demonstration (No 11-W-00001/9)

D. Type of Emergency (The state may check more than one box):

<input checked="" type="radio"/>	Pandemic or Epidemic
<input type="radio"/>	Natural Disaster
<input type="radio"/>	National Security Emergency
<input type="radio"/>	Environmental
<input type="radio"/>	Other (specify):

E. **Brief Description of Emergency.** *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

F. **Proposed Effective Date:** Start Date: 3/01/2020 Anticipated End Date: 2/28/2021

G. **Description of Transition Plan.**

On March 13, 2020, the President of the United States declared the 2019 novel coronavirus ("COVID-19") a nationwide emergency pursuant to Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207. The President's

declaration gives the Secretary of the U.S. Department of Health and Human Services the authority to enhance states' ability to respond to the COVID-19 pandemic, including the power to temporarily waive or modify Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements under Section 1135 and 1115 of the Social Security Act.

Accordingly, the Hawaii Department of Human Services, Med-QUEST Division ("MQD") is requesting authority to waive certain requirements to the extent necessary to respond to the continued spread of COVID-19. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, MQD requests a retroactive effective date of March 1, 2020, for the requested Section 1115 flexibilities to coincide with the effective start date of the public health emergency. MQD requests this waiver authority extend through the duration of the emergency period, or 60 days from the date of the waiver publication if the emergency period ends within 60 days of the waiver's publication, unless otherwise noted.

In addition to requirements that can be waived under a Section 1115 waiver, MQD describes other waivers, policy changes, and concurrences it is seeking from the Secretary in order to respond to the pandemic. MQD understands these requests may be sought through other regulatory vehicles in addition to the Section 1115 requests, per federal guidance.

H. Geographic Areas Affected:

On March 4, 2020, Governor David Ige declared a state of emergency in Hawaii in response to the emerging public health threat posed by COVID-19 pursuant to Hawaii Revised Statutes Chapter 127A. The Governor issued a supplementary proclamation on March 16, 2020.

I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:*

https://dod.hawaii.gov/hiema/files/2017/08/Hi-EOP.FINAL_Version-May-2017.pdf

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ___ Access and Eligibility:

i. ___ Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

Not applicable

ii. Temporarily modify additional targeting criteria.

[Explanation of changes]

Not applicable

b. X Services

i. X Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. X Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

For members who are at risk of deteriorating to the institutional level of care (the “at risk” population), the limits on the number of hours of HCBS or the budget for the following services will be temporarily suspended.

1. Personal Assistance Level I (includes self-direct): Waive service limitation of ten (10) hours per week for individuals who do not meet institutional level of care.
2. Personal Assistance Level I and II (includes self-direct): Waive the lower limit of 5 functional points to receive “at risk” services. In addition, waive the “at risk” criteria that limits personal assistance services to members that score 8 points or greater on a functional assessment. This will allow members that score below 8 points the opportunity to access personal assistance services in the event the member is diagnosed with COVID-19. This would be provided as a temporary wrap-around service for home health covered under the state plan.
3. Private Duty Nursing: Waive the lower limit of 5 functional points to receive “at risk” services. In addition, waive the “at risk” criteria that limits private duty nursing services to members that score 10 points or greater on a functional assessment. This will allow members that score below 10 points the opportunity to access private duty nursing services in the event the member is diagnosed with COVID-19. This would be provided as a temporary wrap-around service for home health covered under the state plan.

The health plan shall not impose service authorization limits or waitlists during the COVID-19 pandemic. The service authorization amount and duration shall be based on medical necessity and assessed need. Needs of the member include but are not limited to frailty, cognition, and behavioral status. The health plan must consider natural support systems when identifying needs of the member.

To ensure member health and safety needs can be met in a timely manner, the prior authorization and/or exception review process may be modified as deemed necessary by the health plan. In emergent situations where the member’s immediate health and safety needs must be addressed,

retrospective authorization may be completed. **Services will be rendered immediately with documentation as soon as is practicable.**

iii. ___ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. _X Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

Expand settings where services may be provided for Adult Day Care and Adult Day Health. These services may be provided in members' homes, whether in a licensed or certified setting or a private home. The use of telehealth and telephonic services are permitted when possible and appropriate. When service is provided in a licensed or certified setting, the service cannot be provided by a member of the household.

Expand settings where service may be provided for Personal Assistance Level I and Level II and Private Duty Nursing. In certain circumstances related to COVID-19 pandemic, alternative settings may include the home of a relative, hotel, cruise ship, etc.

v. ___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

Not applicable

c. _X Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

Allow payment for services rendered by family caregivers or legally responsible individuals for Personal Assistance Level I and Level II as an alternative to agency or independent and unrelated self-direct workers for members with the COVID-19 diagnosis. The option to pay family caregivers or legally responsible individuals will decrease risk and limit the transmission of the COVID-19 virus to the greater community. This also ensures continuity of care for the medically needy population.

The service coordinator must conduct a needs assessment using telehealth that meets privacy requirements in lieu of face-to-face meetings. The self-direct option of service delivery shall be

discussed with the member to allow payment to any family caregivers or legally responsible individuals. When the member agrees upon the self-direct option, the service coordinator shall document the changes in service plan. The service coordinator may complete the service plan by use of e-signatures that meets privacy and security requirements. This will be added as a method for the member or legal guardian signing the service plan to indicate approval of the plan. Services may start immediately while waiting for the signature to be returned to the service coordinator, whether electronically or by mail.

Family caregivers or legally responsible individuals must enroll in self-direct option to receive reimbursements. The health plan shall work with the member to ensure the employee enrollment packet is completed. The health plan shall work with the family caregivers or legally responsible individuals to ensure the employer enrollment packet is completed. The streamline the self-direct enrollment process, the state will allow for flexibilities that may include but not limited to waiving the training requirements, criminal history checks, and employment eligibility verification requirements.

d. X Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. X Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

Expand provider type and qualifications to include provider type H1 (I/DD Waiver Provider) to perform similar service delivery for the following services (see Section A for details)

1. Personal Assistance Level I and II (includes self-direct)
2. Private Duty Nursing (includes self-direct)

ii. X Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

Include provider type and qualifications for provider type H1 (I/DD Waiver Provider) to perform similar service delivery for the following services (see Section A for details)

1. Personal Assistance Level I and II (includes self-direct)
2. Private Duty Nursing (includes self-direct)

iii. X Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

1. Adult Day Care: **Change/add locations where these services may be provided during the emergency.** This provides the flexibility for day care services within the scope to be rendered beyond a “center-based” setting i.e., residential private home or licensed/certified home. In addition, **extend the current licensure/certification for providers in emergent situations where the health and welfare of the member is at risk when there is no access to a licensed/certified provider in the regional area.**

2. Adult Day Health: **Change/add locations where these services may be provided during the emergency.** This provides the flexibility for day care services within the scope to be rendered beyond a “facility-based” setting i.e., residential private home or licensed/certified home. In addition, **extend the current licensure/certification for providers in emergent situations where the health and welfare of the member is at risk when there is no access to a licensed/certified provider in the regional area.**
3. Assisted Living Facility: **Extend the current licensure/certification for providers in emergent situations where the health and welfare of the member is at risk when there is no access to a licensed/certified provider in the regional area.** This will expand the options for residential placement upon hospital discharge and in turn increase the hospital capacity to serve more severe emergency cases.
4. Community Care Foster Family Homes: **Extend the current licensure/certification for providers in emergent situations where the health and welfare of the member is at risk when there is no access to a licensed/certified provider in the regional area.** This will expand the options for residential placement upon hospital discharge and in turn increase the hospital capacity to serve more severe emergency cases.
5. Expanded Adult Residential Care Homes: **Extend the current licensure/certification for providers in emergent situations where the health and welfare of the member is at risk when there is no access to a licensed/certified provider in the regional area.** This will expand the options for residential placement upon hospital discharge and in turn increase the hospital capacity to serve more severe emergency cases.

e. X Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

Allow flexibility to **remotely conduct** a functional assessment to determine initial Level of Care (LOC) for new members needing HCBS services that are isolated or quarantined due to COVID-19. The health plan service coordinator shall document the reason for the **remote assessment**. The initial LOC evaluation may be conducted using telehealth that meets privacy requirements in lieu of face-to-face visits.

The annual Level of Care (LOC) reevaluation requirement will be extended for 6 months for member when health plan service coordinator is unable to safely conduct a face-to-face visit. The health plan service coordinator shall document the reason for the extension and the projected date in which the LOC will be able to be completed.

f. Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

Not applicable

g. X Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Member Safeguards. Also include strategies to ensure that services are received as authorized.]

1. Health plan service coordinators may use telehealth that meets privacy requirements in lieu of face-to-face meetings to conduct Health and Functional Assessments (HFA) to develop or update service plans.

2. The State may modify timeframes or processes for completing the Service Plan.

a) Updates to the service plan may be approved with a retroactive approval date for service needs identified to mitigate harm or risk directly to COVID-19 impacts.

b) The use of electronic signatures that meets privacy and security requirements will be added as a method for member or legal guardian signing the service plan to indicate approval of the plan. Service may be delivered while pending signature to be returned to the service coordinator, whether electronic or by mail.

In order to limit the transmission of COVID-19, suspend requirements for allowing visitors (providers may prohibit/restrict visitation in-line with CMS recommendations for long term care facilities) and suspend requirements for individuals' right to choose with whom to share a bedroom. Any changes that impact members' freedoms of choice and full access to the community related to limiting the transmissions of COVID-19 do not require modifications to the service plan during the period of the emergency.

h. ___ Temporarily modify incident reporting requirements, medication management or other member safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

Not applicable

i. X Temporarily allow for payment for services for the purpose of supporting waiver members in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

Allow for payment for Personal Assistance Level II service for the purpose of supporting HCBS member in an acute care hospital or short-term institutional stay when necessary supports are not available in the setting when the member requires those services for communication and behavioral stabilization and such services are not covered in such settings. The provider will document that these services are not covered in the settings where the member is located.

Payments may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bed-hold" in nursing facilities.

j. X Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

Include retainer payments to primary caregivers in a residential setting when a member is hospitalized or absent from home due to COVID-19 for the following HCBS services:

1. Assisted Living Facility
2. Community Care Foster Family Home
3. Expanded Adult Residential Care Homes

Include retainer payments to a day program setting when a member is hospitalized **due to COVID-19 or is sequestered and/or quarantined based on state, federal and/or medical requirements/orders** for the following HCBS services:

1. Adult Day Care
2. Adult Day Health

Include retainer payment to self-direct workers where Personal Assistance Level I and Level II are delivered under self-direct and a member is hospitalized or absent from home due to COVID-19. The authorized hours per week for a self-direct worker may not to exceed the current authorization based on assessed need and shall not to exceed 40 hours per week.

Retainer payments may not exceed the lesser of 30 consecutive days or the number of days for which the State authorizes a payment for "bed-hold" in nursing facilities.

k. Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of member safeguards]

Not applicable

l. Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

Not applicable

m. X Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Allow members to receive fewer than one service per month for a period of 120 days without being subject to discharge. The service coordinator will provide monthly monitoring to ensure the plan continues to meet the members' needs. Monthly monitoring may be done using telehealth that meets privacy requirements.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

B.

First Name: Judy
Last Name Mohr Peterson, PhD
Title: Administrator
Agency: Department of Human Services, Med-QUEST Division
Address 1: 601 Kamokila Blvd. Suite 506A
Address 2:
City Kapolei
State Hawaii
Zip Code 96707
Telephone: 808-692-8085
E-mail jmohrpeterson@dhs.hawaii.gov
Fax Number 808-692-8087

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:
Last Name
Title:
Agency:
Address 1:
Address 2:
City
State
Zip Code
Telephone:
E-mail
Fax Number

8. Authorizing Signature

Signature:

Date:

State Medicaid Director or Designee

First Name: Pankaj
Last Name Bhanot
Title: Director
Agency: Department of Human Services
Address 1: 190 Miller Street
Address 2: Room 209
City Honolulu
State Hawaii
Zip Code 96813
Telephone: 808-586-4999
E-mail PBhanot@dhs.hawaii.gov
Fax Number 808-692-8087

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Adult Day Care		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
Service Definition (Scope):			
<p>Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the member's service plan. Therapeutic, social, educational, recreational, and other activities are also provided as a regular adult day care service. These services may be delivered in a center-based setting or in a residential setting, in certain circumstances related to the COVID-19 pandemic and is documented in the service plan. The program may conduct wellness calls and check-ins when member is absent due to medical or emergency circumstances. Wellness calls and check-in activities may include education to member and families, medication reminders for self-administration, and coordination for medically necessary appointments and transportation. Additional services may include but not limited to, delivery of essential items such as groceries and meals, translation, and family supports. The use of telehealth and telephonic services are permitted when possible and appropriate</p> <p>Adult day care staff member may not perform health care related services such as medication administration, tube feedings, and other activities which require health care related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family member and professionals, such as an RN or LPN, from an authorized agency. Family supports does not include home care services such as homemaker and personal care services as defined in HAR Chapter 11-700.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies: <div style="background-color: #eee; padding: 2px; margin-top: 2px;">Adult Day Care</div>
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Adult Day Care (Provider type A7) with a current Medicaid provider agreement	Licensed by the Department of Health, Office of Health Care Assurance in accordance to HRS	Certified by the Department of Health, Office of Health Care Assurance	<ol style="list-style-type: none"> 1. Meet Medicaid Provider Services Agreement, e.g., staff must be at least 18 years of age 2. Pass Fingerprinting Criminal Background Check (FCBS). criminal history check 3. Able to work in the United States

	346-83 and HAR Chapter 17-1424		4. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA) 5. Possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET) 6. IRS Form W-9 7. Each agency must be able to enter into contracts with the State and MCOs 8. General Liability Insurance (Optional)
--	--------------------------------	--	---

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Care (Provider type A7)	Department of Human Services, Med-QUEST Division	Initial, Annually, and as Needed

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Member-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
--	--------------------------	--	-------------------------------------	------------------



Service Specification

Service Title:	Adult Day Health
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	
<p>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. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community.</p> <p>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.</p> <p>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. These services may be delivered in a center-based setting or in a residential setting, in certain circumstances related to the COVID-19 pandemic and is documented in the service plan. The program may conduct wellness calls and check-ins when member is absent due to medical or emergency circumstances. Wellness calls and check-in activities may include education to member and families, medication reminders for</p>	

self-administration, and coordination for medically necessary appointments and transportation. Additional services may include but not limited to, delivery of essential items such as groceries and meals, translation, and family supports. The use of telehealth and telephonic services are permitted when possible and appropriate			
Family supports does not include home care services such as homemaker and personal care services as defined in HAR Chapter 11-700.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies: Adult Day Health
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
Relative/Legal Guardian			
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Adult Day Health (Provider type 27) with a current Medicaid provider agreement	Licensed by the Department of Health, Office of Health Care Assurance in accordance HAR Chapter 11-94.1 or HAR Chapter 11-96	Certified by the Department of Health, Office of Health Care Assurance	1. Meet Medicaid Provider Services Agreement, e.g., staff must be at least 18 years of age 2. Pass Fingerprinting Criminal Background Check (FCBS). criminal history check 3. Able to work in the United States 4. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA) 5. Possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET) 6. IRS Form W-9 7. Each agency must be able to enter into contracts with the State and MCOs 8. General Liability Insurance (Optional)
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Adult Day Health (Provider type 27)	Department of Human Services, Med-QUEST Division		Initial, Annually, and as Needed
Service Delivery Method			

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Member-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed
--	--------------------------	--	-------------------------------------	------------------

Service Specification	
Service Title:	Personal Assistance (Level I and Level II)
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	
<p>Personal assistance, sometimes called attendant care for children, are services provided in an individual's home to help them with their IADLs and ADLs. In certain circumstances related to COVID-19 pandemic, alternative settings for service delivery may include the home of a relative, hotel, cruise ship, etc.</p> <p>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 is for individuals who are not living with their family who perform these duties as part of a natural support. Personal assistance services Level I may be self-directed and consist of the following:</p> <ol style="list-style-type: none"> 1. Companion Services: Companion services, pre-authorized by the service coordinator in the member's service plan, means non-medical care, supervision and socialization provided to a member who is assessed to need these 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. 2. Homemaker/Chore Services: Homemaker/Chore services means any of the activities listed below, when the individual that is regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker/chore services, pre-authorized by the service coordinator in the member's service plan, 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/chore services specified in this section shall cover only the activities that need to be provided for the member, and not for other members of the household. <ol style="list-style-type: none"> a) Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish; b) Care of clothing and linen by washing, drying, ironing, mending; c) Marketing and shopping for household supplies and personal essentials (not including cost of supplies); d) Light yard work, such as mowing the lawn; e) Simple home repairs, such as replacing light bulbs; f) Preparing meals; g) Running errands, such as paying bills, picking up medication; h) 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; i) Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer; j) Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate; and k) 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 are provided to individuals requiring assistance with moderate/substantial to total assistance to perform 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. Personal assistance services Level II may be self-directed and consist of the following:

- a) Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;
- b) Assistance with bowel and bladder care;
- c) Assistance with ambulation and mobility;
- d) Assistance with transfers;
- e) Assistance with medications, which are ordinarily self-administered when ordered by member's physician;
- f) 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;
- g) Assistance with feeding, nutrition, meal preparation and other dietary activities;
- h) Assistance with exercise, positioning, and range of motion;
- i) Taking and recording vital signs, including blood pressure;
- j) Measuring and recording intake and output, when ordered;
- k) Collecting and testing specimens as directed;
- l) 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, HAR;
- m) 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;
- n) Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and
- o) 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 service 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. **Chore services will not be provided to individuals receiving Personal Assistance Level II services only.**

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Personal assistance services Level I is limited to ten (10) hours per week for individuals who do not meet institutional level of care. **Service limitation shall be waived during the COVID-19 pandemic.**

Provider Specifications

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
			Home Care Agency	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	

Home Care Provider (Provider type 24) with a current Medicaid provider agreement	Licensed by the Department of Health, Office of Health Care Assurance in accordance to HAR 11-700 for Home Care Agencies		<ol style="list-style-type: none"> 9. Meet Medicaid Provider Services Agreement, e.g., staff must be at least 18 years of age 10. Pass Fingerprinting Criminal Background Check (FCBS). criminal history check 11. Able to work in the United States 12. Trained in the person-centered service plan and be able to perform the assigned tasks 13. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA) 14. Possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET) 15. IRS Form W-9 16. Each agency must be able to enter into contracts with the State and MCOs 17. General Liability Insurance (Optional)
I/DD Waiver Provider (Provider type H1) with a current Medicaid provider agreement			<ol style="list-style-type: none"> 1. Meet Medicaid Provider Services Agreement, e.g., staff must be at least 18 years of age 2. Pass Fingerprinting Criminal Background Check (FCBS). criminal history check 3. Able to work in the United States 4. Trained in the person-centered service plan and be able to perform the assigned tasks 5. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA) 6. Possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET) 7. IRS Form W-9 8. Each agency must be able to enter into contracts with the State and MCOs 9. General Liability Insurance (Optional)

			10. I/DD Waiver Provider agency must be approved by DOH/DDD and DHS/MQD in order to provide waiver HCBS or similar HCBS service 11. I/DD Waiver Provider agency must adhere to staffing qualifications in terms of training, education and certification/licensure stated in 1915(c) waiver standards 12. I/DD Waiver Provider agency must have an approved FFS rate schedule for chore services
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Home Care Provider (Provider type 24)	Department of Human Services, Med-QUEST Division		Initial, Annually, and as Needed
I/DD Waiver Provider (Provider type H1)	Department of Human Services, Med-QUEST Division		Initial, Annually, and as Needed
Service Delivery Method			
Service Delivery Method (check each that applies):	<input checked="" type="checkbox"/>	Member-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification			
Service Title:	Private Duty Nursing		
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:			
Service Definition (Scope):			
Skilled nursing is a service provided to individuals requiring ongoing nursing care (in contrast to Home Health or part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the service plan. The service is provided by licensed nurses (as defined in Chapter 16-89, HAR) within the scope of State law and authorized in the member's service plan. Skilled nursing services may be self-directed under Personal Assistance Level II/Delegated using registered nurse delegation procedures outlined in Chapter 16-89, Subchapter 15, HAR. In certain circumstances related to COVID-19 pandemic, alternative settings for service delivery may include the home of a relative, hotel, cruise ship, etc.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Nursing Agency
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			

Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)
Private Duty Nursing Provider (Provider type 46) with a current Medicaid provider agreement	Licensed by the Department of Health, Office of Health Care Assurance in accordance to HAR Chapter 11-97	Certified by the Department of Health, Office of Health Care Assurance	<ol style="list-style-type: none"> 1. Meet Medicaid Provider Services Agreement, e.g., staff must be at least 18 years of age 2. Pass Fingerprinting Criminal Background Check (FCBS). criminal history check 3. Able to work in the United States 4. Trained in the person-centered service plan and be able to perform the assigned tasks 5. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA) 6. Possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET) 7. IRS Form W-9 8. Each agency must be able to enter into contracts with the State and MCOs 9. General Liability Insurance (Optional) 10. All professional staff (RN and LPN) must be licensed by the Hawaii Board of Nursing
I/DD Waiver Provider (Provider type H1) with a current Medicaid provider agreement			<ol style="list-style-type: none"> 1. Meet Medicaid Provider Services Agreement, e.g., staff must be at least 18 years of age 2. Pass Fingerprinting Criminal Background Check (FCBS). criminal history check 3. Able to work in the United States 4. Trained in the person-centered service plan and be able to perform the assigned tasks 5. Each agency must be a registered business in the State of Hawaii through the Department of Commerce and Consumer Affairs (DCCA) 6. Possess the applicable tax licenses in the State of Hawaii through the Department of Taxation and have a tax license for General Excise Tax (GET) 7. IRS Form W-9

			8. Each agency must be able to enter into contracts with the State and MCOs 9. General Liability Insurance (Optional) 10. All professional staff (RN and LPN) must be licensed by the Hawaii Board of Nursing 11. I/DD Waiver Provider agency must be approved by DOH/DDO and DHS/MQD in order to provide waiver HCBS or similar HCBS service 12. I/DD Waiver Provider agency must adhere to staffing qualifications in terms of training, education and certification/licensure stated in 1915(c) waiver standards 13. I/DD Waiver Provider agency must have an approved FFS rate schedule for private duty nursing services
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Private Duty Nursing Provider (Provider type 46)	Department of Human Services, Med-QUEST Division		Initial, Annually, and as Needed
I/DD Waiver Provider (Provider type H1)	Department of Human Services, Med-QUEST Division		Initial, Annually, and as Needed
Service Delivery Method			
Service Delivery Method (check each that applies):	X	Member-directed as specified in Appendix E	X Provider managed

ⁱ Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

- a ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

- a ☒ Add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for:
 - i ☒ Case management/Service coordination
 - i ☒ Personal care services that only require verbal cueing
 - i ☐ In-home habilitation
 - ix ☒ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
 - v ☒ Other *[Describe]:*

Adult Day Care and Adult Day Health services in the scope outlined in Section A.

- b ☐ Add home-delivered meals
- c ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
- d ☐ Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

- a ☒ Current safeguards authorized in the approved waiver will apply to these entities.
- b ☐ Additional safeguards listed below will apply to these entities.

4. Provider Qualifications

- a ☒ Allow spouses and parents of minor children to provide personal care services
- b ☒ Allow a family member to be paid to render services to an individual.
- c ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

--

- d ☒ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

- a ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date.
- b ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- c ☒ Adjust prior approval/authorization elements approved in waiver.
- d ☒ Adjust assessment requirements
- e ☒ Add an electronic method of signing off on required documents such as the person-centered service plan.

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.¹ This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: Hawaii

B. Waiver Title(s): 1115 QUEST Integration- Home and Community Based Services

C. Control Number(s):

QUEST Integration Medicaid Section 1115 Demonstration (No 11-W-00001/9)

D. Type of Emergency (The state may check more than one box):

<input checked="" type="radio"/>	Pandemic or Epidemic
<input type="radio"/>	Natural Disaster
<input type="radio"/>	National Security Emergency
<input type="radio"/>	Environmental
<input type="radio"/>	Other (specify):

E. **Brief Description of Emergency.** *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This is an amendment to the previously approved Appendix K and will apply state-wide to all individuals impacted by the Public Health Emergency (PHE).

F. Proposed Effective Date: Start Date: 3/01/2020 **Anticipated End Date:** 2/28/2021

G. Description of Transition Plan.

All activities will take place in response to the PHE as efficiently and effectively as possible based on the complexity of the changes.

H. Geographic Areas Affected:

Actions will apply state-wide to all impacted by the PHE.

I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:*

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. Access and Eligibility:

i. Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

ii. Temporarily modify additional targeting criteria.

[Explanation of changes]

b. Services

i. ___ Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

iii. ___ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___ Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

v. ___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c. ___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d. ___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. **___ Temporarily modify provider qualifications.**

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii. **___ Temporarily modify provider types.**

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii. **___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.**

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. **___ Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements).** [Describe]

f. **___ Temporarily increase payment rates.**

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g. **___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.**

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

- h. ☐ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

- i. ☐ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

- j. ☒ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

This amendment is additive to the previously approved Appendix K.

Personal care/assistance is a component of all the following services for which retainer payments will be made:

1. Adult Day Care
2. Adult Day Health
3. Assisted Living Facility
4. Community Care Foster Family Home
5. Expanded Adult Residential Care Homes

The retainer payments will be billed and paid at a flat rate of 75 percent of the per unit of service.

Retainer payments are limited to three (3) 30 billing day periods for a member.

Providers must submit an attestation to the following requirements for retainer payments:

- provider acknowledges that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred (or in periods of disaster, duplicate uses of available funding streams), as identified in a state or federal audit or any other authorized third-party review;
- provider will not lay off staff;
- provider will maintain wages at existing levels;
- provider did not receive aggregate funding from any other sources, including, but not limited to, unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE.
 - 1) Provider did not already received revenues in excess of the pre-PHE level, but receipt of the retainer payment in addition to prior sources of funding results in the provider exceeding the pre-PHE level, then the retainer payment amounts in excess will be recouped.
 - 2) Provider did not already received revenues in excess of the pre-PHE level.

Retainer payments will not be available for self-directed Personal Assistance Level I/Level II.

k. ___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l. ___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m. **Other Changes Necessary** [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

- a ☐ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

- a ☐ Add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for:
- i ☐ Case management
 - i ☐ Personal care services that only require verbal cueing
 - i ☐ In-home habilitation
 - ix ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
 - v ☐ Other [*Describe*]:

- b ☐ Add home-delivered meals
- c ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
- d ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**

- a ☐ Current safeguards authorized in the approved waiver will apply to these entities.
- b ☐ Additional safeguards listed below will apply to these entities.

4. Provider Qualifications

- a ☐ Allow spouses and parents of minor children to provide personal care services
- b ☐ Allow a family member to be paid to render services to an individual.
- c ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

- d ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

- a ☐ Allow an extension for reassessments and reevaluations for up to one year past the due date.
- b ☐ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- c ☐ Adjust prior approval/authorization elements approved in waiver.
- d ☐ Adjust assessment requirements
- e ☐ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name: Judy
Last Name Mohr Peterson, PhD
Title: Administrator
Agency: Hawaii Department of Human Services, Med-QUEST Division
Address 1: 601 Kamokila Blvd.
Address 2: Suite 506A
City Kapolei
State Hawaii
Zip Code 96707
Telephone: 808-692-8085
E-mail jmohrpeterson@dhs.hawaii.gov
Fax Number 808-692-8087

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:
Last Name
Title:
Agency:
Address 1:
Address 2:
City
State
Zip Code
Telephone:
E-mail
Fax Number

8. Authorizing Signature


Signature:

Date: August 12, 2020



State Medicaid Director or Designee

First Name: Pankaj
Last Name Bhanot
Title: Director
Agency: Hawaii Department of Human Services
Address 1: 1390 Miller Street
Address 2: Room 209
City Honolulu
State Hawaii
Zip Code 96813
Telephone: 808-586-4999
E-mail pbhanot@dhs.hawaii.gov
Fax Number 808-692-8087



ⁱ Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.