EXECUTIVECHAMBERS

HONOLULU

DAVID Y. IGE
GOVERNOR

September 14, 2018

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

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

I am pleased to submit the State of Hawai'i's application for an extension of our "QUEST Integration" Demonstration (Project Number 11-W-00001/9) under Section 1115 of the Social Security Act. The extension request is for an additional five years, beginning January 1, 2019 and continuing through December 31, 2023, in order to further transform and improve the healthcare delivery system for low-income Hawai'i residents.

Originally implemented as the QUEST program in 1994, QUEST Integration is the current version of Hawai'i's Section 1115 Demonstration project. Under the Demonstration, the State provides comprehensive benefits to nearly 360,000 Medicaid beneficiaries through a robust, including long term care and supports, managed care delivery system. QUEST Integration has a strong history of providing the most vulnerable residents of Hawai'i with effective, innovative, efficient, and evidence-based health care. The State is requesting approval to build on this success by continuing to deliver services through managed care under our existing program.

We appreciate and look forward to HHS's continued support. If you have any questions about this application, please feel free to contact me or Dr. Judy Mohr Peterson, Med-QUEST Division Administrator, at 808-692-8050 or jmohrpeterson@dhs.hawaii.gov.

Thank you for your consideration of this application.

With warmest regards,

David Y. Ige
Governor, State of Hawai'i

Enclosure

c: Seema Verma, Administrator, Centers for Medicare & Medicaid Services
Timothy Hill, Acting Deputy Administrator and Director, Center for Medicaid and CHIP Services
Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services

QUEST Integration

§1115 Waiver Extension Application

State of Hawai‘i, Department of Human Services,

Med-QUEST Division

September 14, 2018

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B. Interim Demonstration Evaluation Report

C. Hawai‘i Med-QUEST Division Quality Strategy

D. QUEST Integration Special Terms & Conditions (2013-2018)

E. Documentation of 2017 Post-Award Forum

F. UCC Pool Evaluation

G. Budget Neutrality Charts

H. E-mail Notice

I. Abbreviated Public Notice

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K. Tribal Consultation

L. Hawai‘i Medicaid ‘Ohana Nui Project Expansion (HOPE) Project

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Introduction

Pursuant to Section 1115(a) of the Social Security Act, the State of Hawai‘i, Department of Human Services (the State) is seeking a five-year extension of the QUEST Integration Section 1115 demonstration from CMS. Absent an extension, the demonstration will expire on December 31, 2018. The State requests a renewal of our current waiver and expenditure authorities.

For over two decades, the demonstration has efficiently and effectively delivered comprehensive benefits to a large number of beneficiaries, including expansion populations, through a competitive managed care delivery system. Under the extension, "QUEST Integration" (QI) will continue to build on this success by delivering services through managed care, while integrating the demonstration's programs and benefits to ensure more patient-centered care delivery. All eligible beneficiaries will continue to be enrolled under QUEST Integration, and access to services will be determined by clinical criteria and medical necessity. The extension will continue to incorporate the simplified Medicaid eligibility structure under the Affordable Care Act (ACA) into the demonstration.

The Med-QUEST Division (MQD) is committed to laying the foundation for innovative programs that support and create healthy families and healthy communities through the QUEST program. 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. The QUEST Integration waiver will be the vehicle for the HOPE program to be put into practice.

MQD's vision is that the people of Hawai‘i embrace health and wellness. MQD's mission is to empower Hawai‘i residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha. The vision and mission will 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 the life course.
- Addressing 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.

These principles will animate service delivery through QUEST. Initiatives will be undertaken to do the following:

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

Hawai‘i QUEST Waiver History & the Current Demonstration

The State of Hawai‘i implemented QUEST on August 1, 1994. QUEST was a statewide Section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery system. QUEST stands for:

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

The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Medical Assistance Program and its State Children's Health Insurance Program. Low-income women, children, and adults who had been covered by the two programs were enrolled into fully capitated managed care plans throughout the State. This program virtually closed the coverage gap in the State.

Since its implementation, CMS has renewed the QUEST demonstration five times. Over the years, the State has made significant changes to the demonstration, including several eligibility expansions and an extension in 2007 that authorized managed long-term services and supports.

The current Section 1115 demonstration for the State of Hawai‘i is entitled "QUEST Integration" (Project Number 11-W-00001/9). The QUEST Integration demonstration began in October 2013 and is effective through December 2018. The demonstration integrated the demonstration's eligibility groups and benefits within the context of the Affordable Care Act and accomplished several programmatic changes, including:

- Streamlining eligibility pathways by transitioning low-income childless adults and former foster care children from demonstration expansion populations to state plan populations, adding former adoptive and kinship guardianship children as demonstration expansion populations, and reducing the retroactive eligibility period to 10 days for non-long term services and supports populations;
- Consolidating QUEST, QUEST-Net, QUEST-ACE, and QExA into a single QUEST Integration program;
- Removing QUEST-ACE enrollment-related benchmarks from the uncompensated care cost (UCC) pool, evaluating UCC costs, and winding down federal financial participation for UCC pool payments in June 2016; and
- Providing additional benefits like certain specialized behavioral health services, cognitive rehabilitation, and habilitation.

MQD's objectives for the demonstration were:

- Improve the health care status of the member population;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Align the demonstration with Affordable Care Act;

- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCPs);
- Expand access to home and community-based services (HCBS) and allow individuals to have a choice between institutional services and HCBS;
- Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations;
- Establish contractual accountability among the contracted health plans and health care providers;
- Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

The interim evaluation for the current waiver, which includes information on the how the objectives above were met, can be found in Attachment B.

Eligibility and Alignment with the Affordable Care Act

During the current demonstration period, October 2013 through December 2018, QUEST Integration successfully implemented managed care for almost 99% of the Medicaid population. With the addition of the ACA, Hawai'i increased the number of individuals eligible for medical assistance by using Modified Adjusted Gross Income (MAGI) methodology to determine income eligibility for families with dependent children up to 100% of the FPL under Section 1931 of the Social Security Act; Low Income Adults up to 133% of the FPL; Pregnant Women up to 191% of the FPL; Children up to 308% of the FPL; and Former Foster Care children with no income limit. Individuals who were eligible under Section 1931 of the Act with increased earnings qualified for a twelve month period of transitional medical assistance under Section 1925 of the Social Security Act. The MAGI methodology also exempted assets.

Enrollment grew by 25 percent from October 2013 to March 2018, with the greatest increase coming in the low-income adult group during that time. Low-income adults grew by approximately 65,000 individuals or 115 percent between October 2013 and March 2018. Total enrollment has grown to over 360,000 Medicaid beneficiaries. The total enrollment growth is comparable to historical enrollment growth.

Table 1: Enrollment Growth CY2008 - CY2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018 (est)
Average Monthly Enrollment	211,2015	235,206	260.457	272,218	287,902	292,423	307,303	325,151	346,357	353,032	361,113
Percent Growth Year over Year		11.4%	10.7%	4.5%	5.8%	1.6%	5.1%	5.8%	6.5%	1.9%	2.3%

MQD started determining eligibility for Medicaid individuals using new Modified Adjusted Gross Income (MAGI) criteria on October 1, 2013. In addition, MQD fine-tuned its work within its eligibility system called Kauhale (community) On-Line Eligibility Assistance System (KOLEA). MQD encouraged applicants to apply on-line at its www.mybenefits.hawaii.gov website.

MQD implemented other ACA requirements on October 1, 2013. This included the FQHCs becoming navigators with the Hawai'i Health Connector, the state's original state-based exchange. Hawai'i became a state-based exchange using the federal platform for the individual market in 2015, and switched to a fully federally-run exchange in 2017. FQHCs were able to submit applications for Hawai'i Medicaid through the KOLEA system as well.

In addition to encouraging applicants to apply through the KOLEA system, MQD established a new branch in December 2015. The Health Care Outreach Branch (HCOB) was created in response to a demonstrated community need for additional application assistance for some of the hardest to reach populations. The program focused its outreach and enrollment assistance efforts on those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers and justice-involved populations. Due to the multiple challenges faced by these individuals/families, they were traditionally less likely to proactively enroll themselves in health insurance. Having an outreach team in the field that met people where they congregate and offered on-the spot application assistance was helpful in serving this high-risk population.

Program Integration

As noted above, MQD consolidated its QUEST programs into a single program under this Section 1115 demonstration. On January 1, 2015, MQD combined its QUEST and QExA programs into one program called QUEST Integration. The QI program currently has five health plans.

In Hawai'i, those with a behavioral health diagnosis of Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) may have difficulty in accomplishing their activities of daily living (ADLs) and thus require additional services beyond the basic behavioral health services utilized by individuals without SMI or SPMI. The individuals received specialized and non-specialized behavioral health services through a separate behavioral health organization (BHO), but their QI plan was still responsible for providing non-behavioral health services.

Prior to QUEST Integration, MQD converted medical assistance coverage for the population age 65 or older and disabled of all ages from fee-for-service (FFS) to managed care through the QUEST Expanded Access (QExA) program in February 2009. Adults and children eligible for Medicaid received their healthcare through QUEST and QExA. Children and pregnant women eligible for the State Children's Health Insurance Program (SCHIP) were also enrolled in the QUEST program and received the same benefits as QUEST members.

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

UCC Pool

The demonstration included a provision for direct payments to providers through uncompensated care (UCC) pool payments. The State was able to make payments to governmentally-operated hospitals, governmentally-operated freestanding and hospital-based nursing facilities, and private hospitals to cover uncompensated care costs (UCC) for hospital and long-term care services. Federal Financial Participation (FFP) was authorized to pay for hospital and nursing facility uncompensated care until June 30, 2016.

MQD submitted an evaluation report to CMS in February 2016 on the UCC pool and found that hospital uncompensated care costs were mostly attributable to Medicaid underpayments. Hawai‘i did not request an extension of the UCC pool payments after June 30, 2016. Instead, MQD pursued enhancement of the capitated rates paid to Medicaid managed care plans to increase reimbursement to hospitals to support the availability of services and to ensure access to care for beneficiaries. The evaluation can be found as Attachment F to this application.

Additional Benefits & Efforts

The current waiver demonstration allowed a number of additional benefits not always seen in state Medicaid program benefit packages, notably Home and Community Based Services (HCBS) for beneficiaries at an institutional level of care and for certain individuals who are assessed to be at risk of deteriorating to institutional level of care (the “at-risk” population), supportive housing services for individuals with SMI and SPMI, and other specialized behavioral health services. The current waiver also featured a continuing focus on pay-for-performance initiatives through the QI plans.

Supportive Housing

The BHO offered supportive housing services alongside service coordination services for eligible individuals. The BHO began to operationalize the supportive housing benefit within a year of the waiver being renewed and included pre-tenancy services such as housing search, filling out and submitting applications for housing, gathering documents to put members on waiting lists for housing, coordinating resources to assist with start up security deposit/rent, and ensuring monthly income is sustained. Tenancy/post-tenancy services were also covered, including: identification of triggers and intervention for negative behaviors which can jeopardize placement, coaching on development/negotiation with roommates or landlords as appropriate, education/training on responsibilities of tenant/landlord, development of daily living skills, and development of housing support plans. MQD plans to focus more energy on supportive housing services during the waiver extension period.

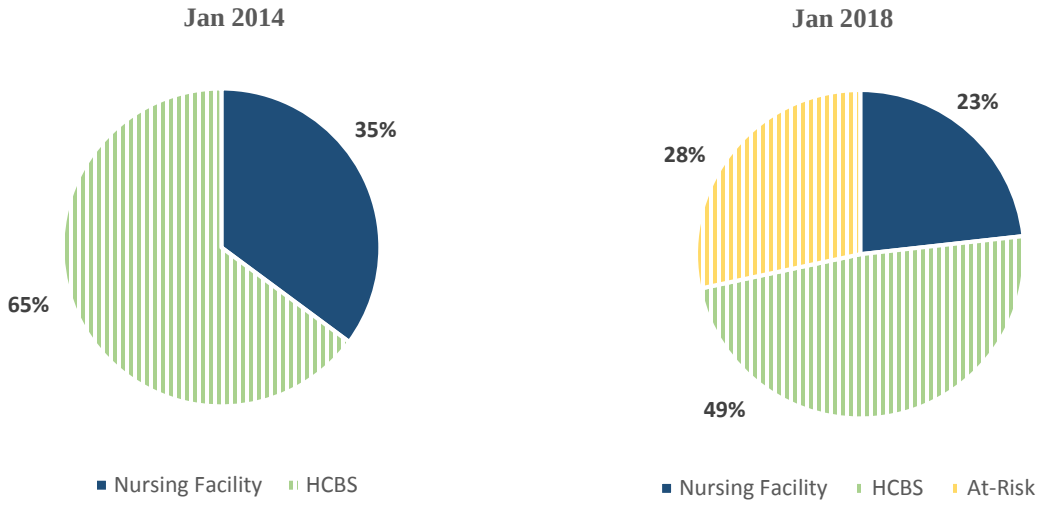
The At-Risk Population

One of the goals of the demonstration was to expand access to HCBS and allow individuals to have a choice between institutional services and HCBS. MQD sought to accomplish this by opening up HCBS to individuals at-risk of deteriorating to an institutional level of care.

The services were intended to prevent a decline in health status and maintain individuals safely in their homes and communities. During the current demonstration, the at-risk population had access to a set of HCBS that included personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS), and skilled nursing.

For the at-risk population, Hawai‘i has seen some positive results in the number of individuals that receive care in a nursing home in relation to those that receive HCBS. The number of individuals receiving care in a nursing home has gone down 17.6 percent between January 2014 and January 2018. The number of individuals meeting an institutional level of care receiving HCBS also went down 7 percent. These shifts happened at the same time as more beneficiaries received at-risk services.

Figure 1: Proportion of Individuals Receiving LTSS in NF and HCBS Settings - Jan 2014-Jan 2018



	January 2014	July 2014	January 2015	July 2015	January 2016	July 2016	January 2017	July 2017	January 2018
Nursing Facility	2,584	2,605	2,479	2,442	1,917	2,148	2,356	2,250	2,129
HCBS	4,770	4,765	4,556	4,829	4,062	4,846	4,194	4,493	4,434
At-Risk					1,403	1,587	2,379	2,530	2,599

It should be noted that beneficiaries in Hawai‘i must meet a relatively high standard in order to receive HCBS or nursing facility services through a nursing facility level-of-care assessment. If the at-risk population were to be removed from the analysis, MQD still reduced the percentage of those receiving LTSS in a nursing facility from 35.1 percent to 32.4 percent from January 2014 to January 2018.

Pay for Performance

The QI program under the current demonstration featured several initiatives related to payment and delivery system reform, including enhancing MQD’s pay for performance (P4P) program. Beginning in CY2015, MQD increased the capitated payment withhold of $2.00 PMPM for the non-ABD population and $1.00 PMPM for the aged, blind, and disabled (ABD) population for QI plans. Furthermore, MQD made the following improvements:

- Expanded measure set – increased the number of measures from six (6) to nine (9). MQD used HEDIS measures for the P4P program and set aggressive targets.
- Recognized both improvement and goal achievement of individual measure scores – added incremental achievement targets to the current excellence target, with corresponding additional percentage incentives.
- Weighted the measures differently based on the percentage of ABD enrollment each MCO served during the time period.

Table 2: P4P Results CY2014-CY2016

Measures and Descriptions		CY2014			CY2015			CY2016		
		Hawai'i Rate	Target Percent	Difference Between Rates	Hawai'i Rate	Target Percent	Difference Between Rates	Hawai'i Rate	Target Percent	Difference Between Rates
Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	58.57%	63.23%	-4.66%	58.48%	61.50%	-3.02%	61.72%	63.33%	-1.61%
Comprehensive Diabetes Care	HbA1c Control (<8.0%)	40.37%	54.01%	-13.64%	43.59%	52.55%	-8.96%	45.80%	53.65%	-7.85%
Childhood Immunization Status	Combination 3	57.81%	76.50%	-18.69%	64.63%	75.60%	-10.97%	57.92%	75.91%	-17.99%
Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up	29.69%	56.78%	-27.09%	34.89%	55.34%	-20.45%	38.63%	56.22%	-17.59%
Plan All-Cause Readmissions	Total	12.15%		12.15%	13.76%	13.17%	-.49%	13.14%	13.55%	.41%
Prenatal and Postpartum Care	Postpartum Care	51.10%	68.85%	-17.75%	51.56%	67.53%	-15.97%	54.74%	69.44%	-14.70%
Prenatal and Postpartum Care	Timeliness of Prenatal Care	69.46%	88.66%	-19.20%	72.95%	87.56%	-14.61%	74.55%	88.59%	-14.04%
Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	72.91%	66.24%	6.67%	67.59%	67.76%	-0.17%	71.32%	68.66%	2.66%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	75.80%	78.46%	-2.66%	72.39%	77.57%	-5.18%	71.51%	78.51%	-7.00%

The source for data contained in this document in the table above is Quality Compass® 2015, 2016, and 2017 and is used with the permission of NCQA. Quality Compass 2015, 2016, and 2017 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

The QI program improved performance on seven of the nine measures included in the P4P program, but only met two of its HEDIS targets. In addition to this longitudinal improvement, the QI program also narrowed the distance between the Hawai‘i rate and the national HEDIS target rate for the seven measures. However, Med-QUEST also saw decreases in performance in measures on well-child visits and immunizations.

QUEST Integration Initiatives

Since 1994, the foundation of the QUEST programs has been a capitated managed care system. Over the history of the QUEST and QUEST Integration demonstrations, the State has found that capitated managed care leads to a more predictable and slower rate of expenditure growth, thereby allowing the State to make the most efficient use of taxpayer dollars and provide high- quality care to the maximum number of individuals.

Under the extension, MQD will continue its current programs and provide all beneficiaries enrolled under the demonstration with access to the same single benefit package, of which access to certain services will be based on clinical criteria and medical necessity. The benefit package will include benefits consisting of full State plan benefits and will offer certain additional benefits as described in the sections below and in our current Special Terms and Conditions (Attachment D).

The State plans to continue to provide most benefits through capitated managed care and mandate managed care enrollment for most beneficiaries. The State will use a FFS system for long-term care services for individuals with developmental or intellectual disabilities, applicants eligible for retroactive coverage only, certain medically needy non-ABD individuals, and medical services under the State of Hawai‘i Organ and Tissue Transplant (SHOTT) program, among other services.

The HOPE Initiative

MQD’s strategic focus under the QUEST Integration demonstration extension will be the Hawai‘i ‘Ohana Nui Project Expansion (HOPE) initiative. The goal of the HOPE initiative 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 through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and a continued sustainable growth rate in health care spending by reducing unnecessary care and shifting care to appropriate settings.

The HOPE initiative is focused on four key strategies. 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 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 QUEST Integration demonstration's managed care program will be the vehicle to turn the HOPE principles into reality. In the extension, MQD will explore a number of different payment and delivery system reform approaches to effectuate the HOPE vision. Many of the approaches should be covered under our existing waiver and expenditure authorities and under flexibilities found under federal regulations as outlined in the managed care rule.

MQD will spend much of 2019 refining these strategies into defined policies. The programs and initiatives are ambitious. We expect the forum to discuss most of these changes with CMS will be through the MCO contract review and MCO rate setting processes. However, additional waiver and expenditure authorities, post-approval protocols, and state plan amendments (SPAs) may be needed as well once the approaches are refined. As such, we have included the description of the 'Ohana Nui principles and our plan for integrating HOPE into the future of the QUEST demonstration in Attachments L and M.

Demonstration Objectives, Waiver Hypotheses, and Extension Evaluation

As noted above, an interim evaluation report of the demonstration, inclusive of evaluation activities and findings to date can be found in Attachment B. In order to streamline the demonstration's historical objectives with the HOPE Initiative's focus, MQD proposes the following objectives for the extension below. The objectives have been consolidated and updated from the current demonstration.

- 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
- Support strategies and interventions targeting the social determinants of health.

MQD seeks to meet these goals through a managed care model that will feature a greater focus on the principles and strategies described in Attachments L and M.

MQD will work with stakeholders and CMS to translate our goals and model to appropriate and well defined research hypotheses. As a starting point, the State proposes the following research hypotheses and initial design approach.

Demonstration Objectives	Evaluation Hypotheses	Potential Approaches
Improve health outcomes for Medicaid beneficiaries covered under the demonstration	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.	Measure intervention impacts on trends in utilization, targeted HEDIS and state-defined health care quality and outcome measures, and total cost of care per beneficiary. Data will be drawn from a variety of sources including: • Administrative data (i.e., claims; encounters, enrollment in Hawaii Prepaid Medical Management Information System (HPMMIS), health plan reports, etc.); • Electronic Health Records; • Member and provider feedback (External Quality Review Organization (EQRO)-conducted surveys, grievances, Ombudsman reports); and • Inter-agency data from other divisions within the Department of Human Services and potentially other agencies such as the Department of Health, Department of Education, and Department of Labor and Industrial Relations.
	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 high-needs, high-cost individuals.	
Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth.	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.	
Support strategies and interventions targeting the social determinants of health.	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.	

Evaluation and greater use of data are a key building block of the HOPE initiative and MQD will work with CMS to design a robust and thoughtful evaluation strategy that will effectively measure the extension demonstration. Within 120 days of approval of the terms and conditions for the demonstration, MQD will develop a comprehensive draft evaluation plan for CMS's review. No later than 60 days after receiving comments on the draft evaluation plan from CMS, MQD will submit its final evaluation plan.

Demonstration Eligibility

Hawai'i intends to cover the same eligibility groups in the waiver extension as it covers currently. The demonstration affects the vast majority of all the mandatory and optional Medicaid eligibility groups set forth in the State's approved state plan. The groups are described below.

Table 3: Mandatory State Plan Groups

Mandatory State Plan Groups		
Eligibility Group Name	**Authority**	**Qualifying Criteria**
Parents or caretaker relatives	§1902(a)(10)(A)(i)(I), (IV), (V) § 1931(b), (d) 42 C.F.R.§ 435.110	Up to and including 100% FPL
Pregnant Women	§1902(a)(10)(A)(i)(III)-(IV) 42 C.F.R. §435.116	Up to and including 191% FPL
	§1902(e)(5) and §1902(e)(6) 42 C.F.R. §435.170	Extended and continuous eligibility for pregnant women
Infants	§1902(a)(10)(A)(i)(IV) §1902(l)(1)(B) 42 C.F.R. § 435.118(c)(2)(iii)	Infants up to age 1, up to and including 191% FPL
	§1902(e)(4) 42. C.F.R §435.117	Deemed newborn children
	§1902(e)(7) 42. C.F.R §435.172	Continuous eligibility for hospitalized children
Children	§1902(a)(10)(A)(i)(VI) and (VII) §1902(l)(1)(C)-(D) 42 C.F.R. §435.118	Children ages 1 through 18, up to and including 133% FPL
	§1902(e)(7) 42. C.F.R §435.172	Continuous eligibility for hospitalized children
Low Income Adult Age 19 Through 64 Group	§1902(a)(10)(A)(i)(VIII) 42 C.F.R. §435.119	Up to and including 133% FPL

Children with adoption assistance, foster care, or guardianship care under title IV-E.	§1902(a)(10)(A)(i)(I) and 473(b)(3) 42 C.F.R. §435.145	An adoption assistance agreement is in effect under title IV-E of the Act; or Foster care or kinship guardianship assistance maintenance payments are being made by a State under title IV-E.
Former Foster Children under age 26	§1902(a)(10)(A)(i)(IX) 42 C.F.R. §435.150	No income limit
State Plan Mandatory Aged, Blind, or Disabled Groups	§1902(a)(10)(A)(i)(II) 42 C.F.R. §435.120	ABD individuals who meet more restrictive requirements for Medicaid than the SSI requirements. Uses SSI payment standard.
	§1902(a)(10)(A)(i)(II) §1905(q) 42 C.F.R. §435.120	Qualified severely impaired blind and disabled individuals under age 65
	§1634, §1634(a), §1634(b), §1634(c), §1634(d), §1634(e) 42 C.F.R. §435.121, 122, 130, 131, 132, 133, 134, 135, 138	Other ABD groups as described in the State Plan
Transitional Medical Assistance	§1925 42 C.F.R. §435.112	Coverage for one twelve month period due to increased earnings that would otherwise make the individual ineligible under Section 1931
1931 Extension	§1931(c)(1)-(2) 42 C.F.R. §435.115	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*	1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	Standard eligibility provisions for this population as described in the State Plan.
Specified low-income Medicare beneficiaries*	1902(a){1 O)(E)(iii), 1905(p)(3)(A){ii), and 1860D-14(a){3)(D) of the Act	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.

Table 4: Optional State Plan Groups

Optional State Plan Groups		
Eligibility Group Name	**Authority**	**Qualifying Criteria**
Optional Coverage of Families and Children and the Aged, Blind, or Disabled	§1902(a)(10)(ii) §1905(a) 42 C.F.R. § 435.210	ABD individuals who do not receive cash assistance but meet income and resource requirements
	42 C.F.R. § 435.211	Individuals eligible for assistance but for being in a medical institution
	§1902(a)(10)(ii)(VII)	Individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care
	§1902(a)(10)(ii)(XI) 42 C.F.R. § 435.121 42 C.F.R. § 435.230	ABD individuals in domiciliary facilities or other group living arrangements
	§1902(a)(10)(ii)(X) §1902(m)	Aged or disabled individuals with income up to and including 100% FPL
Optional targeted low- income children	§1902(a)(10)(A)(ii)(XIV) Title XXI 42 C.F.R. § 435.229	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	§1902(a)(10)(A) §1920	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non- Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. § 435.301(b)(1) 42 C.F.R. §435.308	Up to and including 300% FPL, if spend down to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. §§435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology
Foster Children	§1902(a)(10)(A)(ii)(VIII) 42 C.F.R. §435.227	Children with non IV-E adoption assistance

Foster Children (19-20 years old)	§1902(a)(10)(A)(ii)(VIII) 42 C.F.R. §435.227	Receiving foster care maintenance payments or under adoption assistance

Table 5: Expansion Populations

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

The demonstration extension will include application of Modified Adjusted Gross Income (MAGI) eligibility standards as required by applicable law and regulations, which includes not having an asset test for MAGI populations. There will be no changes in eligibility methodology. Eligibility for the Aged, Blind and Disabled groups will continue to be determined using current income and resource methodologies.

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

There will be no changes in the demonstration's post-eligibility treatment of income. Individuals receiving nursing facility services will be subject to the post-eligibility treatment of income rules set forth in Section 1924 and 42 C.F.R. §435.733. The application of beneficiary income to the cost of care

will be made to the nursing facility. Individuals receiving HCBS will be subject to the post-eligibility treatment of income rules set forth in Section 1924 of the Social Security Act and 42 C.F.R. § 435.735, if they are medically needy.

Hawai‘i proposes to continue its policy of encouraging timely enrollment in Medicaid through a shortened retroactive eligibility period. The current demonstration limits retroactive eligibility to a 10-day period prior to application, except for those beneficiaries requesting LTSS. Both Hawai‘i and the federal government have taken significant steps to simplify and streamline the Medicaid eligibility and enrollment process.

Retaining a limited retroactive eligibility period will encourage individuals to apply when eligible, will allow them to benefit more quickly from the program, and will help alleviate the administrative burden on the managed care plans and the State.

Current Demonstration Benefits and Features to Continue Under the Extension

Under the extension, Hawai‘i will continue to provide services in the way it provides them under the current 1115 waiver. MQD will offer one comprehensive set of benefits available to all demonstration populations. Hawai‘i will continue to offer one primary and acute care services package consisting of full State plan benefits to all demonstration populations, with certain additional benefits available based on clinical criteria and medical necessity. This benefit structure will be easier for beneficiaries to navigate, better equipped to serve patients with changing needs, and less burdensome for the State to administer.

In the extension, MQD will continue to provide a set of Home and Community Based Services (HCBS). Individuals who meet institutional level of care (“1147 certified”) will have access to a wide variety of Long Term Services and Supports, including specialized case management, home maintenance, personal assistance, adult day health, respite care, and adult day care, among others. Moreover, Hawai‘i will provide HCBS to certain individuals who are assessed to be at risk of deteriorating to institutional level of care, in order to prevent a decline in health status and maintain individuals safely in their homes and communities. These individuals (the “at risk” population) will have access to a set of HCBS that includes personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS), and skilled nursing, subject to limits on the number of hours of HCBS or the budget for such services. MQD intends to offer HCBS services as they are described in our current Special Terms and Conditions (Attachment D).

Hawai‘i also will continue to include in the QI benefit package the following benefits, subject to clinical criteria and medical necessity, and as described in our Special Terms and Conditions (Attachment D):

- Covered substance abuse treatment services provided by a certified (as opposed to licensed) substance abuse counselor.

- 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 Housing.
    - 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. 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.
- 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.

The delivery system used to provide the vast majority of benefits will continue to be through managed care, as opposed to fee-for-service (FFS). A statewide managed care delivery system will help Hawai‘i ensure access to high-quality, cost-effective care; establish contractual accountability among the health plans and health care providers; and continue the predictable and slower rate of expenditure growth associated with managed care.

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

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

Health Plan Enrollment

In an effort to balance beneficiary choice with service coordination and continuity, MQD will continue the enrollment and health plan selection process that it employs under the current demonstration.

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

In accordance with federal rules, all individuals will have a single 90-day period from their initial enrollment action to change their health plan. That is, an individual who chooses a health plan either at the time of eligibility notification or during the 15-day choice period, or switches health plans during the annual open enrollment, will have an additional 90-day period from the enrollment action to change plans.

Similarly, an individual who is auto-assigned for not selecting a health plan upon eligibility notification and during the 15-day choice period will have 90 days from the auto-enrollment action to change health plans. An individual enrolled in a health plan who chooses to remain in that plan during the annual open enrollment period will not be given a 90-day change period. Individuals will be able to change health plans for cause at any time. These rules apply to all enrollees, including ABD enrollees.

After a beneficiary selects a health plan, he or she will receive a survey or a welcome call from the health plan, which will identify if the beneficiary has any special health needs. A welcome call will be required for those who do not respond to the survey if applicable. If special health needs are identified, the health plan will assign a licensed or qualified professional as the beneficiary's service coordinator and perform a face-to-face assessment. In addition, health plans will still be required to perform a face-to-face assessment on individuals with identified special health care needs, such as those receiving long-term services and supports (LTSS).

A modification to the health plan selection process may be implemented in the extension period as it relates to dual eligibles. MQD is interested in promoting greater alignment between Medicaid and Medicare health plans and may use auto-enrollment as a means to accomplish greater aligned enrollment. An example would be to auto-enroll a beneficiary into a QI health plan from the same organization offering the beneficiary's current Medicare Advantage plan.

Long-Term Services and Supports

MQD will provide long term services and supports (LTSS) in the way it provides them under the current 1115 waiver. Under the extension, the State will continue its policy of allowing beneficiaries who meet an institutional level of care to choose between institutional services or HCBS. Access to both institutional and HCBS LTSS will be based on a functional level of care (LOC) assessment to be performed by the health plans or those with delegated authority. Each beneficiary who has a disability, or who requests or receives LTSS, will receive a functional assessment at least every twelve months, or more frequently when there has been a significant change in the beneficiary's condition or circumstances. In addition, each member who requests a functional assessment will receive one.

The State will review the assessments and make a determination as to whether the beneficiary meets an institutional (hospital or nursing facility) level of care.

Individuals who meet the institutional level of care may access institutional care or HCBS through their health plan. Certain individuals who are assessed to be "at risk" of deteriorating to the institutional level of care (the "at risk" population) will continue to have access to defined HCBS services as described in the State's current Special Terms and Conditions. The State requests authority to limit the number of hours of HCBS provided to "at risk" individuals or the budget for such services.

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

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

If the estimated costs of providing necessary HCBS to the beneficiary exceed the estimated costs of providing necessary care in an institution (hospital or nursing facility), a health plan may refuse to offer HCBS, if the State so approves. In reviewing such a request by a health plan, the State will take into account the health plan's aggregate HCBS costs as compared to the aggregate costs that it would have paid for institutional care.

Although the intent of HCBS is to utilize social supports, the State recognizes and seeks to accommodate temporary medical or social conditions that require additional services. Accordingly, adults meeting an institutional LOC may be limited to receive up to 90 days per benefit period of 24 hours of HCBS per day.

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

Though Hawai‘i has not had to establish a waiting list for HCBS, the State continues to request authority to allow the QI health plans to establish waiting lists, upon approval by the State, for the provision of HCBS. Waiting list policies will be based on objective criteria and applied consistently in all geographic areas served. The State will monitor the waiting lists on a monthly basis, and will meet with the health plans on a quarterly basis to discuss any issues associated with management of the

waiting lists. Members who are on a waiting list may opt to change to another health plan if it appears that HCBS are available in the other health plan.

Behavioral Health Services

Under the extension, MQD intends to provide behavioral services the same way it provides them under the current QI program. The QUEST Integration demonstration will continue to offer a full array of standard state plan behavioral health services through managed care. It will also continue to offer additional, specialized state plan and waiver 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. The standard behavioral health services include inpatient psychiatric hospitalization, emergency department services, ambulatory services that includes crisis management and residential services, medications, medication management, diagnostic services, psychiatric and psychological evaluation and management, medically necessary substance use disorder (SUD) treatment, and methadone management.

Beneficiaries with SMI, SPMI, or SEBD may be in need of specialized behavioral health services. For children (individuals <21), the SEBD services are provided through the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD); for adults (individuals >21) the SMI/SPMI services are provided through the 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.

CCS program provides specialized behavioral health services to adults diagnosed with an eligible serious mental illness (SMI) or serious and persistent mental illness (SPMI) who exhibit emotional cognitive, or behavioral functioning which interferes substantially with their activities of daily living and capacity to remain in the community without supportive treatment or services.

All QI health plans provide all their beneficiaries with standard behavioral health services. Referrals are sent to the QI health plans by providers who have identified beneficiaries with SMI/SPMI for review. The QI health plan then submits the referral to the MQD for CCS eligibility determination. Eligible beneficiaries are then enrolled into CCS. Once enrolled, all behavioral health services are provided by CCS.

Children requiring SEBD receive specialized behavioral health services through the Hawai‘i Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD). Medicaid beneficiaries over

18 years old with SMI/SPMI who are legally encumbered have their behavioral health services coordinated and provided by DOH's Adult Mental Health Division (AMHD).

Community Integration Services

MQD is currently working with CMS on an 1115 waiver amendment to expand the population that is eligible to receive what are known in the current demonstration as supportive housing services. The new benefit for pre-tenancy and tenancy services, called "Community Integration Services" (CIS), will be available to all beneficiaries above the age of 18 that meet certain needs-based criteria. The needs-based criteria is focused on chronically homeless, homeless, and beneficiaries at-risk of eviction with mental health, SUD, or complex physical health needs or high ED and hospital utilization risk factors. The approach of that amendment is repeated here.

The expenditure authority is needed because Hawai'i has had the highest per capita homeless population in the country. This issue has raised both public health and safety concerns among Hawai'i residents statewide. Studies have shown that the chronically homeless population's high use of hospital facilities and emergency rooms accounts for their disproportionately high annual health care costs.

To combat this issue, both public and private stakeholders have partnered to implement "Housing First" and other permanent and supported housing solutions in Hawai'i. Access to safe, quality, affordable housing and the supports necessary to maintain this housing constitute one of the most basic and powerful social determinants of health. For beneficiaries and families trapped in a cycle of crisis and housing instability or homelessness due to extreme poverty, trauma, violence, mental illness, addiction or other chronic health conditions, lack of housing is a major barrier to escaping this cycle. Hawai'i wants to provide these supports to beneficiaries who are identified as homeless or who have a combination of housing instability and health conditions that establish their need for supportive housing services.

In regard to person-centered service planning, the State will add a standardized housing assessment tool as an appendix to the "Health and Functional Assessment" (HFA) tool to assess beneficiary eligibility and need for supportive housing services. The evaluation occurs in-person and for the amendment population will be conducted by the MCO service coordinator. Adding the standardized housing assessment tool as an appendix to the larger HFA will allow the MCO to consider housing support services alongside the other health, behavioral, and social needs of the beneficiary.

The HFA results inform the beneficiary's person-centered plan across domains, which helps link the beneficiary's housing goals with their health, behavioral, and other social goals. The beneficiary is engaged in the process and is able to review their plan.

The individual will be re-evaluated using the housing assessment tool at quarterly intervals and the person-centered service plan will be updated as necessary using the results of that assessment. A beneficiary can be re-evaluated in between quarterly intervals if significant changes occur in their status.

In regard to conflicts of interest, for the amendment population the MCO service coordinator conducts the HFA and writes the plan with the beneficiary. The MCO will maintain contracts with case management/homeless agencies to provide the services for the beneficiary.

The benefit package includes services that would otherwise be allowable under a Section 1915(i) authority, are determined to be necessary for an individual to obtain and reside in an independent community setting and are tailored to the end goal of maintaining beneficiary's personal health and welfare in a home and community-based setting. CIS may include a mix of pre-tenancy and tenancy sustaining supports.

The CIS benefit does not include: payment of rent or other room and board costs; capital costs related to the development or modification of housing; expenses for regular utilities or other regular occurring bills; goods or services intended for leisure or recreation; duplicative services from other state or federal programs; or services to individuals in a correctional institution or an institution for mental disease ((IMD) - other than services that meet the exception to the IMD exclusion).

Other Features that Will Continue

Medically Needy Non-ABD Individuals

Medically needy non Aged, Blind and Disabled (ABD) individuals with shorter eligibility spans will not be enrolled in a QI health plan and will be subject to the medically needy spend-down. They will receive services on a fee-for- service basis. This category might include, for example, persons who become medically needy for a short-term period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically.

Medically Needy ABD Individuals

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

Self-Direction Opportunities

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

- Personal assistance- Level I
- Personal assistance- Level II
- Respite care

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

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

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

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

Additional Hospice Payment for Nursing Facility Residents

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

Cost-Sharing

The State will continue the cost-sharing policies it has employed under the current demonstration. The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan. The State allows managed care capitation costs as an expense that can be counted toward meeting an enrollment fee in order to meet the spend-down obligation for Medically Needy ABD health plan enrollees.

Under QUEST Integration, the State can charge an enrollment fee to health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate for the Medically Needy ABD population in the amount equal to the estimated spend-down or cost share amount or where applicable, the amount of patient income applied to the cost of long-term care.

The state plan does not currently have an enrollment fee for the Medically Needy ABD group.

Proposed Waiver and Expenditure Authorities

The following table summarizes the current waiver provisions and whether MQD is requesting to continue these provisions in the next extension period. As noted above, MQD may seek to use the existing authorities in new ways in order to realize the HOPE vision.

Table 6: Waiver Authorities

Current Waiver Authority	Status under Extension
Medically Needy (Section 1902(a)(10)(C); 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.	Continue
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.	Continue
Retroactive Eligibility (Section 1902(a)(34) To enable the state to limit retroactive eligibility to a ten (10) day period prior to application, or up to three months for individuals requesting long-term care services.	Continue
Freedom of Choice (Section 1902(a)(23)(A)) To enable Hawai'i to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932.	Continue
Annual Redeterminations (Section 1902(a)(17) and Section 1902(a)(19)) To the extent necessary to enable the state to extend the eligibility span of enrollees who will need a redetermination between October 1, 2013, and December 31, 2013, to a reasonable date in 2014.	Discontinue
Title XIX Requirements Not Applicable to Demonstration Expansion Populations **Cost Sharing** **Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**	Continue

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.	

Table 7: Expenditure Authorities

Current Expenditure Authority	Status for Extension
Managed Care Payments. Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m): Expenditures for capitation payments provided to managed care organizations (MCOs) in which the state restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island. Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and federal regulations at 42 CFR section 438.52.	Continue
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.	Continue
Demonstration Expansion Eligibility. Expenditures to provide coverage to the following demonstration expansion populations:	Continue for Demonstration populations 1 through 5.

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 f. Demonstration Population 6. Individuals who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not	Discontinue for Demonstration Populations 6 through 7.

impose an asset limit on this population. Authority for this demonstration population expires December 31, 2013. g. Demonstration Population 7. Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Medicare part A or enrolled for benefits under Medicare part B and are not a mandatory state plan population and whose income (as determined using modified adjusted gross income) does not exceed 133 percent of the FPL, determined using modified adjusted gross income. Authority for this demonstration population expires December 31, 2013.	
Hospital Uncompensated Care Costs. Expenditures for actual uncompensated care costs incurred by certain hospital providers and nursing facility providers for inpatient and outpatient hospital services and long-term care services provided to the uninsured as well as Medicaid managed care and fee-for-service shortfalls, subject to the restrictions placed on hospital and nursing facility uncompensated care costs, as defined in the STCs and the CMS approved Certified Public Expenditures/Government-Owned Hospital Uncompensated Care Cost Protocol. This expenditure authority is effective through June 30, 2016.	Discontinue
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. 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	Continue

long as such limits are sufficient to meet the assessed needs of the individual.	
PLACEHOLDER **Community Integration Services** Community Integration Services would be an expenditure authority that would read: *Community Integration Services (CIS), described in the Special Terms and Conditions, are available for individuals 18 years or older who meet certain needs-based criteria.*	Continue
Additional Benefits: Expenditures to provide the following additional benefits. a. 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). i. Supportive Housing. ii. Supportive Employment. iii. 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.	Continue

Hawai‘i looks forward to receiving technical guidance to identify any other expenditure or waiver authorities needed to implement the initiatives described in the previous sections or to implement the HOPE initiative.

Quality and Monitoring

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

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

To maintain its independence, the EQRO must be governed by a board whose members are not government employees; and must not:

a) review an MCO if the EQRO or the MCO exerts control over the other as evidenced by stock ownership, stock options, voting trusts, common management, and contractual relationships;
b) furnish health care services to Medicaid recipients;
c) perform Medicaid managed care program operations related to the oversight of the quality of the MCO on the State's behalf, except for the activities specified in 42 CFR 438.358; or
d) have a financial relationship with the MCO that it will review.

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

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

The EQR results and technical reports are reviewed by the appropriate Quality Strategy Committee (QSC) and the Quality Strategy Leadership Team (QSLT). The QSC will analyze the information and make recommendations for corrective actions, quality improvement and system changes to the MCOs and will

monitor MCO compliance to corrective actions. The QSLT provides oversight of implementation of quality recommendations and will review and revise the Quality Strategy accordingly.

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

Sources for Monitoring and Quality Improvement MCO Monitoring Reports: These are contractual reporting required from MCOs. Topics in the reports include Provider Network and Credentialing, Authorization Denials, Member Grievances, Provider Complaints, Timely Access, Availability of Services, Claims Payment, Call Center, Long-Term Services and Supports, Special Health Care Needs, among others.

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

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

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

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

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

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

Public Summary Report: MQD developed a public summary report that compiles health plan data on their overall performance. This document reports information in an easy to follow format that includes normalized data presented in both numbers and charts for ease of understanding. MQD obtained public input into the report format in June/July 2015. MQD designed this report to promote transparency with the daily functioning of the QI health plans.

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

Summaries of completed quality and monitoring reports can be found in Attachment A. Further information on managed care organization and State quality assurance monitoring, and other documentation of the quality of and access to care provided under the demonstration can be found on MQD's website at https://medquest.hawaii.gov/en/resources/reports.html.

Financing

Under the principle of budget neutrality, states must demonstrate that actual expenditures under the demonstration do not exceed certain cost thresholds. i.e., they may not exceed what the costs of providing those services would have been under a traditional Medicaid fee-for-service program.

MQD has proposed a capitation and trend rate by Medicaid eligibility group (MEG) that demonstrates that QUEST Integration has met this condition and generated savings for both the state and federal governments. Detailed information can be found in the budget neutrality sheets in Attachment G. Existing with and without waiver per-member, per-month estimates were trended forward using historical trend rates. MQD continues to use the same MEGs as the current waiver term. Cumulative savings through the end of DY24 is approximately $6.5 billion.

The five year projection for the demonstration extension is approximately $15.8 billion, inclusive of the Group VIII population. The without waiver estimate for the extension is $26.8 billion.

Table 8: Estimated Spending During the Demonstration

	Estimated Spending During the Demonstration (including Group VIII)					
	CY2019	CY2020	CY2021	CY2022	CY2023	Total
Without Waiver	$4,081,250,424	$4,316,143,256	$4,565,622,025	$4,830,648,530	$5,112,250,874	$26,765,958,746
With Waiver	$2,416,681,076	$2,557,340,193	$2,706,674,404	$2,865,251,879	$3,033,679,738	$15,863,792,552

From January 1, 2016 to December 31, 2017, there an average of 353,052 individuals were enrolled in the current demonstration (and covered in part by a federal match). During the five-year extension period, the annual increase in enrollment is expected to be 2.5% per year for non-ABD recipients and 1% for ABD recipients. The approximate enrollment growth over the demonstration is described below.

Table 9: Projected Average Enrollment Growth

	Estimated Enrollment Growth During the Demonstration				
	Growth in CY2019	Growth in CY2020	Growth in CY2021	Growth in CY2022	Growth in CY2023
Growth	8,275	8,474	8,679	8,888	9,102
Total Enrollment	369,388	377,862	386,541	395,429	404,531

Compliance with Special Terms and Conditions

STC 8(a)(ii) stipulates that MQD must provide documentation of its compliance with each of the STCs. Per CMS guidance, this waiver submission and its attachments demonstrate that all of the STCs have been met for the current waiver.

Public Notice

Post Award Forums for the Current Demonstration

The State has complied with the post-award public notice and input procedures as outlined in 42 C.F.R. §431.420(c) for the current demonstration. MQD hosted public forums on October 31, 2014, May 26, 2015, March 21, 2016, and June 19, 2017. The 2018 public forum will be held before December 31, 2018. Documentation of the 2017 post-award forum can be found in Attachment E.

QUEST Integration Extension Public Input Process

The concepts outlined in this extension application are informed by ongoing input from a diverse group of

stakeholders and providers throughout Hawai‘i. MQD is deeply committed to providing robust opportunities for suggestions and feedback on strategies for effectively managing the QUEST delivery system and ensuring that beneficiaries have access to high quality health care services that meet the needs of “the whole person.”

Public Comment Periods

The State’s first public notice and comment period for the QUEST Integration extension began on February 17, 2018 and concluded on March 23, 2018.

On February 15, 2018, the State issued a full public notice document with a comprehensive description of the proposed QUEST waiver extension. Consistent with 42 C.F.R. 431.408, the notice included the location and internet address where copies of the extension application were available for review and comment; the dates for the public comment period; postal and e-mail addresses where written comments could be sent; and the locations, dates and times of the two (2) public hearing convened by the State to seek public input about the extension application. This public notice document was available in a prominent location at https://medquest.hawaii.gov/ for the duration of the comment period.

On February 17, 2018, the State published an abbreviated public notice in the newspapers of widest circulation in each city with a population of 100,000 or more, which included a description of the demonstration extension request; the location and internet address where copies of the extension application were available for review and comment; the locations, dates, and times of two public hearings designed to seek public input on the extension application; and an active link to the full public notice document on the State’s web site. On February 20, 2018 and March 1, 2018, the State used an electronic mailing list to notify potentially interested parties of the opportunity to review the public notice and provide comments.

As required, the State held two in-person public hearings to solicit public input and comment about the demonstration extension application:

- March 2, 2018 from 8:00 am to 12:00 pm
  Hawai‘i Department of Human Services
  1390 Miller Street, Conference Room 1 & 2
  Honolulu, Hawai‘i

- March 6, 2018 from 8:00 am to 12:00 pm via teleconference at:

  Oahu — Kakuhihewa Videoconference Center
  Kakuhihewa State Office Building
  601 Kamokila Boulevard, Room 167B
  Kapolei, Hawai’i

  Hawai‘i — Hilo Videoconference Center
  Hilo State Office Building
  75 Aupuni Street, Basement
  Hilo, Hawai’i

Kauai	Lihue Videoconference Center Lihue State Office Building 3060 Eiwa Street, Basement Lihue, Hawai'i
Maui	Wailuku Videoconference Center Wailuku Judiciary Building 2145 Main Street, First Floor Wailuku, Hawai'i

The notice included contact information for individuals who could not attend and who would need accommodations in order to participate in the public forum. The State did not receive any calls, emails, or other forms of communication requesting accommodations. These formal public meetings supplemented several other meetings where MQD presented its vision for the waiver. These meetings included the following:

- November 20, 2017 – Act 43 Affordable Health Insurance Working Group Meeting. Responded to questions from legislative stakeholders.
- January 10, 2018, State of Reform 2018 Conference – Afternoon Keynote speaker. Presented "An Update from MQD" which covered the Vision document, the ACA Workgroup, and two upcoming events (public health week and 1115 Demonstration Extension plans).
- April 5, 2018, National Public Health Week Event –Featured speaker. Topics covered in addition to Vision document were "Changing our Future Together" and "Medicaid Initiatives to Support Healthy Families and Communities in Hawai'i."
- April 23, 2018, Hawai'i Medical Education Council (HMEC) – HMEC is a Governor appointed council charged with monitoring healthcare workforce issues.

The State elected to provide a second opportunity for public comment from July 31, 2018 to August 30, 2018. Because the required public meetings were held in March 2018, CMS informed MQD that a second round of public meetings was not necessary. The full public notice was published on the Department's website on July 31, 2018. The State also published an abbreviated public notice in the newspapers of widest circulation in each city with a population of 100,000 or more, which included a description of the demonstration extension request on July 31, 2018. The State posted the updated demonstration application on the website and circulated the link to the document and a notification to potentially interested parties regarding the second opportunity to comment.

Documentation of the CMS public notice requirements can be found in Attachments H through K.

Summary of Public Comments Received

MQD received comments from a total of 32 organizations and individuals during the first and second comment periods. Commenters represented organizations from across the state, including providers, hospitals, associations, community organizations, health plans, consumer advocates, and others.

Specifically, the state received five comments from individual providers, five comments from health plans, six comments from professional associations, two comments from hospitals, four comments from community health centers, five comments from advocates, three comments from other state agencies, and two academic institutions.

The vast majority of comments related to the potential expansion of benefits and movement toward value-based purchasing as proposed under the state's HOPE initiative, which are future program enhancements and not the subject of this Section 1115 waiver extension per se. A summary of all comments received is included below:

1. **Investments in Primary Care, Health Promotion, and Prevention.** The vast majority of commenters expressed strong support for the QUEST waiver extension and the integration of the HOPE vision into the demonstration. In particular, the stakeholders appreciated the emphasis on primary care, behavioral health integration, strategies for addressing the social determinants of health (SDOH), and restoration of the Medicaid dental benefit and the oral health initiative. Several commenters noted that strategies for integrating behavioral health and addressing the social determinants of health are already underway, both within provider groups but also Medicaid Managed Care Organizations (MCOs) in the state.

2. **Focus on People with the Highest, Most Complex Health and Social Needs.** Most commenters pointed out that investments in primary care, health promotion, and prevention are critically important in the context of addressing the needs of high cost/high need utilizers of care. Many pointed out on the need for improved real-time availability and transparency of data, especially on the part of Medicaid MCOs, along with the need for a common platform for data sharing. One commenter suggested that the state consider how the use of advanced care planning tools can be used in the context of caring for individuals with high cost/high utilizers of care.

3. **Movement Toward Payment Transformation and Integrated Delivery Systems.** Overall, commenters indicated support for a move toward value-based purchasing (VBP). They recommended alignment across VBP strategies and MCOs in order to ensure consistency. Commenters support the increased emphasis on performance and outcomes measures (as opposed to process measures) and the use of data to track improved costs and health outcomes, including consideration of incentives to facilitate the transition. They recommended leveraging the HEDIS measure set in order to have a standard that will allow comparisons across health plans. One commenter asked the state how they might measure compliance while transitioning toward VBP. Several comments related to the need for risk adjustment and careful consideration for patient attribution as it relates to payment reform efforts, especially in the context of working with low-income populations. One commenter pointed out that assuming risk for specific populations "is a goal of Medicaid MCOs, not low-income communities."

4. **Investments in Community Care, Community-Based Initiatives, and Links Between Integrated Health Systems and Community Resources.** Commenters were very supportive of community-based health reform initiatives, especially if those that are locally-created and implemented. Some commenters emphasized the need for community-based initiatives to be "standardized" or aligned across all Medicaid MCOs. FQHCs and other providers commented that community investment strategies be incorporated into the state's thinking. One commenter pointed out the need for a

continuous eligibility policy that would allow Medicaid beneficiaries to stay enrolled despite job changes.

Other Related Efforts:

Care Coordination: Several commenters expressed support for increased efforts aimed at improved care coordination. Two commenters highlighted the need for provider-based care coordination, rather than Medicaid MCO care coordination, and suggested that the focus should be on individual needs, not enrollment or access.

Beneficiary Engagement and Communications: One commenter suggested that the state use mobile applications, text messaging, and other social media strategies in order to more effectively engage with beneficiaries.

Miscellaneous Comments:

Health Plan Enrollment: One health plan had several suggestions for the state as they operationalize the extension of the waiver. Specifically, they requested that the state ensure adequate numbers of covered lives when re-procuring managed care contracts, consider rebalancing the mix of MedQUEST membership to ensure that specific populations are spread across all managed care plans, and apply quality improvement requirements across all managed care plans. The comments also requested that the state consider continuous eligibility for all MedQUEST enrollees and passive enrollment for those who are dually eligible.

Shared Learning: A few commenters encouraged the state to consider how to set up a process for which providers, health plans, and other stakeholders can share health care transformation learnings and best practices. Many pointed out that various health reform efforts are already underway and that learnings would be happily shared with the state and other stakeholders.

Provider Satisfaction: One commenter suggested that MQD augment its approach to achieving the Triple Aim by adopting a fourth "aim" to include provider satisfaction. Another related comment emphasized the need to address provider burnout and focus on implementing more administrative simplification.

Additional MCO Responsibilities: Some commenters expressed concerns that the responsibilities of MCOs will increase significantly without a corresponding increase in reimbursement.

Health Disparities: Some commenters raised concerns that the models that HOPE is based on do not directly translate to addressing the health disparities and cultural needs of Hawai‘i residents. They suggested that a combination of health home cultural proficiency and payment incentives designed to address chronic conditions at the first onset could help mitigate the disparities.

Rural Health Care: One commenter focused on the lack of emphasis on rural health care in the HOPE initiative.

Workforce: Several commenters pointed out the need to consider workforce shortages and investments in the context of the HOPE initiative, including the need for new ways to think about teaching facilities ("teaching health centers" vs. "teaching hospitals").

Implementation Concerns: Concerns expressed through the public comment process related to waiver implementation and were focused more on the process for implementation, not the reform concepts themselves. They noted that most everyone would agree with the high-level concepts, but that it is important for stakeholders to have opportunities to be engaged in and weigh in on the details. Specifically, commenters warned the state about potential duplication of services and care coordination, the need for a robust vetting process through a steering committee or other advisory body in order to ensure that the strategies are coordinated, payment reform strategies included flexibility and would be based on a robust community stakeholder input process. Commenters shared their concerns about the amount of time it will take to get the necessary resources in place to achieve the HOPE vision and the need for initial investments up front to assist in transformation. Some commenters reminded the state that demonstrating Medicaid savings takes time and that there is no "magic bullet" for health reform efforts.

MQD Response to Public Comments

This demonstration extension request and MQD's vision for the HOPE initiative are strongly informed by an ongoing and continuous flow of input from stakeholders. MQD meets regularly with stakeholder organizations and the State was able to incorporate the feedback received through this process into the development of the draft demonstration application. As noted above, most of the comments were focused on the state's HOPE initiative as opposed to the Section 1115 waiver extension itself. As such, none of the public comments requested significant changes to the content or waiver authorities needed for the demonstration. However, the comments have been incorporated into MQD's strategic vision for the HOPE initiative.

Stakeholders were uniformly supportive of the vision for HOPE and the state's approach to achieving it. Instead, the feedback centered around areas for future planning around implementation of the HOPE initiative – such as addressing health disparities, augmenting care coordination strategies, and focusing on provider satisfaction – in the context of the demonstration. In response to comments, MQD added the "Potential Initiatives under HOPE" document as Attachment M in order to give more detail on planning and implementation activities. MQD is already taking all suggestions from stakeholders under consideration in implementation planning and we will continue to engage with our stakeholders as the waiver extension progresses.

Tribal Consultation

Consistent with section 42 C.F.R. 431.408(b) of Hawai'i 's Medicaid State Plan, the State notified its sole urban Indian Organization Ke Ola Mamo, about its plans for the QUEST Integration extension and provided an opportunity for consultation, feedback and recommendations on behalf of designees of its health organization. The State provided Ke Ola Mamo with written correspondence on January 12, 2018 and July 30, 2018 (see Attachment K).

The State received no comments from Ke Ola Mamo in response to the first or second notification. The State continues to have an amicable and productive relationship with Ke Ola Mamo through written correspondence, email and face-to-face meetings, as requested.

More detail and documentation can be found in Attachment K.

The Post-Award Public Input Process

The State will comply with the post-award public notice and input procedures in 42 C.F.R. §431.420(c). Within six months of implementation of the extension, and annually thereafter, the State will hold a public forum to solicit public comments on the progress of QUEST Integration, at which the public will have an opportunity to comment. The State will publish the date, time, and location of the public forum in a prominent location on its web site at least 30 days prior to the date of the public forum.

Demonstration Administration

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Attachment A

State of Hawaii

Department of Human Services

Med-QUEST Division

2014 External Quality Review Report of Results *for the* QUEST and QUEST Expanded Access Health Plans and the Community Care Services Program

November 2014

HSAG Health Services Advisory Group

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016

Phone 602.264.6382 ◆ Fax 602.241.0757

Overview

The 2014 Hawaii External Quality Review Report of Results for the QUEST and QUEST Expanded Access (QExA) Health Plans and the Community Care Services (CCS) Program is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR 438.364. Health Services Advisory Group, Inc. (HSAG) is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), the single State agency responsible for the overall administration of Hawaii's Medicaid managed care program.

This report describes how data from activities conducted in accordance with 42 CFR 438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid recipients by the five QUEST health plans, two QExA health plans, and the CCS program. The QUEST health plans were AlohaCare QUEST (AlohaCare), Hawaii Medical Service Association QUEST (HMSA), Kaiser Permanente Hawaii QUEST (Kaiser), 'Ohana Health Plan ('Ohana), and UnitedHealthcare Community Plan (UHC CP). The QExA plans were 'Ohana and UHC CP; these two plans served both QUEST and QExA enrollees. 'Ohana also held the contract for the CCS program operational since March 2013. CCS is a carved-out behavioral health specialty services plan for QExA-enrolled individuals determined by the MQD to have a serious mental illness.

According to the managed care regulations (42 CFR 438), the QUEST and QExA health plans qualify as managed care organizations (MCOs) and the CCS program meets the definition as a pre-paid inpatient health plan (PIHP). For discussion purposes throughout this report, the Hawaii MCOs and PIHP will be referred to as "health plans" unless there is a need to distinguish a particular plan type.

HSAG's external quality review (EQR) of the health plans included directly performing the three federally mandated activities as set forth in 42 CFR 438.358—a review and evaluation of compliance with select federal managed care standards and associated State contract requirements, validation of performance measures/Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] compliance audits, and validation of performance improvement projects (PIPs). One optional EQR activity was also performed this year: Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] surveys of Medicaid adult members and Children's Health Insurance Program (CHIP) child members using the CAHPS 5.0H Adult Medicaid and Child Medicaid CAHPS survey instruments. While the adult survey was conducted at the plan level and provided results at a plan-specific and statewide aggregate level, the child CHIP survey was conducted at a statewide level due to small enrollment numbers, producing statewide aggregate results.

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

This report includes the following for each EQR activity conducted:

- Objectives
- Technical methods of data collection and analysis
- A description of data obtained
- Conclusions drawn from the data

In addition, an assessment of the strengths and weaknesses of each health plan, as well as plan comparative information, is included. The report also discusses the status of improvement activities initiated by the health plans and offers recommendations for improving the quality and timeliness of, and access to, health care services provided by each health plan.

This is the tenth year HSAG has produced the EQR report of results for the State of Hawaii. Report information does not disclose the identity of any patient, in accordance with 42 CFR 438.364(c).

External Quality Review Activities, Conclusions, and Recommendations

HSAG, as the EQRO for the MQD, conducted EQR activities and analyzed the results as described in the next sections of this report. HSAG also offered conclusions and recommendations for improvement to the QUEST, QExA, and CCS health plans.

Compliance Monitoring Review of Standards

Description

For the 2014 evaluation of health plan compliance, HSAG used standardized monitoring tools to assess and document the health plans' compliance with a select set of standards and requirements. The standards selected for review were related to the health plans' State contract requirements and the federal Medicaid managed care regulations in the Code of Federal Regulations (CFR). Both a pre-on-site desk review and an on-site review with interview sessions were conducted.

Findings, Conclusions, and Recommendations

The following table illustrates each health plan's individual performance in each of the standard areas and a statewide total score for each standard and for the health plans overall.

Table 1-1—Compliance Standards and Scores										
Standard #	Standard Name	AlohaCare QUEST	HMSA QUEST	Kaiser QUEST	'Ohana QUEST	'Ohana QExA	'Ohana CCS	UHC CP QUEST	UHC CP QExA	Statewide All Plans
I	Provider Selection	100%	100%	100%	100%	100%	100%	100%	100%	100%
II	Subcontracts and Delegation	95%	100%	88%	100%	100%	100%	100%	100%	98%
III	Credentialing^	100%*	100%	100%*	100%*	100%*	100%*	100%	100%	100%
IV	Quality Assessment and Performance Improvement	100%	100%	92%	100%	100%	100%	100%	100%	98%
V	Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%
VI	Practice Guidelines^	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Compliance Score:		99%	100%	97%	100%	100%	100%	100%	100%	99%

Scores were calculated by assigning 1 point to *Met* items, 0.5 points to *Partially Met* items, and 0 points to *Not Met* and *NA* items, then dividing the total by the number of applicable items.

^Some Credentialing and Practice Guidelines elements were "deemed" compliant for certain health plans. See Appendix B of this report for details regarding the deemed compliance decisions.

* Although three Credentialing elements (related to provider disclosures) were "Not Scored", they were not fully met by these plans and required corrective actions to address identified deficiencies.

Statewide performance across all standards was quite strong, with an overall statewide score of 99 percent. Three plans (HMSA, UHC CP QUEST, and UHC CP QExA) fully met all standards and required no corrective actions. The remaining five plans had relatively strong performance also, with few findings requiring corrective actions. The Hawaii health plans demonstrated continuing maturation as Medicaid managed care plans through these high levels of performance and compliance.

Each health plan received a detailed written report of findings and, if applicable, recommendations and was required to develop and implement a corrective action plan (CAP) for all items not fully *Met*. The MQD and HSAG reviewed and approved the plans' CAPs and will provide follow-up monitoring within the next several months until the identified deficiencies are resolved.

Validation of Performance Measures—HEDIS Compliance Audits

Description

HSAG performed independent audits of the HEDIS and performance measure data for the QUEST, QExA, and CCS health plans consistent with the *2014 NCQA HEDIS Compliance Audit*[1-3]

[1-3] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Standards, Policies, and Procedures, HEDIS Volume 5, and with the CMS protocol for performance measure validation. Each HEDIS Compliance Audit (for the QUEST and QExA health plans) incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. The performance measure validation for CCS included a review of the 'Ohana CCS program's ability to collect and report on a set of HEDIS and non-HEDIS measures relevant to behavioral health.

During the HEDIS audits, HSAG reviewed the performance of the health plans on State-selected HEDIS performance measures. The six measures reviewed for the QUEST health plans were:

- *Childhood Immunization Status*
- *Well-Child Visits in the First 15 Months of Life*
- *Controlling High Blood Pressure*
- *Comprehensive Diabetes Care*
- *Breast Cancer Screening*
- *Chlamydia Screening in Women*

The six measures reviewed for the QExA health plans were:

- *Controlling High Blood Pressure*
- *Comprehensive Diabetes Care*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Ambulatory Care*
- *Inpatient Utilization—General Hospital/Acute Care*
- *Plan All-Cause Readmissions*

The 10 measures reviewed for the CCS program included seven HEDIS Medicaid measures and three non-HEDIS measures:

- *Follow-Up After Hospitalization for Mental Illness*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*
- *Mental Health Utilization*
- *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Diabetes Monitoring for People With Diabetes and Schizophrenia*
- *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia*
- *Follow-Up with Assigned PCP After Hospitalization for Mental Illness*
- *Behavioral Health Assessment*
- *Plan All-Cause Readmissions*

The measurement period was calendar year (CY) 2013 (January 1, 2013, through December 31, 2013) and the audit activities were conducted concurrently with HEDIS 2014 reporting. There were five QUEST plans (AlohaCare, HMSA, Kaiser, 'Ohana, and UHC CP) and two QExA plans ('Ohana and UHC CP) subject to HSAG's HEDIS audit activities this year. As 'Ohana's CCS program began operations on March 1, 2013 and did not have a full calendar year of data for the measurement period for some measures, HSAG's performance measure validation included validating those measures not requiring a full data year and conducting a "system readiness" review to assess the plan's readiness in using its various data systems and processes for collection and calculation of CCS-specific measures for the next year. 'Ohana CCS was evaluated to be sufficiently prepared to collect and report measure data for its CCS population.

Findings, Conclusions, and Recommendations

HSAG evaluated each health plan's compliance with the National Committee for Quality Assurance's (NCQA's) IS standards and found that all health plans were fully compliant with all standards and able to report valid performance measure rates.

All plans except Kaiser used software, the source code of which had been certified by NCQA, to generate the HEDIS measures. Kaiser calculated the required measures using internally developed programming code. Most plans used supplemental pharmacy and lab data to augment their internal claims/encounter data, which is allowable for HEDIS reporting.

HSAG analyzed the performance measure results separately for the health plans because of differences in the populations served. For each performance measure indicator, HSAG compared the results to the national Medicaid HEDIS 2013 means and percentiles. In general, the MQD Quality Strategy target is the national HEDIS 2013 Medicaid 75th percentile. However, for the inverse measure indicators (e.g., *HbA1c Poor Control [>9.0%]*, *Well-Child Visits in the First 15 Months of Life--0 Visits*, *Plan All-Cause Readmissions*, and *Ambulatory Care–ED Visits)* where a lower rate indicates better performance, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied.[1-4]

The "n" in the following figures indicates the number of indicators in the QUEST and QExA plans' performance measures that fell within the designated percentile range compared to the HEDIS 2013 national Medicaid percentiles. Rates representing a population too small for reporting purposes were referred to as "*Not Applicable*" or *NA*, and were not included in the performance calculations.

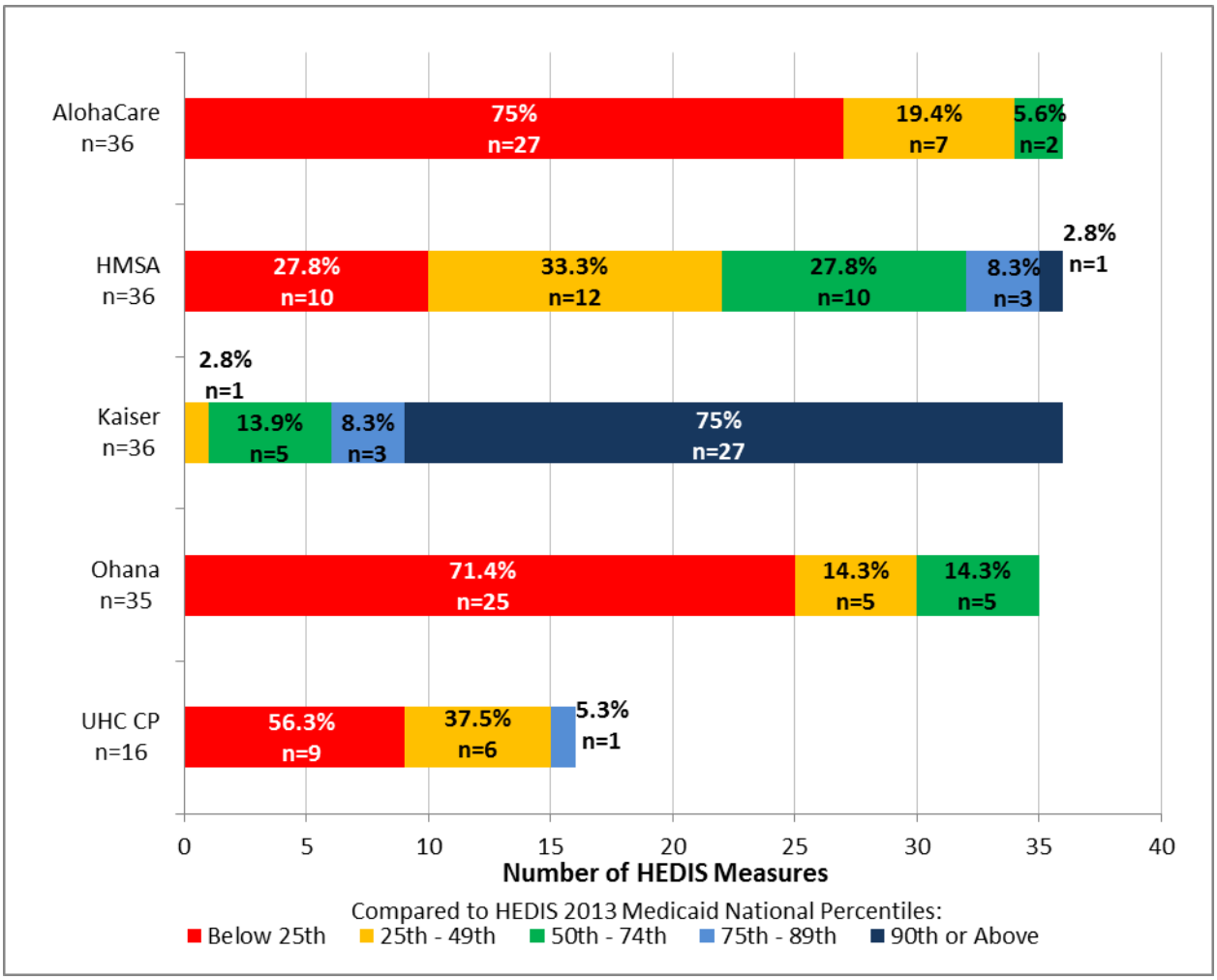
Similarly, for the seven 'Ohana CCS-specific measures that followed HEDIS Medicaid calculation and reporting specifications, HSAG compared the results to the national Medicaid HEDIS 2013 means and percentiles. Figure 1-3 displays the number of CCS indicators that fell within the designated percentile range based on the HEDIS 2013 national Medicaid percentiles.

HSAG validated six performance measures for HEDIS 2014 for the QUEST and QExA health plans, resulting in a total of 36 separate indicator rates reported across all audited measures. Three QUEST plans were able to report all 36 indicators. 'Ohana and UHC CP had one and 20 indicators,

[1-4] For example, because the value associated with the national 10th percentile reflects better performance, HSAG reversed the percentile to the measure's 90th percentile. Similarly, the value associated with the 25th percentile was reversed to the 75th percentile. This value also serves as the MQD Quality Strategy target.

respectively, with denominator(s) less than 30 and therefore could not report a valid rate. For those indicators, these two QUEST plans received an audit result of *NA* (small denominator). Figure 1-1 shows the QUEST plans' performance on the indicators compared to the national percentiles.

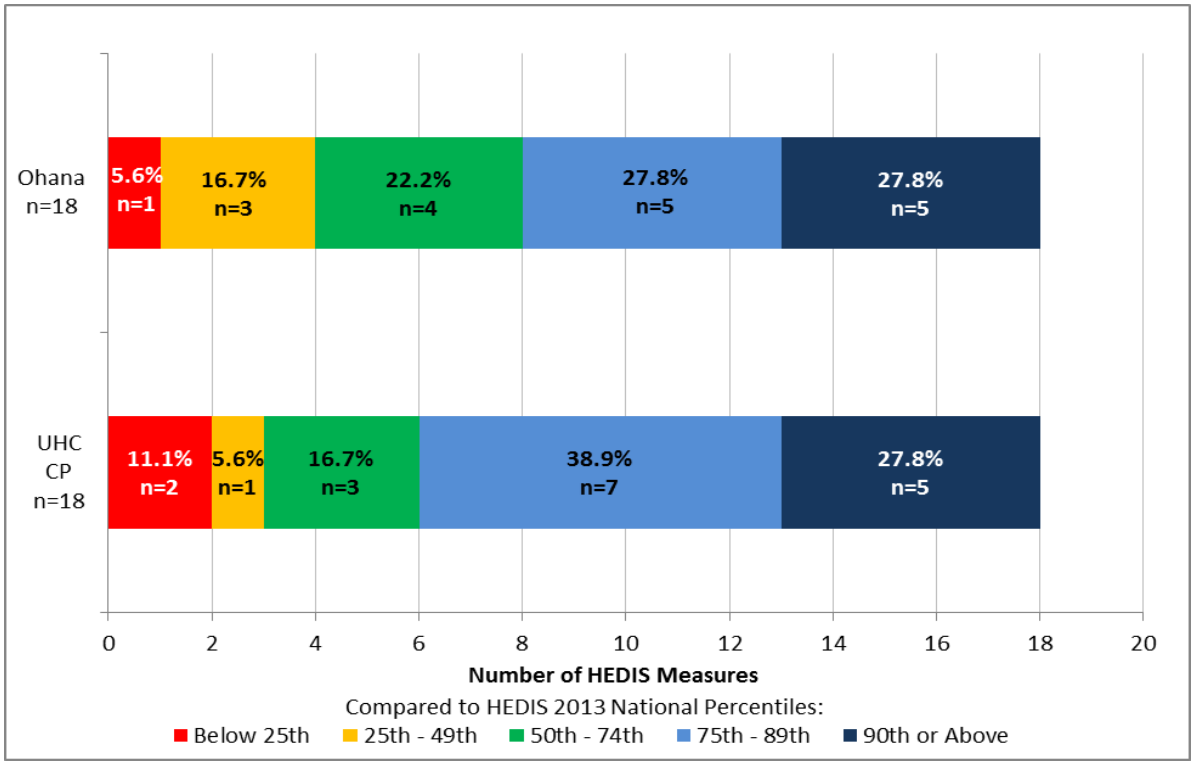
Figure 1-1—Comparison of QUEST Plan Indicators to HEDIS Medicaid National Percentiles



The QUEST plans were diverse in their performance. Kaiser, the best performing plan for HEDIS 2014, reported 75 percent of its indicators (27 of 36) at or above the HEDIS 2013 national Medicaid 90th percentile. Together with three indicators reporting at or above the national 75th percentile, Kaiser had a total of 30 rates meeting the MQD Quality Strategy targets. HMSA reported 14 out of 36 rates above the 50th percentiles, including three rates above the 75th percentiles and one rate above the 90th percentile. AlohaCare, 'Ohana, and UHC CP had below average performance, reporting more than 50 percent of their measures with valid rates below the HEDIS 2013 national 25th percentile. UHC CP had one rate above the national 75th percentile, meeting the MQD Quality Strategy target. No AlohaCare or 'Ohana rates met the MQD Quality Strategy targets.

HSAG validated six performance measures for the QExA plans for HEDIS 2014, which resulted in 30 indicators, 18 of which are displayed below, compared to HEDIS 2013 Medicaid national percentiles. Figure 1-2 shows the QExA plans' performance compared with the national percentiles.

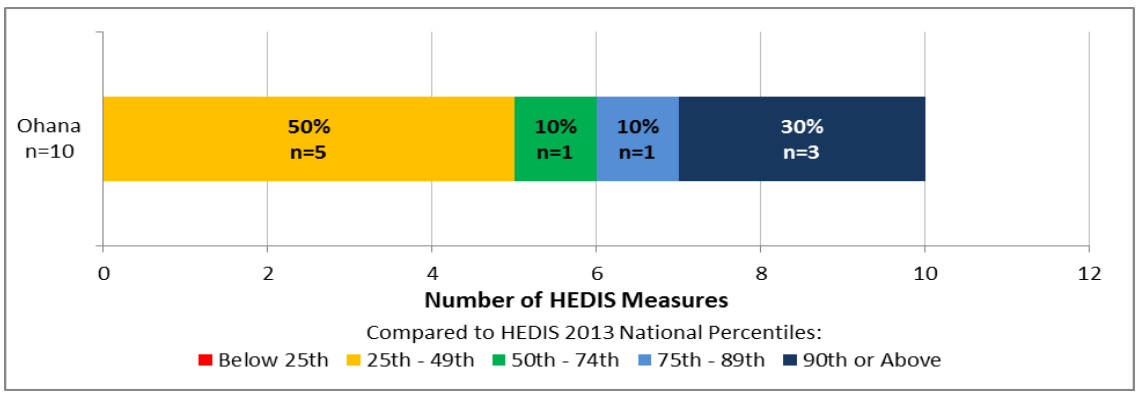
Figure 1-2—Comparison of QExA Plan Indicators to HEDIS Medicaid National Percentiles



Performance between the two QExA plans varied slightly. UHC CP was the better-performing QExA plan with 15 of the 18 rates with available benchmarks for comparison (or 83.3 percent) at or above the HEDIS 2013 national Medicaid 50th percentile. 'Ohana reported 14 of the 18 indicators (or 77.8 percent) at or above the HEDIS 2013 national 50th percentile. UHC CP had 12 indicators meeting the MQD Quality Strategy targets whereas 'Ohana reported 10.

HSAG validated 10 performance measures for the 'Ohana CCS program. These performance measures resulted in 16 rates. 'Ohana CCS received an audit result of NA (small denominator) for five indicators. Of the 11 rates, 10 were compared to the national HEDIS 2013 percentiles. Figure 1-3 shows 'Ohana's CCS performance compared with the national percentiles.

Figure 1-3—Comparison of 'Ohana's CCS Rates to HEDIS Medicaid National Percentiles



'Ohana's CCS performance was mixed for HEDIS 2014. Half of the HEDIS measures with available benchmarks for comparison ranked above the national HEDIS 2013 50th percentile. Three rates were above the 90th percentile. On the other hand, five rates ranked below the 50th percentile, suggesting opportunities for improvement.

Recommendations for improvement varied across the indicators for each plan type. HSAG recommends that each QUEST, QExA, and CCS plan target the lower-performing measures/indicators for improvement. Each plan should conduct a barrier analysis to determine why performance was low, coupled with data analysis and drill-down evaluations of noncompliant cases.

Validation of Performance Improvement Projects (PIPs)

Description

PIPs are designed as an organized way to assist health plans in assessing their health care processes, implementing process improvements, and improving outcomes of care. In 2014, HSAG validated two PIPs for each of the QUEST, QExA, and CCS health plans, for a total of 16 PIPs. The five QUEST plans were required by the MQD to conduct PIPs related to the *Plan All-Cause Readmissions* (PCR) measure and a second topic to improve the *Comprehensive Diabetes Care* (CDC) HEDIS measure. Both QExA plans also conducted PIPs related to the HEDIS measure on diabetes care. For their second PIP topic, the QExA plans focused on an aspect of obesity care—documentation of body mass index (BMI). This was the first year the CCS program conducted PIPs; its two topics were *Follow-up After Hospitalization for Mental Illness* and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*.

HSAG validated each health plan's PIPs by following standardized validation procedures, assessing the degree to which the projects were designed, conducted, and reported in a methodologically sound manner. This process facilitates improvements in care and generates confidence that reported improvement has, in fact, been accomplished.

Findings, Conclusions, and Recommendations

Following the review and validation of the plans' 2014 PIPs, HSAG concluded that:

- All health plans performed well in the Design stage. This indicates plans demonstrated the ability to document required information for that stage of their PIPs. The health plans designed scientifically sound studies supported by use of key research principles. The design of the PIPs promoted progression to the next stage of the PIP process.
- All health plans performed well in the Implementation stage. These findings suggest health plans accurately documented a thorough process for analyzing data, identifying barriers, and developing interventions.
- All health plans' PIPs received an overall *Met* validation status.
- The 'Ohana CCS, 'Ohana QExA, and 'Ohana QUEST PIPs had no recommendations from the 2014 validation.

- This was the first year submission for the CCS plans, and the PIPs progressed to including baseline results.
- 'Ohana and UHC QUEST plans submitted baseline results for the *All-Cause Readmissions* PIP for the 2014 validation. The AlohaCare, HMSA, and Kaiser QUEST plans progressed to reporting Remeasurement 1 results for the *All-Cause Readmissions* PIP. HMSA demonstrated statistically significant improvement in the study indicator result. AlohaCare and Kaiser had increases in the rate of readmissions, a decline in performance.
- For the QUEST *Diabetes Care* PIPs, 'Ohana and UHC reported baseline results and AlohaCare, HMSA, and Kaiser reported first remeasurement results for the 2014 validation. Kaiser achieved statistically significant improvement for its study indicator. AlohaCare had improvement that was not statistically significant in two of four study indicators, and HMSA had improvement that was not statistically significant in one of three study indicators.
- The UHC QExA BMI PIP reported Remeasurement 3 results in the 2014 submission. Both study indicators demonstrated statistically significant and sustained improvement. The 'Ohana QExA BMI PIP reported Remeasurement 2 results in the 2014 submission. One study indicator demonstrated sustained improvement and the other two study indicators achieved statistically significant improvement. For the study indicators that achieved statistically significant improvement for the 2014 validation, another measurement period result is required to assess for sustained improvement.
- The UHC QExA *Diabetes Care* PIP reported Remeasurement 3 results. Both study indicators demonstrated improvement that was not statistically significant. The health plan has not yet achieved statistically significant improvement over baseline for this PIP. The 'Ohana QExA *Diabetes Care* PIP reported Remeasurement 4 results. All three study indicators demonstrated statistically significant improvement over baseline for the 2014 validation and one study indicator achieved sustained improvement. For the study indicators that achieved statistically significant improvement for the 2014 validation, another measurement period result is required to assess for sustained improvement.

The health plans that did not have improvement in all study indicators for the 2014 validation received the recommendation to implement strategies to improve performance. The health plans should regularly evaluate interventions to ensure they are having the desired effects. If a health plan's evaluation of interventions and/or review of data indicates that interventions are not having the desired effects, it should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions, as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

Other recommendations HSAG made were to correct inaccuracies or inconsistencies documented in the PIP forms.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Plan-Specific Adult Survey and Statewide CHIP Survey

Description

The CAHPS health plan surveys are standardized survey instruments which measure members' satisfaction levels with their health care. For 2014, HSAG administered the CAHPS 5.0H Adult Medicaid Health Plan Survey to Medicaid members of the QUEST and QExA plans who met age and enrollment criteria. In addition, HSAG administered the CAHPS 5.0H Child Medicaid Survey (without the Children with Chronic Conditions [CCC] measurement set), via a statewide sampling methodology, to Hawaii's CHIP-eligible enrollees who met age and enrollment criteria. Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan and/or State level CAHPS data.

For each survey, the results of 11 measures of satisfaction were reported. These measures included four global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and five composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*). In addition, two individual items were assessed (*Coordination of Care* and *Health Promotion and Education*).

Findings, Conclusions, and Recommendations

For the QUEST plans and the statewide QUEST aggregate scores as compared to the 2013 NCQA national adult Medicaid average, the following results were noted:[1-5]

- The QUEST aggregate scores were above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care.*
- AlohaCare scored above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Coordination of Care*.
- HMSA scored above the NCQA national adult Medicaid average on none of the nine comparable measures.
- Kaiser scored above the NCQA national adult Medicaid average on seven of the nine comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.
- 'Ohana scored above the NCQA national adult Medicaid average on two of the nine comparable measures: *How Well Doctors Communicate* and *Coordination of Care.*
- UHC CP scored above the NCQA national adult Medicaid average on two of the nine comparable measures: *Rating of All Health Care* and *Coordination of Care.*

[1-5] Due to changes to the *Shared Decision Making* composite measure and the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for these CAHPS measures; thus, comparisons could not be performed for 2014.

Figure 1-4 depicts the top-box scores for the statewide QUEST aggregate and the 2013 NCQA national adult Medicaid average for each of the global ratings.

Figure 1-4—QUEST Aggregate: Global Ratings

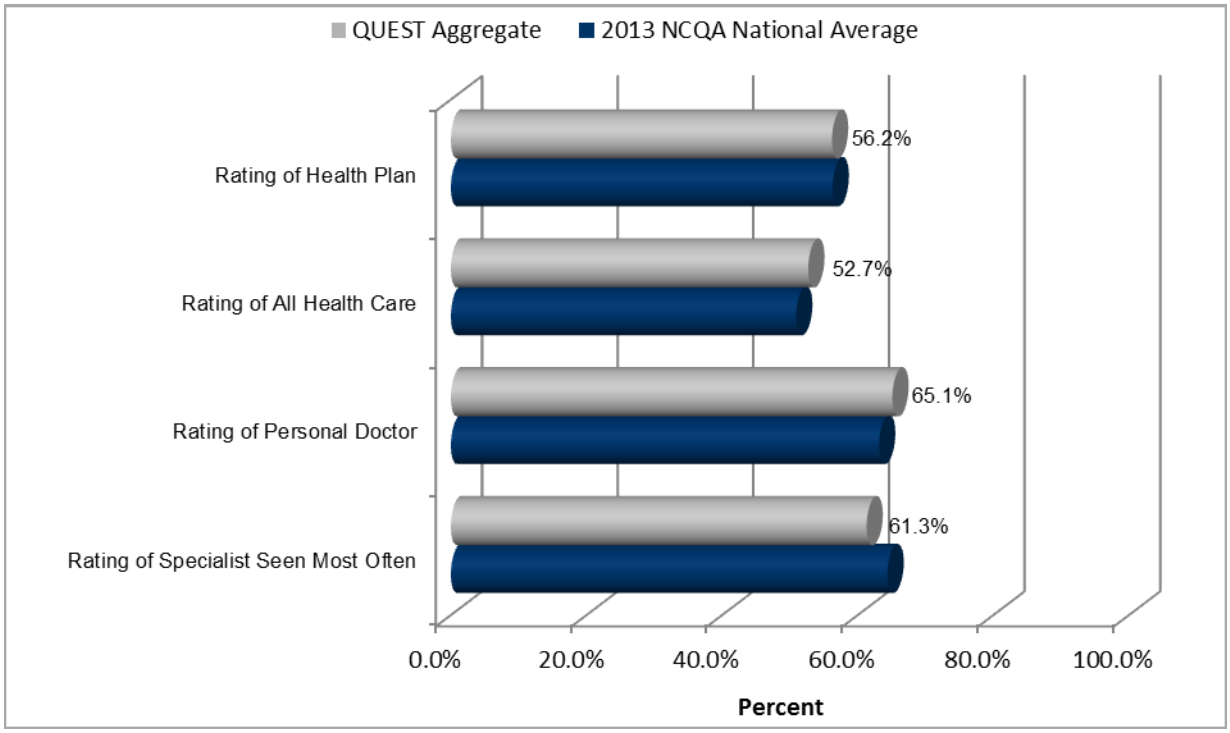
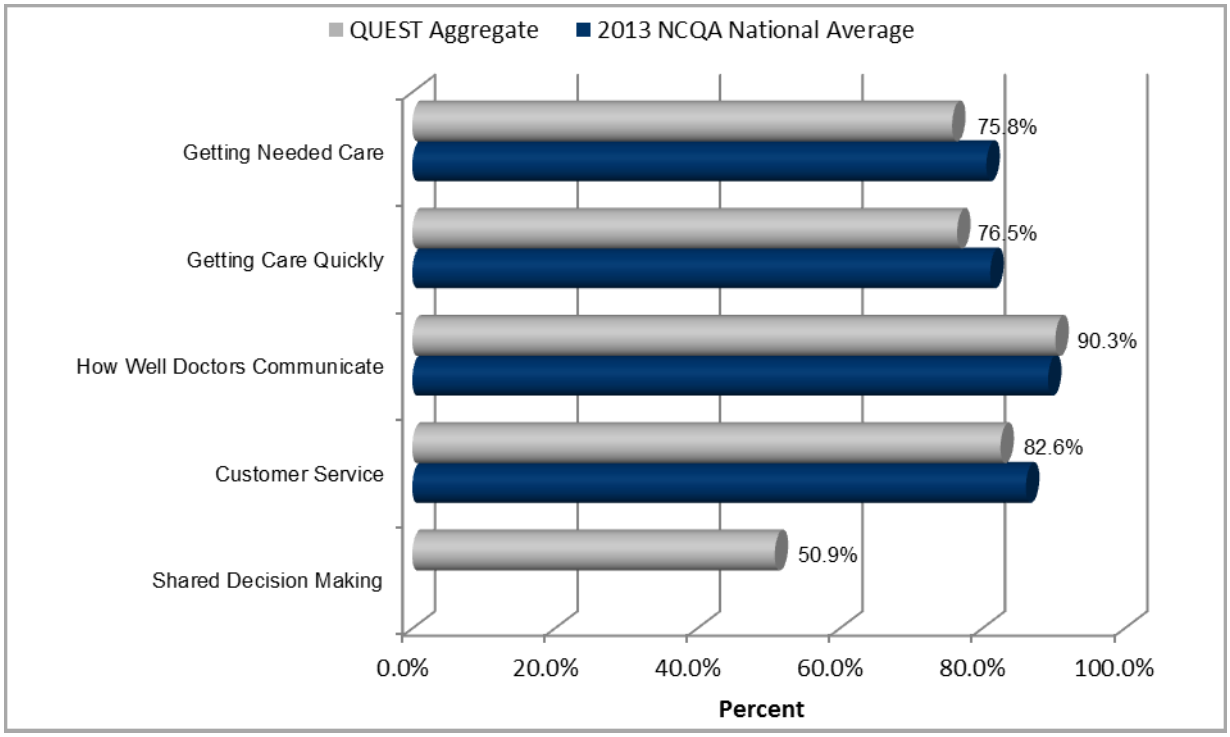


Figure 1-5 depicts the top-box scores for the statewide QUEST aggregate and the 2013 NCQA national adult Medicaid average for each of the composite measures.

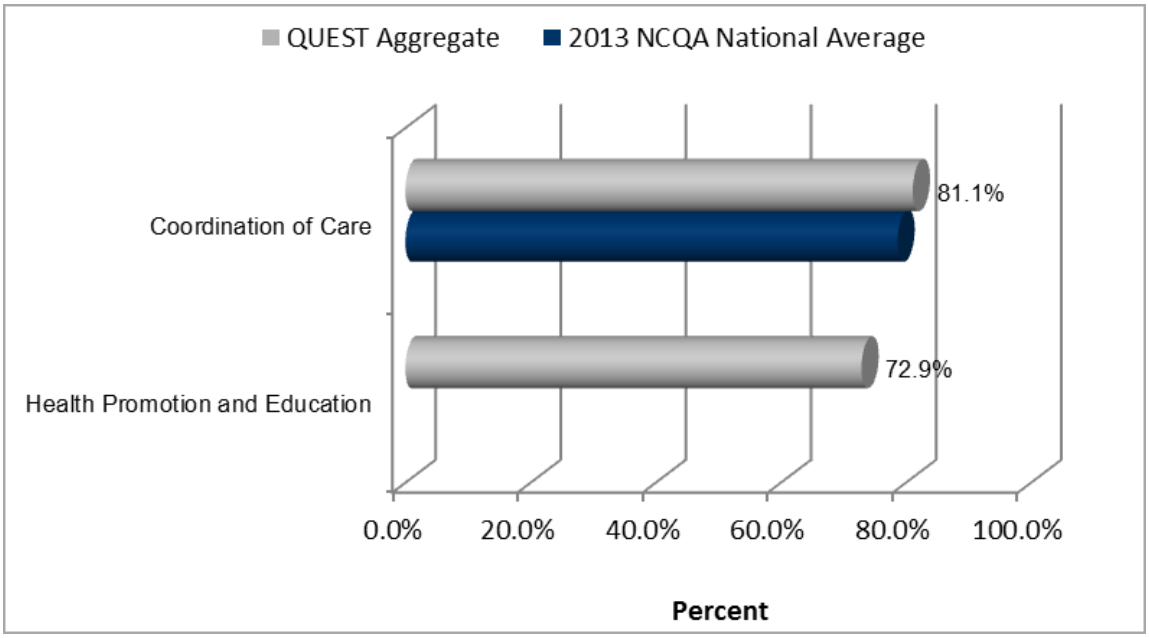
Figure 1-5—QUEST Aggregate: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

Figure 1-6 depicts the top-box scores for the statewide QUEST aggregate and the 2013 NCQA national adult Medicaid average for each of the individual item measures.

Figure 1-6—QUEST Aggregate: Individual Item Measures



Please note: Due to changes to the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

For the QExA plans and the statewide QExA aggregate scores as compared to the 2013 NCQA national adult Medicaid average, the following results were noted:

- The QExA aggregate scores were above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, and *Coordination of Care.*
- 'Ohana scored above the NCQA national adult Medicaid average on four of the nine comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Customer Service*, and *Coordination of Care.*
- UHC CP scored above the NCQA national adult Medicaid average on five of the nine comparable measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Coordination of Care.*

Figure 1-7 depicts the top-box scores for the statewide QExA aggregate and the 2013 NCQA national adult Medicaid average for each of the global ratings.

Figure 1-7—QExA Aggregate: Global Ratings

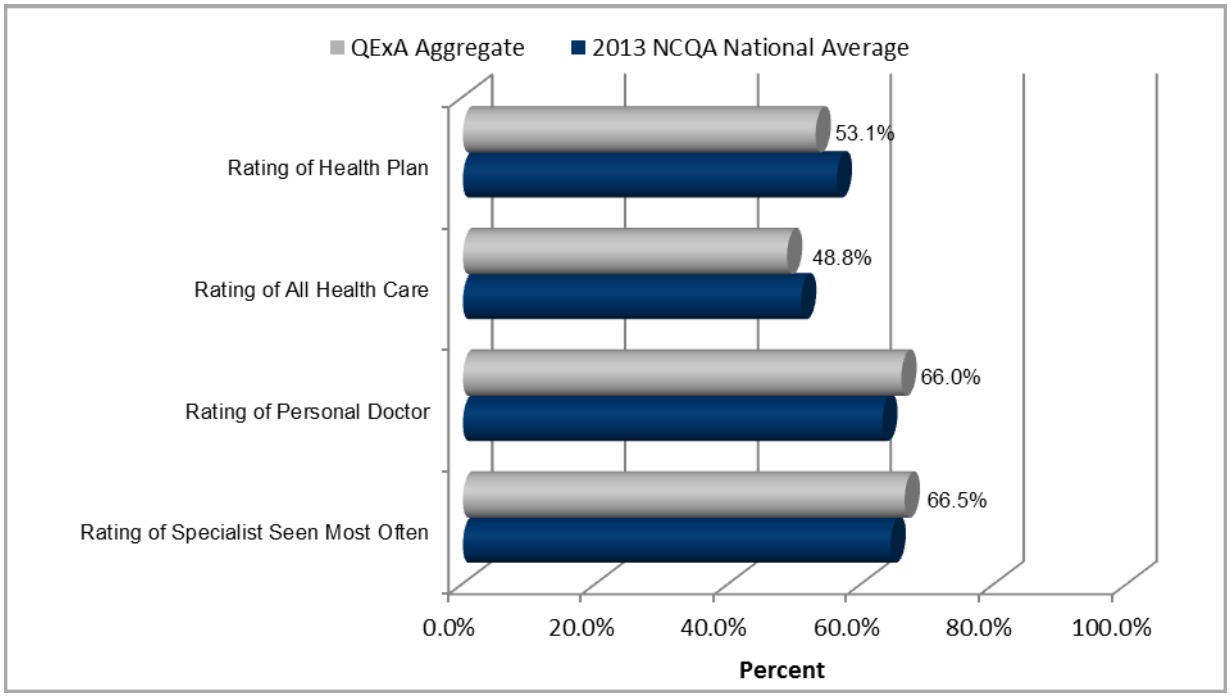
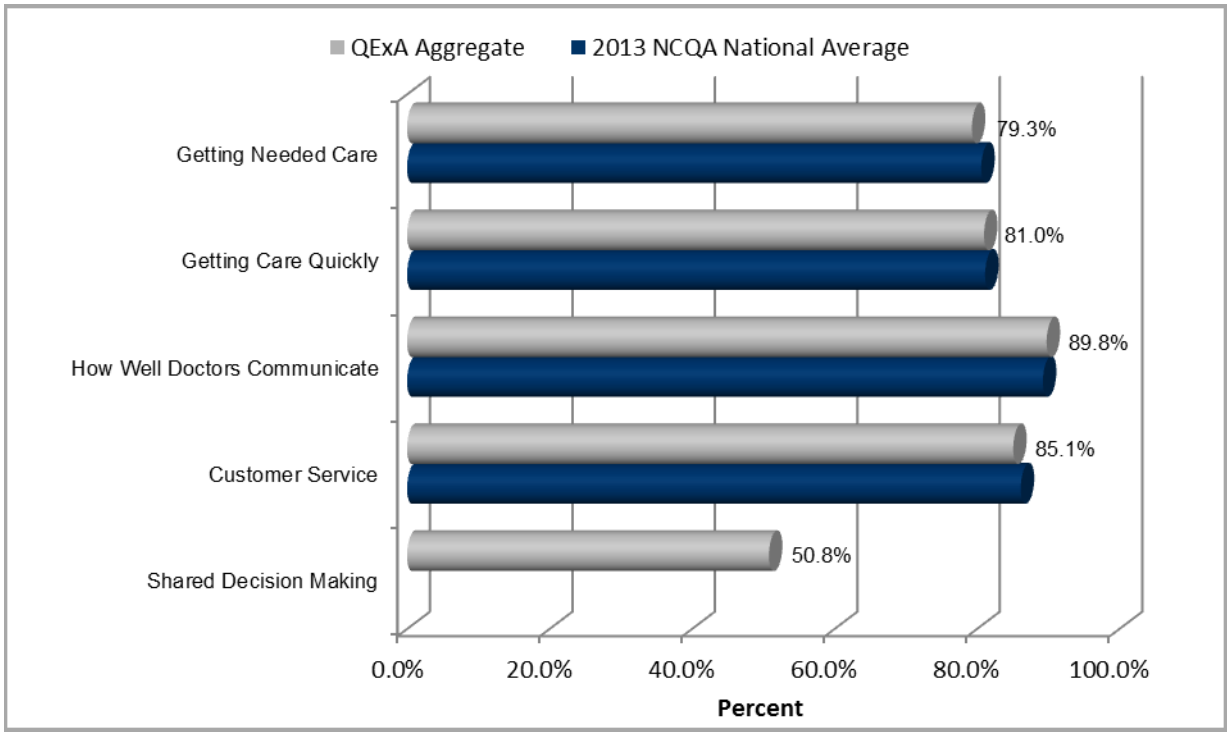


Figure 1-8 depicts the top-box scores for the statewide QExA aggregate and the 2013 NCQA national adult Medicaid average for each of the composite measures.

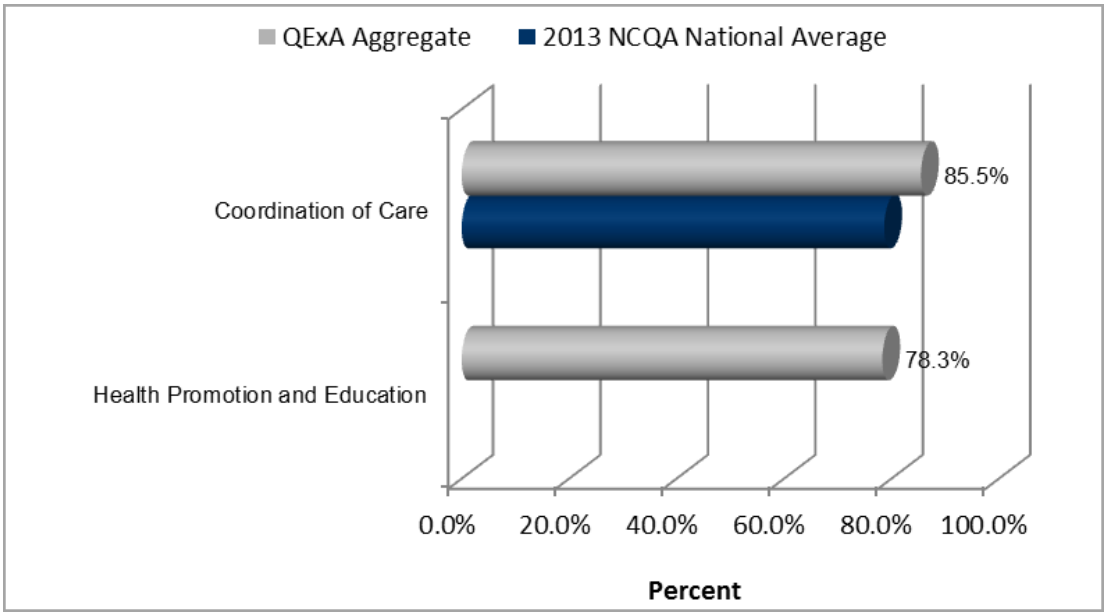
Figure 1-8—QExA Aggregate: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

Figure 1-9 depicts the top-box scores for the statewide QExA aggregate and the 2013 NCQA national adult Medicaid average for each of the individual item measures.

Figure 1-9—QExA Aggregate: Individual Item Measures



Please note: Due to changes to the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

HSAG provided both the QUEST and QExA health plans recommendations related to these findings for each measure considered a "key driver" of member satisfaction.

As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparative purposes. As compared to the 2013 NCQA national child Medicaid average, the following results were noted for the CHIP population:

- CHIP scored above the NCQA national child Medicaid average on four of the nine comparable measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care.*

Figure 1-10 depicts the top-box scores for CHIP and the 2013 NCQA national child Medicaid average for each of the global ratings.

Figure 1-10—CHIP: Global Ratings

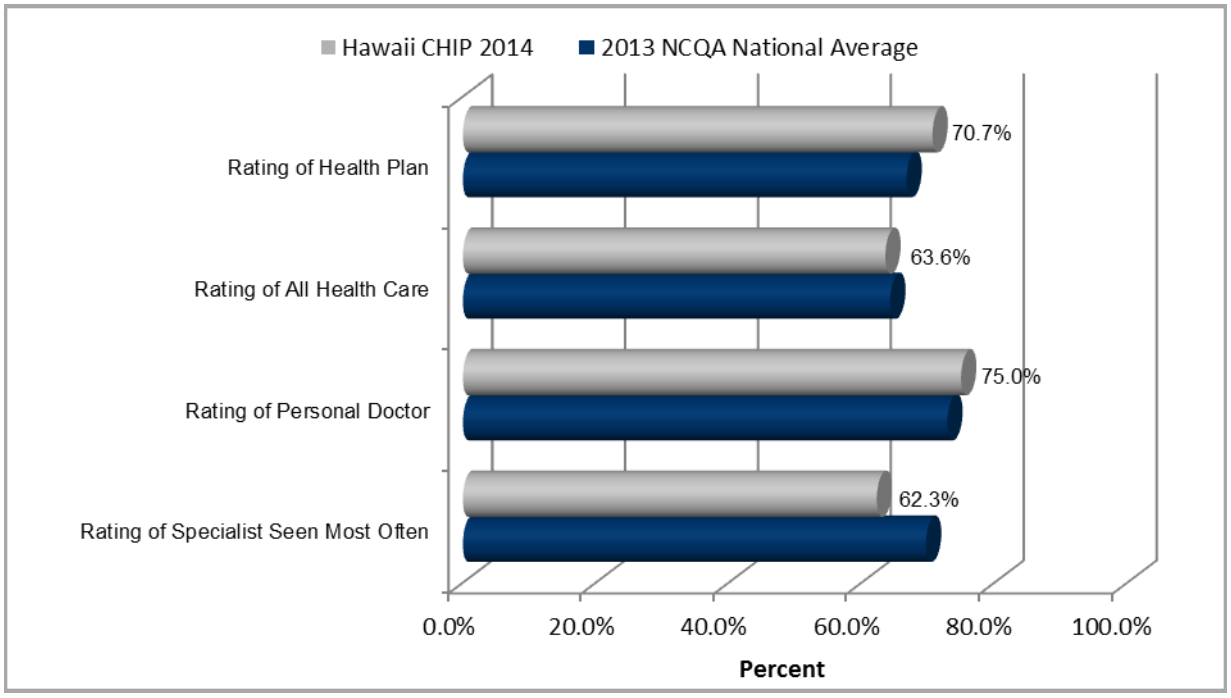
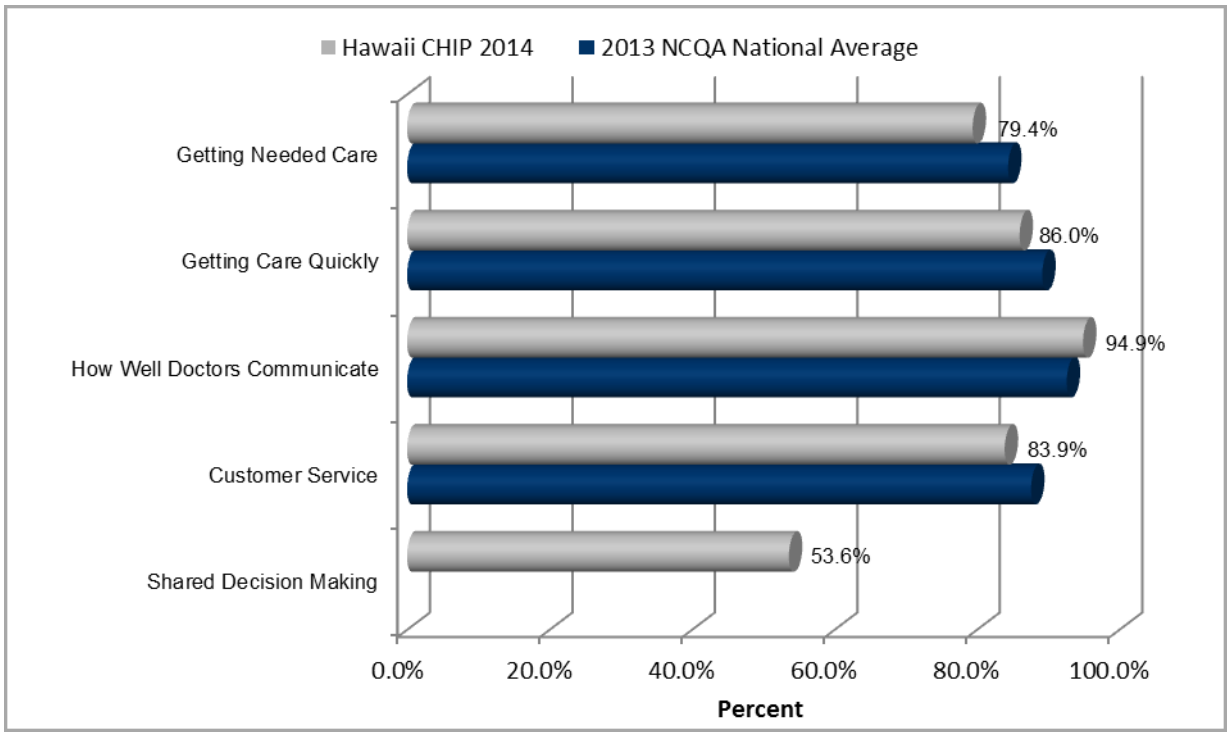


Figure 1-11 depicts the top-box scores for CHIP and the 2013 NCQA national child Medicaid average for each of the composite measures.

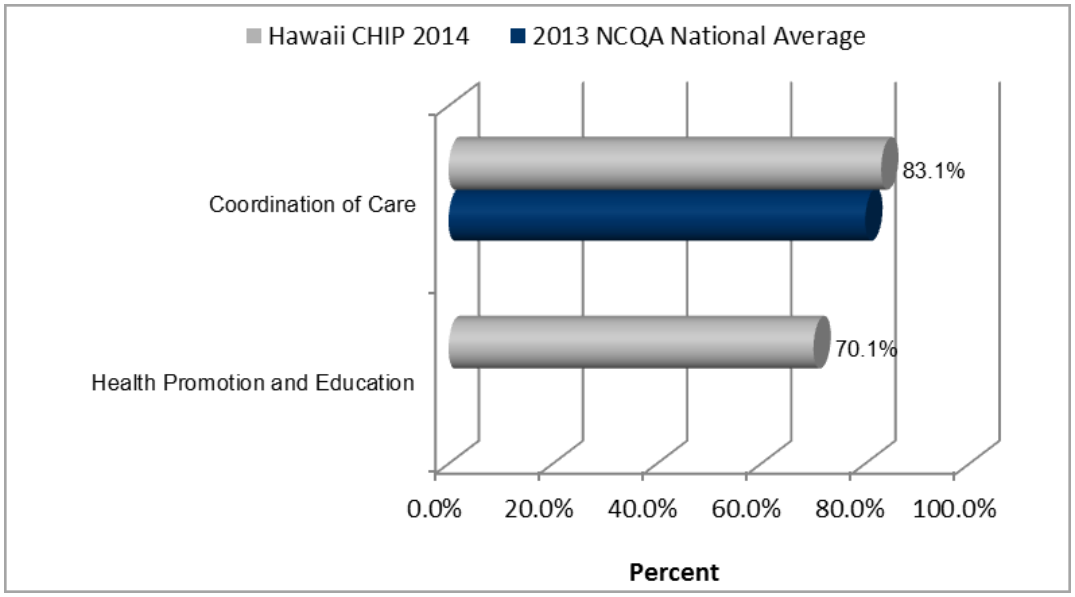
Figure 1-11—CHIP: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

Figure 1-12 depicts the top-box scores for the statewide CHIP aggregate and the 2013 NCQA national child Medicaid average for each of the individual item measures.

Figure 1-12—CHIP: Individual Item Measures



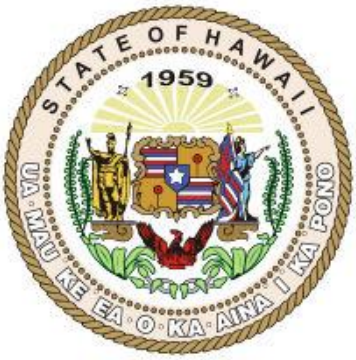
Please note: Due to changes to the *Health Promotion and Education* individual item measure, 2013 NCQA national averages were not available for this CAHPS measure and therefore comparisons to NCQA national averages could not be performed for 2014.

HSAG provided the MQD general recommendations related to these findings for each measure considered a "key driver" of member satisfaction.

State of Hawaii

Department of Human Services

Med-QUEST Division



2015 External Quality Review Report of Results *for the* QUEST Integration Health Plans and the Community Care Services Program

November 2015

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Overview

The 2015 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) Health Plans and the Community Care Services (CCS) program is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR 438.364. Health Services Advisory Group, Inc. (HSAG), is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), the single State agency responsible for the overall administration of Hawaii's Medicaid managed care program.

This report describes how data from activities conducted in accordance with 42 CFR 438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid recipients by the five QI health plans and the CCS program. The QI health plans were AlohaCare QUEST Integration Plan (AlohaCare), Hawaii Medical Service Association QUEST Integration Plan (HMSA), Kaiser Permanente Hawaii QUEST Integration Plan (Kaiser), 'Ohana Health Plan QUEST Integration ('Ohana), and UnitedHealthcare Community Plan QUEST Integration (UHC CP). 'Ohana also has held the contract for the Community Care Services (CCS) program since March 2013. CCS is a carved-out behavioral health specialty services plan for individuals who have been determined by the MQD to have a serious mental illness.

According to the federal Medicaid managed care regulations (42 CFR 438), the QI health plans qualify as managed care organizations (MCOs) and the CCS program meets the definition as a pre-paid inpatient health plan (PIHP). For discussion purposes throughout this report, however, the Hawaii MCOs and PIHP will be referred to collectively as "health plans" unless there is a need to distinguish a particular plan type.

HSAG's external quality review (EQR) of the health plans included directly performing the three federally mandated activities as set forth in 42 CFR 438.358—review and evaluation of compliance with select federal managed care standards and associated State contract requirements, validation of performance measures/Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] compliance audits, and validation of performance improvement projects (PIPs). Two optional EQR activities were also performed this year: Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] surveys of Medicaid child members and Children's Health Insurance Program (CHIP) members using the CAHPS 5.0H Child Medicaid CAHPS survey instruments. While the child Medicaid survey was conducted at the plan level and provided results at a plan-specific and statewide aggregate level, the child CHIP survey was conducted at a statewide level due to small enrollment numbers, producing statewide aggregate results.

This report includes the following for each EQR activity conducted:

- Objectives

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- Technical methods of data collection and analysis
- A description of data obtained
- Conclusions drawn from the data

In addition, an assessment of the strengths and weaknesses of each health plan, as well as plan comparative information, is included. The report also discusses the status of improvement activities initiated by the health plans and offers recommendations for improving the quality and timeliness of, and access to, healthcare services provided by each health plan.

This is the eleventh year HSAG has produced the EQR report of results for the State of Hawaii. Report information does not disclose the identity of any patient, in accordance with 42 CFR 438.364(c).

External Quality Review Activities, Conclusions, and Recommendations

HSAG, as the EQRO for the MQD, conducted the EQR activities and analyzed the results as described in the next sections of this report. HSAG also offered conclusions and recommendations for improvement to the QI and CCS health plans.

Compliance Monitoring Review of Standards

Description

For the 2015 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the CCS program, using monitoring tools to assess and document compliance with a set of federal and State requirements. This review brought the CCS program into alignment with the review schedule for the QI plans to ensure all standards were reviewed within a three-year period for all health plans. The standards selected for review were related to the CCS program's State contract requirements and the federal Medicaid managed care regulations in the Code of Federal Regulations (CFR) for five areas of review, or standards. A pre-on-site desk review and an on-site review with interview sessions and record reviews were conducted.

The second compliance review activity in 2015 involved HSAG's and the MQD's follow-up monitoring of the three health plans that were required to take corrective actions related to findings from HSAG's 2014 compliance review, and the follow-up monitoring of CCS' corrective actions related to its 2015 compliance review.

Findings, Conclusions, and Recommendations

For the compliance review of CCS, the following table illustrates the CCS program's performance in each of the standard areas reviewed. For comparison purposes, the statewide average score for the QI health plans is also presented, based on HSAG's review of these same standards in 2013.

Table 1-1—Compliance Standards and Scores			
Standard #	Standard Name	2015 ʻOhana CCS	2013 Statewide All Plans
I	Member Rights and Protections and Member Information	**100%**	**92%**
II	Member Grievance System	**89%**	**90%**
III	Access and Availability	**100%**	**98%**
IV	Coverage and Authorization	**94%**	**94%**
V	Coordination and Continuity of Care	**100%**	**99%**
	Total Compliance Score:	**95%**	**93%**

Scores were calculated by assigning 1 point to *Met* items, 0.5 points to *Partially Met* items, and 0 points to *Not Met* and *NA* items, then dividing the total by the number of applicable items.

CCS' performance across all standards was strong, with three standard areas achieving 100 percent (Member Rights and Protections and Member Information, Access and Availability, and Coordination and Continuity of Care) and only one standard area (Member Grievance System) scoring slightly below 90 percent. CCS' overall score of 95 percent exceeded the health plans' statewide score from HSAG's review of the same standards in 2013 (93 percent).

CCS was required to develop a corrective action plan (CAP) to address and resolve deficiencies identified in the review. HSAG and the MQD provided follow-up monitoring. ʻOhana CCS completed all of the CAP activities as planned and was found to be in full compliance with the standards by July 2015.

The QI health plans' CAP implementation resulting from HSAG's 2014 compliance review was also monitored by HSAG and the MQD. AlohaCare, Kaiser, and ʻOhana health plans had continuing corrective actions implemented in 2015, mostly related to policies, procedures, forms, and required reporting to the MQD of the plans' provider disclosure information. The compliance review CAPs were closed out as completed in July 2015; however, the MQD continued its oversight and monitoring to ensure timely and complete capture and reporting of the provider disclosure information required under 42 CFR 455.

With the completion of these reviews, the health plans and CCS have demonstrated their structural and operational compliance and ability to provide quality, timely, and accessible services. Calendar year 2016 will begin a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program.

Validation of Performance Measures—HEDIS Compliance Audits

Description

HSAG performed independent audits of the performance measure data calculated by the QUEST, QExA, and CCS health plans according to the *2015 NCQA HEDIS Compliance Audit*[1-3] *Standards, Policies, and Procedures, HEDIS Volume 5*. The audit procedures were also consistent with the CMS protocol for performance measure validation: *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-4] The health plans that contracted with MQD during the measurement year (2014) for either the QUEST or QUEST Expanded Access (QExA) programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each NCQA HEDIS Compliance Audit (for the QUEST and QExA health plans) incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health.

During the HEDIS audits, HSAG reviewed the performance of the health plans on State-selected HEDIS or non-HEDIS performance measures. The health plans with populations other than aged, blind, or disabled (ABD) populations were required to report on 33 measures. Health plans with ABD populations were required to report on 36 measures. CCS was required to report on nine HEDIS measures and two non-HEDIS measures. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality and timeliness of, and access to, Medicaid care and services. These domains included:

- Children's Preventive Care
- Women's Health
- Care for Chronic Conditions
- Access to Care
- Utilization
- Effectiveness of Care

The measurement period was calendar year (CY) 2014 (January 1, 2014, through December 31, 2014), and the audit activities were conducted concurrently with HEDIS 2015 reporting. All five former QUEST plans (AlohaCare, HMSA, Kaiser, 'Ohana, and UHC CP) were required to report the non-ABD measures. The two former QExA health plans ('Ohana and UHC CP) were required to report the ABD measures. In addition, 'Ohana was required to report rates for the CCS-specific measures.

[1-3] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).
[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2015.

Findings, Conclusions, and Recommendations

HSAG evaluated each health plan's compliance with the National Committee for Quality Assurance's (NCQA's) IS standards. All health plans but one (AlohaCare) were fully compliant with all standards and able to report valid performance measure rates. AlohaCare did not capture all the data elements required for certain measures in one of its supplemental databases and therefore was found substantially compliant with IS 5.0 (Supplemental Data—Capture, Transfer and Entry). Nonetheless, since the plan could still use medical record abstracted data to report the measures, the impact of having this database disapproved for reporting was mitigated. AlohaCare was, therefore, still able to report valid performance measure rates.

All plans except Kaiser used software vendors that participated in NCQA's measure certification program. All HEDIS measures generated by these vendors and required by MQD for reporting were certified by NCQA. Kaiser calculated the required measures using internally developed programming code. All plans used supplemental data to augment their internal claims/encounter data, which is allowable for HEDIS reporting.

HSAG analyzed the performance measure results separately for the health plans because of differences in the populations served. For each performance measure indicator, HSAG compared the results to the NCQA national Medicaid HEDIS 2014 means and percentiles. For the inverse measure indicators, where a lower rate indicates better performance (i.e., *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%]*, *Well-Child Visits in the First 15 Months of Life—0 Visits*, *Plan All-Cause Readmissions*, *Frequency of Prenatal Care—<21 Percent*, and *Ambulatory Care—ED Visits/1,000)*, HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied.[1-5]

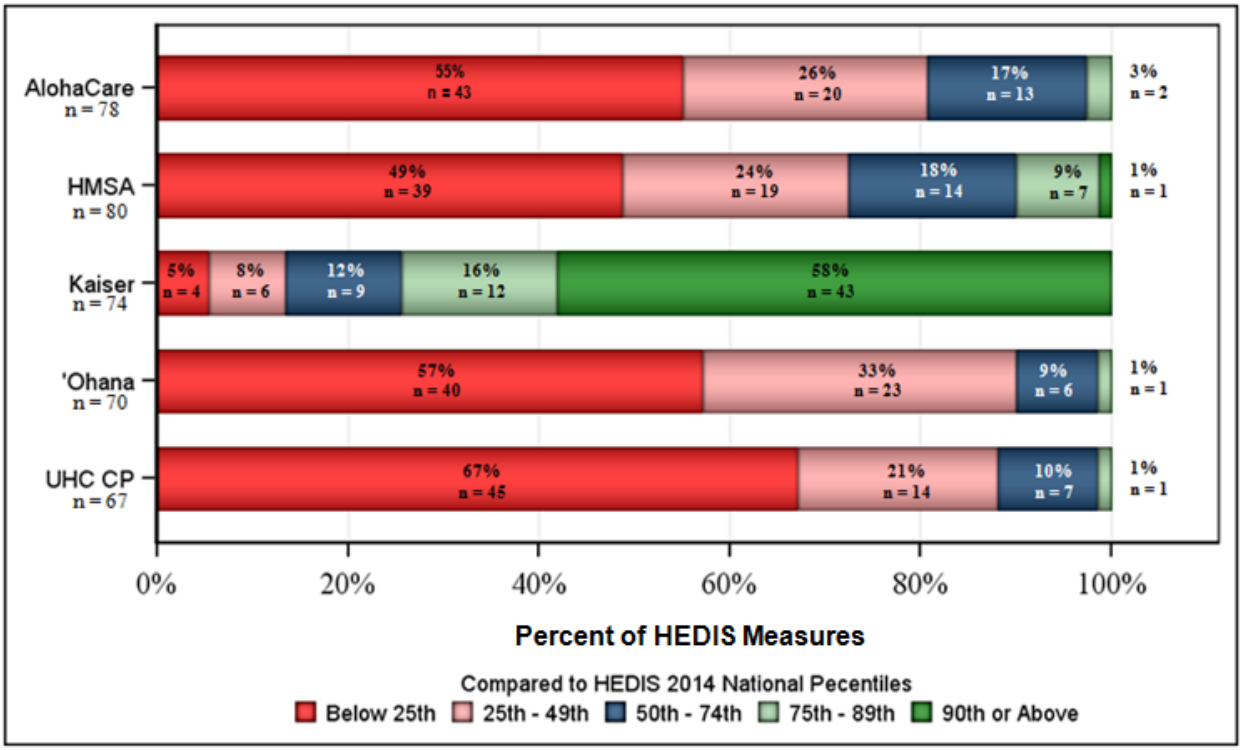
The "n" in the following figures indicates, by health plan, the number of indicators in the non-ABD, ABD, and CCS performance measures that fell within the designated percentile range compared to the HEDIS 2014 national Medicaid percentiles. Rates representing a population too small for reporting purposes were referred to as "*Not Applicable*," or *NA*, and were not included in the performance calculations.

HSAG validated 33 HEDIS 2015 non-ABD performance measures, resulting in a total of 103 separate indicator rates reported across all audited measures, of which 81 indicators were compared to national Medicaid HEDIS 2014 percentiles.[1-6] None of the plans reported all 81 indicators. AlohaCare had three indicators, HMSA had one indicator, Kaiser had seven indicators, 'Ohana had 11 indicators, and UHC CP had 14 indicators with denominator(s) less than 30 for which valid rates could not be reported. For those indicators, the plans received an audit result of *NA* (small denominator). Figure 1-1 shows the plans' performance on the non-ABD population measure indicators compared to the national percentiles.

[1-5] For example, because the value associated with the national 10th percentile reflects better performance, HSAG reversed the percentile to the measure's 90th percentile. Similarly, the value associated with the 25th percentile was reversed to the 75th percentile.

[1-6] The *Enrollment by Product Line*, *Inpatient Utilization-General Hospital/Acute Care*, and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, Medicaid national percentiles do not exist for *Plan All-Cause Readmissions* and *Colorectal Cancer Screening*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

Figure 1-1—Comparison of Non-ABD Measure Indicators to HEDIS Medicaid National Percentiles

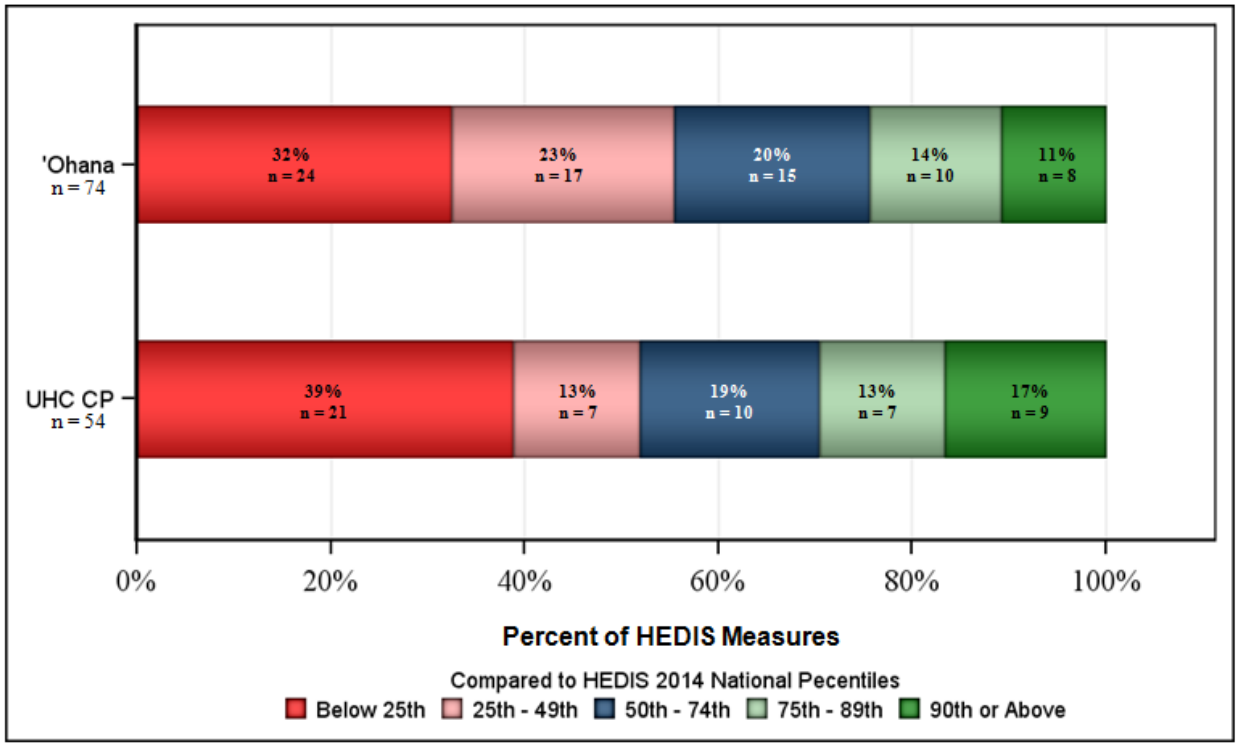


Please note: Percentages may not total 100% due to rounding.

As presented in Figure 1-1, the plans were diverse in their performance. Kaiser, the best-performing plan for HEDIS 2015, reported 58 percent of its indicators (43 of 74) at or above the HEDIS 2014 national Medicaid 90th percentile, along with 16 percent of its indicators (12 of 74) reporting at or above the national 75th percentile but below the 90th percentile. HMSA reported 22 out of 80 rates above the 50th percentile, including eight rates above the 75th percentile and one rate above the 90th percentile. AlohaCare, 'Ohana, and UHC CP were the lowest-performing plans compared to the national percentiles, reporting at least 55 percent of their measures with valid rates below the national 25th percentile. HMSA had eight measures above the national 75th percentile. While AlohaCare had two rates above the national 75th percentile, UHC CP and 'Ohana only had one rate above the national 75th percentile.

HSAG validated 36 HEDIS 2015 ABD population performance measures for the two former QExA health plans, resulting in a total of 106 separate indicator rates reported across all audited measures, of which 82 indicators were compared to national Medicaid HEDIS 2014 percentiles.[1-7] Neither of the plans reported all 82 indicators. 'Ohana had eight indicators and UHC CP had 28 indicators with denominators less than 30 (and for which a valid rate could not be reported). For those indicators, the two plans received an audit result of *NA* (small denominator). Figure 1-2 shows the plans' performance on the ABD population measures compared with the national percentiles.

Figure 1-2—Comparison of ABD Measure Indicators to HEDIS Medicaid National Percentiles



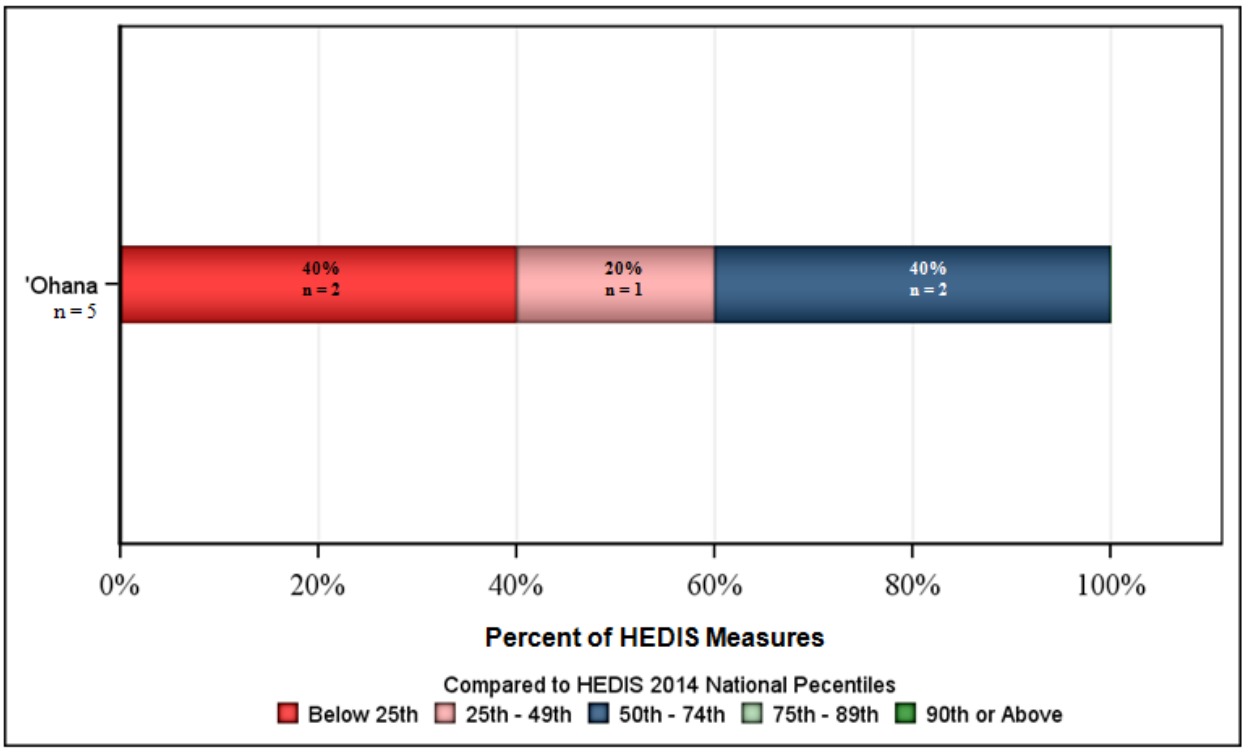
Please note: Percentages may not total 100% due to rounding.

As presented in Figure 1-2, performance between the two plans varied slightly. UHC CP was the better-performing plan, with 26 of the 54 rates with available benchmarks for comparison (or 48 percent) at or above the national 50th percentile. 'Ohana reported 33 of the 74 indicators (or 45 percent) at or above the national 50th percentile.

[1-7] The *Enrollment by Product Line*, *Inpatient Utilization—General Hospital/Acute Care*, and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, Medicaid national percentiles do not exist for *Plan All-Cause Readmissions*, *Care for Older Adults*, *Colorectal Cancer Screening*, and *Medication Reconciliation Post-Discharge*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

HSAG validated nine HEDIS 2015 and two non-HEDIS performance measures for the ‘Ohana CCS program. These performance measures resulted in 20 indicator rates, of which eight indicators were compared to national Medicaid HEDIS 2014 percentiles.[1-8] ‘Ohana CCS received an audit result of *NA* (small denominator) for three indicators. Figure 1-3 shows the CCS performance compared with the national percentiles.

Figure 1-3—Comparison of ‘Ohana’s CCS Rates to HEDIS Medicaid National Percentiles



As presented in Figure 1-3, ‘Ohana CCS program’s performance was below average for HEDIS 2015. Sixty percent of the HEDIS indicators with available benchmarks for comparison ranked below the national 50th percentile. The remaining 40 percent of the indicators fell at or above the national 50th percentile but below the 75th percentile.

Recommendations for improvement are presented in the plan-specific results sections of this report. In general, HSAG recommends that each plan target the lower-performing measures/indicators for improvement for its respective populations. Each plan should conduct a barrier analysis to determine why performance was low, coupled with data analysis and drill-down evaluations of noncompliant cases.

[1-8] The *Enrollment by Product Line* and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, Medicaid national percentiles do not exist for *Plan All-Cause Readmissions*, and the two non-HEDIS measures: *Behavioral Health Assessment* and *Follow-up with Assigned PCP Following Hospitalization for Mental Illness.* For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

Validation of Performance Improvement Projects (PIPs)

Description

PIPs are designed as an organized way to assist health plans in assessing their healthcare processes, implementing process improvements, and improving outcomes of care. In 2015, HSAG validated two PIPs for each of the QUEST Integration and CCS health plans, for a total of 12 PIPs. The five QUEST Integration plans were required by the MQD to conduct PIPs related to *All-Cause Readmissions* and a second topic to improve *Diabetes Care*. CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*.

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the health plan with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings.

In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement.[1-9] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The new methodology focuses on evaluating and refining small process changes in order to determine the most effective strategies for achieving real improvement.

The key concepts of the new PIP framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.

For this new PIP framework, HSAG developed five modules, each with a companion guide. Each module includes validation criteria necessary for successful completion of a valid PIP. Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

- *High confidence* = the PIP was methodologically sound, achieved meaningful improvement for the SMART (specific, measureable, achievable, relevant, and time-bound) Aim measure, and the demonstrated improvement was clearly linked to the quality improvement processes conducted.
- *Confidence* = the PIP was methodologically sound; achieved meaningful improvement for the SMART Aim measure; and some of the quality improvement processes were clearly linked to the demonstrated improvement, but there was not a clear link between all quality improvement processes and the demonstrated improvement.

[1-9] Institute for Healthcare Improvement. How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: September 24, 2015.

- *Low confidence* = (1) the PIP was methodologically sound, but improvement was not achieved for the SMART Aim measure; or (2) improvement was achieved for the SMART Aim measure, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Findings, Conclusions, and Recommendations

Following the review and validation of the health plans' 2015 PIPs, HSAG concluded that:

- The 2015 PIP validation was a transition year with the health plans moving from submitting PIP Summary Forms with 10 activities to HSAG's rapid-cycle PIP process with five modules.
- The health plans had not yet progressed to reporting healthcare measure outcomes at the time of the validation.
- The performance on the PIPs suggests that the health plans were able to successfully complete Modules 1 through 3 (PIP Initiation, SMART Aim Data Collection, and Intervention Determination) for each PIP topic after receiving feedback and technical assistance from HSAG.
- The PIPs included methodologies that used quality improvement science and were appropriate to measure and monitor outcomes using HSAG's rapid-cycle process.
- Starting in August 2015, the health plans began implementing and testing interventions. Module 4 (Plan-Do-Study-Act) will be submitted for each intervention tested after the results have been obtained.
- Module 5 (PIP Conclusions) will be submitted within a few weeks of the SMART Aim end date.
- The health plans should request technical assistance from HSAG at any point in the process, if needed.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Plan-Specific Child Medicaid Survey and Statewide CHIP Survey

Description

The CAHPS health plan surveys are standardized survey instruments which measure members' satisfaction levels with their healthcare. For 2015, HSAG administered the CAHPS 5.0H Child Medicaid Health Plan Survey (without the Children with Chronic Condition [CCC] measurement set), to Medicaid members of the QI health plans, including CHIP-eligible enrollees via a statewide sampling methodology, who met age and enrollment criteria. All parents or caretakers of sampled child Medicaid and CHIP members completed the surveys from February to May 2015 and received an English version of the survey with the option to complete the survey in one of four non-English prevalent languages: Chinese, Ilocano, Korean, or Vietnamese. Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan and/or State-level CAHPS data.

For each survey, the results of 11 measures of satisfaction were reported. These measures included four global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and five composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*). In addition, two individual items were assessed (*Coordination of Care* and *Health Promotion and Education*).

Findings, Conclusions, and Recommendations

For the QI health plans and the statewide QI Program aggregate scores as compared to the 2014 NCQA national child Medicaid average, the following results were noted:[1-10]

- The QI Program aggregate scores were above the NCQA national child Medicaid average on five of the 10 comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Coordination of Care*, and *Health Promotion and Education*.
- AlohaCare QI scored above the NCQA national child Medicaid average on five of the 10 comparable measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, *Coordination of Care*, and *Health Promotion and Education*.
- HMSA QI scored above the NCQA national adult Medicaid average on seven of the 10 comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.
- Kaiser QI scored above the NCQA national child Medicaid average on nine of the 10 comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Coordination of Care*, and *Health Promotion and Education*.
- 'Ohana QI scored above the NCQA national child Medicaid average on one of the 10 comparable measures: *Health Promotion and Education.*
- UHC CP QI scored above the NCQA national child Medicaid average on five of the 10 comparable measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Coordination of Care*, and *Health Promotion and Education.*

Figure 1-4 depicts the top-box scores for the statewide QI Program aggregate and the 2014 NCQA national child Medicaid average for each of the global ratings.

[1-10] Due to changes to the *Shared Decision Making* composite measure, comparisons to 2014 NCQA national averages could not be performed for 2015.

Figure 1-4—QI Program Aggregate: Global Ratings

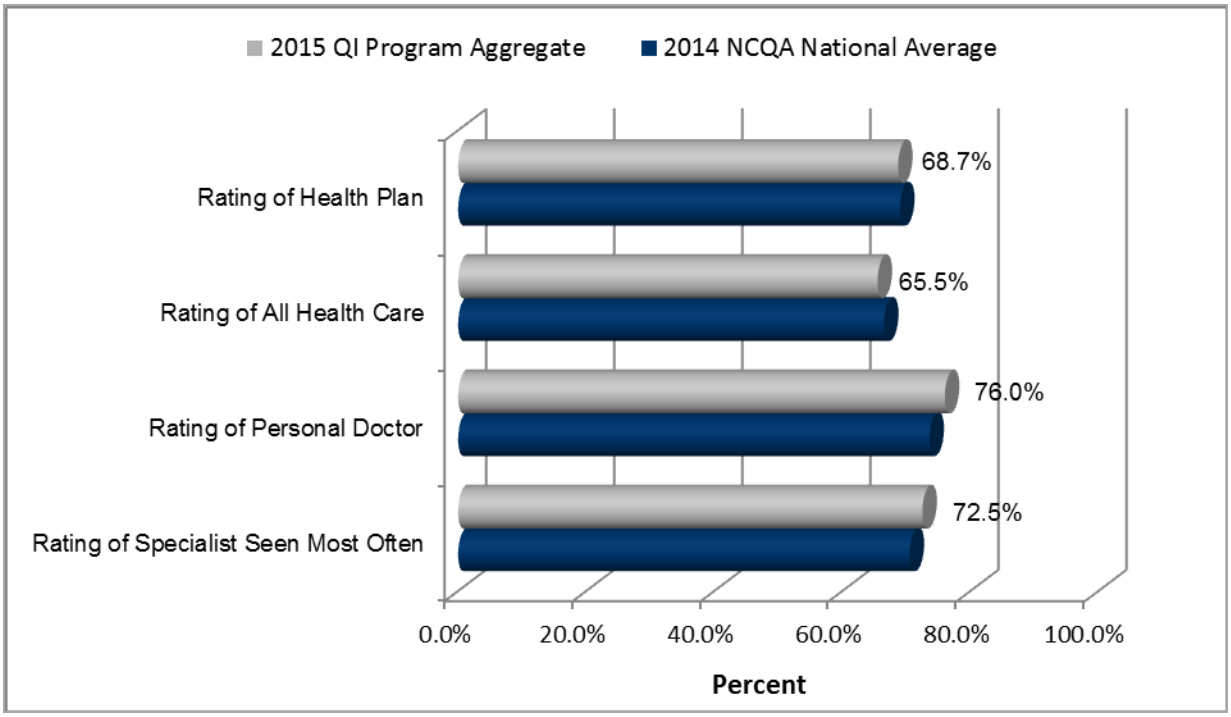
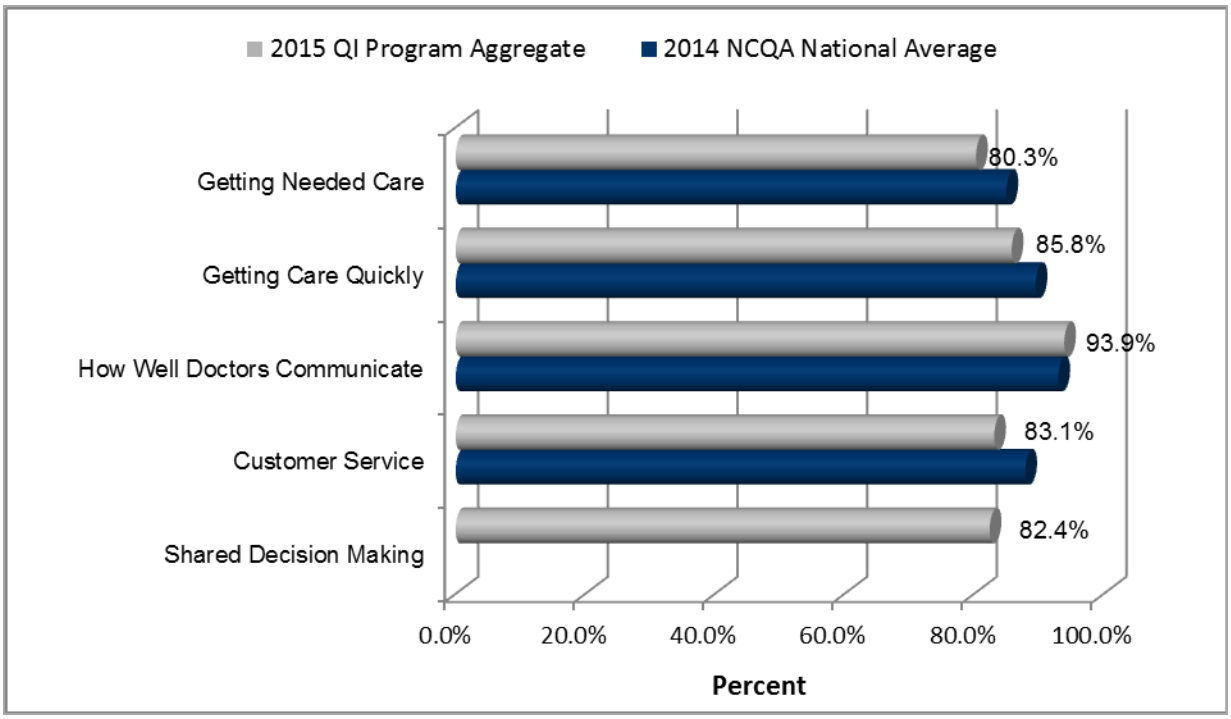


Figure 1-5 depicts the top-box scores for the statewide QI Program aggregate and the 2014 NCQA national child Medicaid average for each of the composite measures.

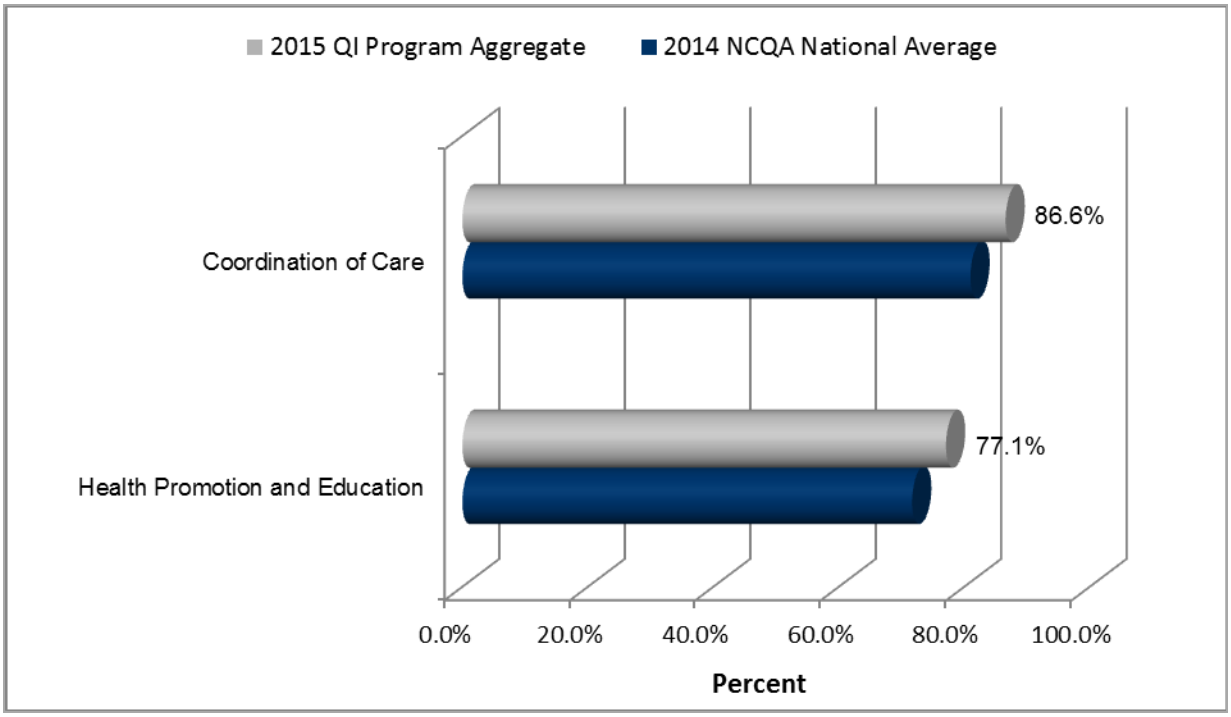
Figure 1-5—QI Program Aggregate: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.

Figure 1-6 depicts the top-box scores for the statewide QI Program aggregate and the 2014 NCQA national child Medicaid average for each of the individual item measures.

Figure 1-6—QI Program Aggregate: Individual Item Measures

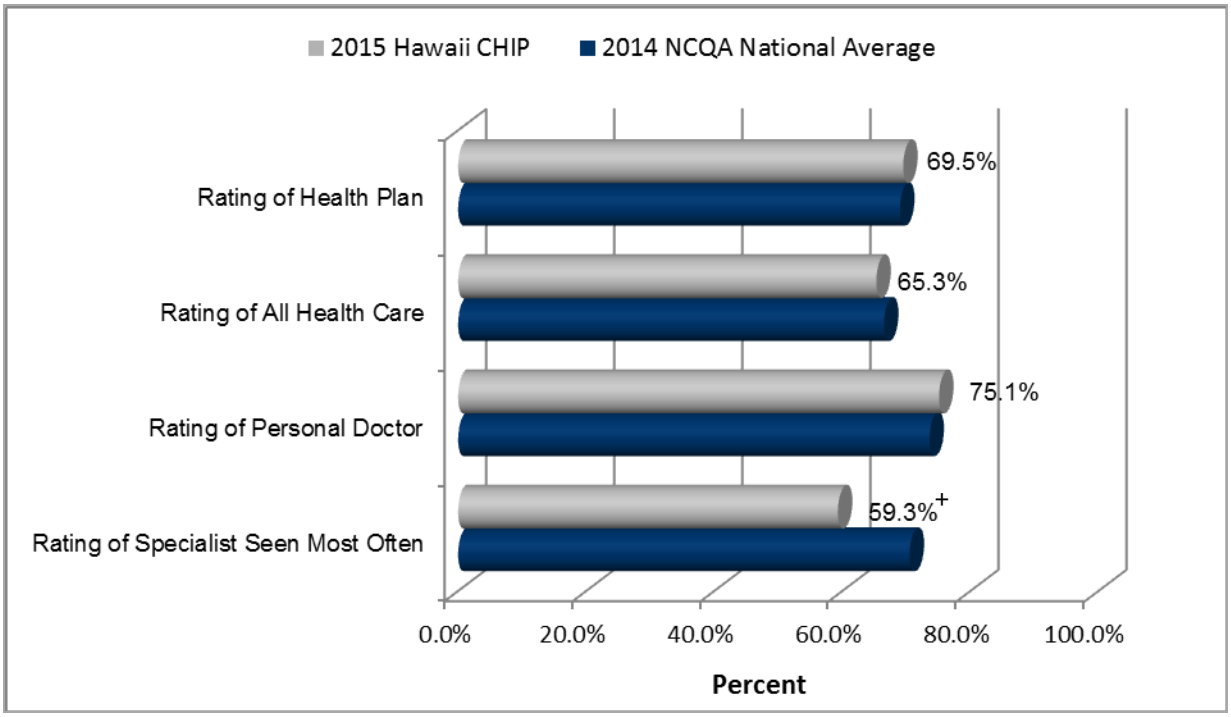


As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparative purposes. As compared to the 2014 NCQA national child Medicaid average, the following results were noted for the CHIP population:

- CHIP scored above the NCQA national child Medicaid average on five of the 10 comparable measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, *Coordination of Care*, and *Health Promotion and Education.*

Figure 1-7 depicts the top-box scores for CHIP and the 2014 NCQA national child Medicaid average for each of the global ratings.

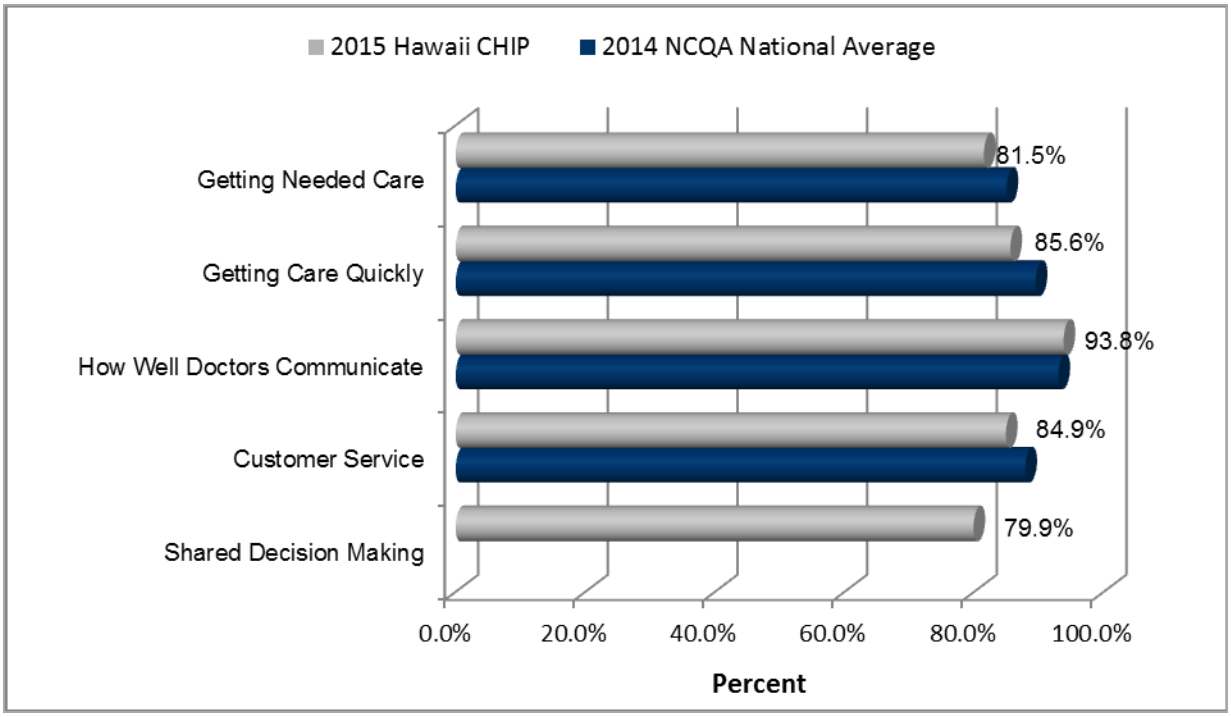
Figure 1-7—CHIP: Global Ratings



+ There were fewer than 100 respondents for the CAHPS measure; therefore, caution should be exercised when interpreting these results.

Figure 1-8 depicts the top-box scores for CHIP and the 2014 NCQA national child Medicaid average for each of the composite measures.

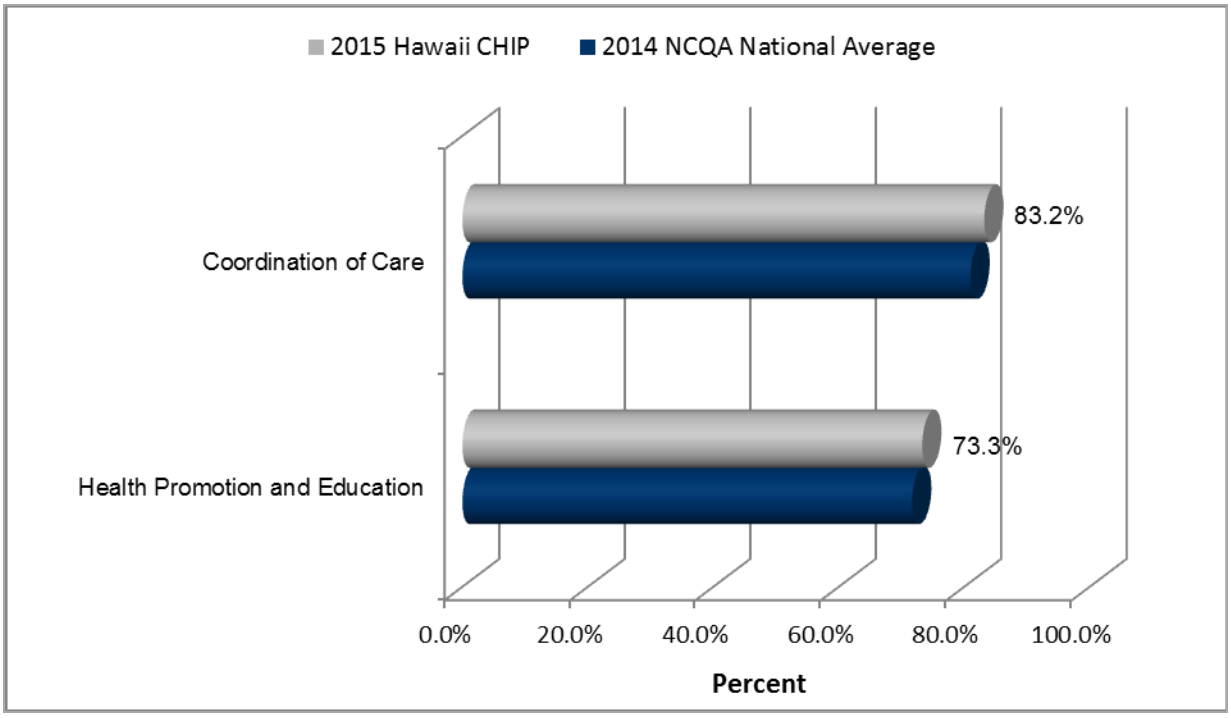
Figure 1-8—CHIP: Composite Measures



Please note: Due to changes to the *Shared Decision Making* composite measure, comparisons to 2014 NCQA national averages could not be performed for this CAHPS measure for 2015.

Figure 1-9 depicts the top-box scores for the statewide CHIP aggregate and the 2014 NCQA national child Medicaid average for each of the individual item measures.

Figure 1-9—CHIP: Individual Item Measures



HSAG provided the MQD general recommendations related to these findings for each measure considered a "key driver" of member satisfaction.

Provider Survey

HSAG conducted a provider survey during 2015 at the request of the MQD. The objective of this activity was to provide meaningful information to the MQD and the health plans about providers' perceptions of the health plans. The survey was last conducted in 2013, and those results were used for comparison purposes to the extent possible.

Description

A sample of Medicaid providers (primary care practitioners and specialists) contracted with or employed by the QI health plans were surveyed to assess satisfaction. Surveys were mailed and follow-up was conducted to increase response rates. Providers had the option of responding to the survey via the mailed hard copy or completing an online version of the survey instrument. Results were compiled and determined within six domains of satisfaction: General Positions, Providing Quality Care, Formulary, Service Coordinators, Specialists, and Behavioral Health.

Because of network model differences, sampling was performed separately for Kaiser providers (N=400) and non-Kaiser providers (N=1,100). Non-Kaiser providers were those contracted with one or more of the QI health plans, excluding Kaiser.

Findings, Conclusions, and Recommendations

- The overall response rate for the 2015 survey of 19.6 percent exceeded the 2013 response rate (5.8 percentage points higher). The response rate of Kaiser providers was higher than non-Kaiser providers (26.4 percent and 17.1 percent, respectively). A total of 260 providers responded to the survey. Approximately one-third of the respondents were PCPs, with the other two-thirds identifying themselves as specialists.
- Comparisons of the health plans' 2015 top-box rates revealed statistically significant differences between plan performance. AlohaCare QI's performance was significantly lower when compared to the aggregate performance of the other plans on two measures. HMSA QI scored significantly higher than the aggregate performance of the other plans on five measures. Kaiser QI's performance was significantly higher than the aggregate performance of the other plans on eight measures. 'Ohana QI scored significantly lower than the aggregate performance of the other plans on seven measures. 'Ohana CCS' performance was significantly lower when compared to the aggregate performance of the other plans on five measures. UHC CP QI performed significantly lower than the aggregate performance of the other plans on eight measures.
- A trending analysis of 2013 top-box rates to their corresponding 2015 top-box scores revealed that none of the health plans showed statistically significant differences in 2015.

Based on the results of this survey, HSAG provided recommendations to the MQD regarding how the health plans might improve provider perceptions and satisfaction. In addition, to continue to increase survey response rates, HSAG provided suggestions to the MQD regarding the survey administration and on how it might increase the number of respondents for future surveys.

State of Hawaii

Department of Human Services

Med-QUEST Division

2016 External Quality Review Report of Results

For the

QUEST Integration Health Plans

and the

Community Care Services Program

March 2017

HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

Overview

The 2016 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) Health Plans and the Community Care Services (CCS) program is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR 438.364. Health Services Advisory Group, Inc. (HSAG), is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), the single State agency responsible for the overall administration of Hawaii's Medicaid managed care program.

This report describes how data from activities conducted in accordance with 42 CFR 438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid recipients by the five QI health plans and the CCS program. The QI health plans were AlohaCare QUEST Integration Plan (AlohaCare QI), Hawaii Medical Service Association QUEST Integration Plan (HMSA QI), Kaiser Permanente Hawaii QUEST Integration Plan (Kaiser QI), 'Ohana Health Plan QUEST Integration ('Ohana QI), and UnitedHealthcare Community Plan QUEST Integration (UHC CP QI). 'Ohana also has held the contract for the Community Care Services ('Ohana CCS) program since March 2013. CCS is a carved-out behavioral health specialty services plan for individuals who have been determined by the MQD to have a serious mental illness.

According to the federal Medicaid managed care regulations (42 CFR 438), the QI health plans qualify as managed care organizations (MCOs), and the CCS program meets the definition as a pre-paid inpatient health plan (PIHP). Throughout this report, however, the Hawaii MCOs and PIHP will be referred to collectively as "health plans" unless there is a need to distinguish a particular plan type.

HSAG's external quality review (EQR) of the health plans included directly performing the three federally mandated activities as set forth in 42 CFR 438.358—review and evaluation of compliance with select federal managed care standards and associated State contract requirements, validation of performance measures/Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] compliance audits, and validation of performance improvement projects (PIPs). Two optional EQR activities were also performed this year: Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] surveys of Medicaid adult members and Children's Health Insurance Program (CHIP) members using the CAHPS 5.0H Child Medicaid CAHPS survey instruments. While the adult Medicaid survey was conducted at the plan level and provided results at a plan-specific and statewide aggregate level, the CHIP survey was conducted at a statewide level due to small enrollment numbers, producing statewide aggregate results.

This report includes the following for each EQR activity conducted:

- Objectives

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- Technical methods of data collection and analysis
- A description of data obtained
- Conclusions drawn from the data

In addition, an assessment of the strengths and weaknesses of each health plan, as well as plan comparative information, is included. The report also discusses the status of improvement activities initiated by the health plans and offers recommendations for improving the quality and timeliness of, and access to, healthcare services provided by each health plan.

This is the 12th year HSAG has produced the EQR report of results for the State of Hawaii. Report information does not disclose the identity of any patient, in accordance with 42 CFR 438.364(c).

External Quality Review Activities, Conclusions, and Recommendations

HSAG, as the EQRO for the MQD, conducted the EQR activities and analyzed the results as described in the next sections of this report. HSAG also offered conclusions and recommendations for improvement to the QI and CCS health plans.

Compliance Monitoring Review of Standards

Description

Calendar year (CY) 2016 began a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program.

For the 2016 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs, using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the (CFR) for five areas of review, or standards. A pre-on-site desk review and an on-site review with interview sessions, system and process demonstrations, and record reviews were conducted.

The second compliance review activity in 2016 involved HSAG's and the MQD's follow-up monitoring of CCS' corrective actions related to its 2015 compliance review, which were all addressed by the end of 2015 or very early 2016. Note: A compliance review was conducted only on the 'Ohana CCS program during 2015. This review brought the CCS program into alignment with the review schedule for the QI plans to ensure all standards are reviewed within a three-year period for all health plans.

Findings, Conclusions, and Recommendations

For the compliance review of health plans and the CCS program, the following tables illustrate the performance of the health plans and the CCS program in each of the standard areas reviewed. For comparison purposes, the statewide average score for the QI health plans is also presented.

Table 1-1—Compliance Standards and Scores

Standard #	Standard Name	AlohaCare QI	HMSA QI	Kaiser QI	'Ohana QI	'Ohana CCS	UHC CP QI	Statewide/ All Plans
I	Member Rights and Protections and Member Information	95%	93%	84%	95%	96%	95%	93%
II	Member Grievance System	98%	94%	97%	98%	98%	98%	97%
III	Access and Availability	100%	95%	95%	95%	100%	100%	98%
IV	Coverage and Authorization	100%	100%	96%	100%	100%	100%	99%
V	Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	100%
Total Compliance Score:		98%	96%	93%	98%	98%	98%	97%

Scores were calculated by assigning 1 point to *Met* items, 0.5 points to *Partially Met* items, and 0 points to *Not Met* and *NA* items, then dividing the total by the number of applicable items.

Statewide areas of strong performance that emerged were Standards V (Coordination and Continuity of Care) at 100 percent, Standard IV (Coverage and Authorization) at 99 percent, Standard III (Access and Availability) at 98 percent, and Standard II (Member Grievance System) at 97 percent. Identified as having the greatest opportunity for improvement was Standard I (Member Rights and Protections and Member Information) at 93 percent.

All but one of the health plans (Kaiser at 93 percent) scored at or above 96 percent for overall total compliance, indicating a high degree of compliance with managed care requirements.

AlohaCare QI's performance across all standards was strong, exceeding the state-wide average for each standard and having three standard areas achieving 100 percent (Access and Availability, Coverage and Authorization, and Coordination and Continuity of Care).

AlohaCare QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until AlohaCare QI is found to be in full compliance with the standards.

HMSA QI's performance across all standards was solid. The health plan met or exceeded the statewide average for three of the five compliance standards, and its 96 percent total compliance score fell just short

of the statewide average of 97 percent. HMSA QI achieved 100 percent scores for two standards (Coverage and Authorization, and Coordination and Continuity of Care).

HMSA QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until HMSA QI is found to be in full compliance with the standards.

Kaiser QI's performance across four of the five standards was also solid. The health plan met or exceeded the statewide average for two of the five compliance standards. However, its 93 percent total compliance score fell short of the statewide average score of 97 percent. Kaiser QI achieved a 100 percent score for one standard (Coordination and Continuity of Care). The Member Rights and Protections and Member Information standard represented the greatest area for improvement, with a score of 84 percent.

Kaiser QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until Kaiser QI is found to be in full compliance with the standards.

'Ohana QI's performance across all standards was strong. Three standards exceeded statewide scores, and one standard was equal to the statewide score at 100 percent (Coordination and Continuity of Care). 'Ohana QI's overall score of 98 percent exceeded the health plans' statewide score from HSAG's review of the same standards (97 percent).

'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until 'Ohana QI is found to be in full compliance with the standards.

'Ohana CCS' performance across all standards was also strong. Four standards exceeded statewide scores, and one standard met the statewide score of 100 percent. 'Ohana CCS had three standard areas achieving 100 percent (Access and Availability, Coverage and Authorization, and Coordination and Continuity of Care). 'Ohana CCS' overall score of 98 percent exceeded the health plans' statewide score from HSAG's review of the same standards (97 percent).

'Ohana CCS was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until CCS is found to be in full compliance with the standards.

UHC CP QI's performance across all standards was strong as well. All standards exceeded statewide scores, and one standard was equal to the statewide score at 100 percent. UHC CP QI had three standard areas achieving 100 percent (Access and Availability, Coverage and Authorization, and Coordination and Continuity of Care). UHC CP QI's overall score of 98 percent exceeded the health plans' statewide score from HSAG's review of the same standards (97 percent).

UHC CP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD will provide follow-up monitoring until UHC CP QI is found to be in full compliance with the standards.

With the completion of these reviews, the health plans and CCS have demonstrated their structural and operational compliance and ability to provide quality, timely, and accessible services. Calendar year 2017 will be the second year in the three-year cycle for compliance reviews. The reviews will target the remaining six standards: Provider Selection, Credentialing, Subcontractual Relationships and Delegation, Practice Guidelines, Quality Assessment and Performance Improvement, and Health Information Systems.

Validation of Performance Measures—NCQA HEDIS Compliance Audits[1-3]

Description

HSAG performed independent audits of the performance measure results calculated by the QUEST Integration (QI) health plans and Community Care Services (CCS) program according to the *2016 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5*. The audit procedures were also consistent with the CMS protocol for performance measure validation: *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[1-4] The health plans that contracted with the Med-QUEST Division (MQD) during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each NCQA HEDIS Compliance Audit incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health.

The measurement period was CY 2015 (January 1, 2015, through December 31, 2015), and the audit activities were conducted concurrently with HEDIS 2016 reporting. The five QI health plans (AlohaCare QI, HMSA QI, Kaiser QI, 'Ohana QI, and UHC CP QI) were required to report the QI, aged, blind, or disabled (ABD), and non-ABD measures. In addition, 'Ohana CCS was required to report rates for the CCS program-specific measures.

During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 31 measures, yielding a total of 96 measure indicators, for the QI population. For the ABD population, health plans were required to report on 32 measures, yielding a total of 100 measure indicators. The health plans were required to report on 30 measures, yielding a total of 95 measure indicators, for the non-ABD population. 'Ohana CCS was required to report on 10 measures, yielding a total of 16 measure indicators, for the CCS program. The measures were organized into categories, or domains, to evaluate

[1-3] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Sept 27, 2016.

the health plans' performance and the quality and timeliness of, and access to, Medicaid care and services. These domains included:

- Access to Care
- Effectiveness of Care
- Children's Preventive Care
- Women's Health
- Care for Chronic Conditions
- Behavioral Health
- Utilization and Health Plan Descriptive Information

Findings, Conclusions and Recommendations

HSAG evaluated each health plan's compliance with NCQA's IS standards. All health plans were fully compliant with all standards and able to report valid performance measure rates. All health plans used software vendors that participated in NCQA's measure certification program to generate the rates required by MQD. However, Kaiser QI calculated two measures using internally developed programming code. All health plans used supplemental data to augment their internal claims/encounter data, which is allowable for HEDIS reporting.

HSAG analyzed the health plan-specific performance measure results for the combined QI population, as well as rates for the non-ABD and ABD populations, and the CCS program. For each performance measure indicator within this report, HSAG compared the HEDIS 2016 results to the NCQA national Medicaid HEDIS 2015 Audit Means and Percentiles and, where appropriate, performed significance testing to determine statistically significant changes between 2015 and 2016. Additionally, HSAG compared 18 measure indicators to Quality Strategy targets established by the MQD based on the national 2015 HEDIS Medicaid HMO percentiles.[1-5] The MQD Quality Strategy targets are defined in Section 3 (Plan-Specific Results, Conclusions, and Recommendations) in Table 3-7.

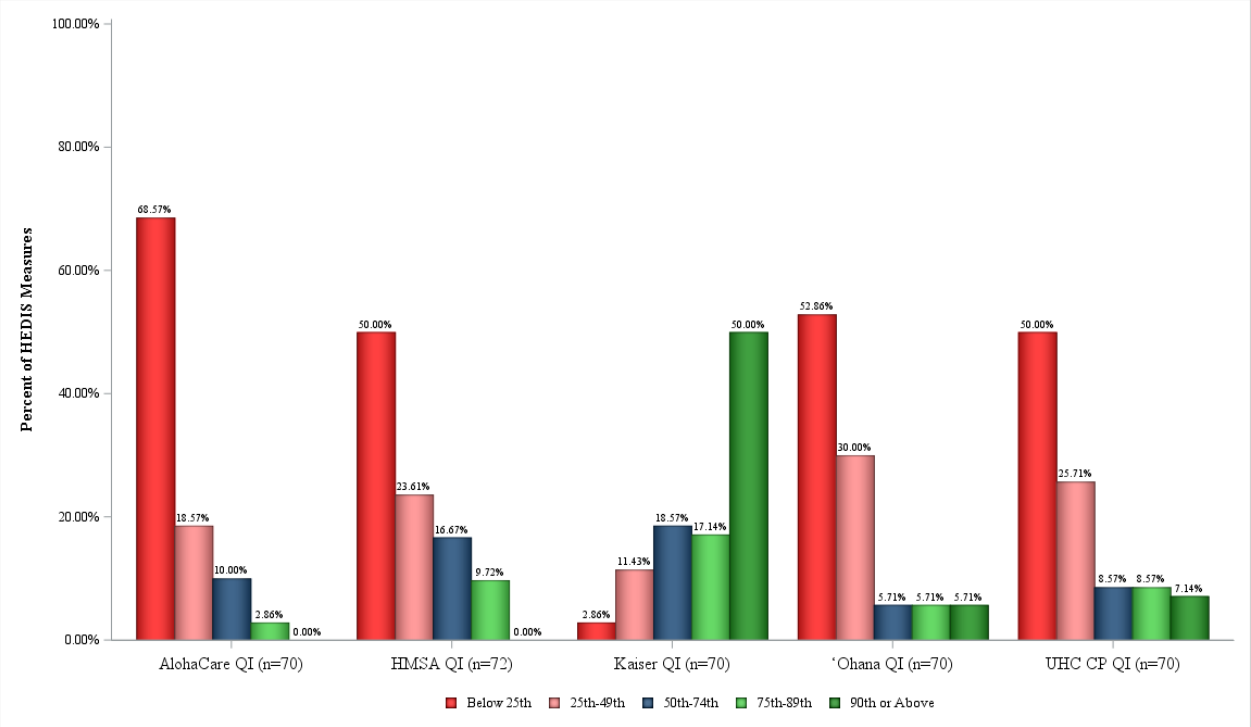
QI Performance Measure Results

The health plans reported and HSAG validated 96 HEDIS 2016 performance measure indicators for the QI population, of which up to 72 indicators were compared to national Medicaid percentiles.[1-6] Of note, 2016 is the first year that rates for the QI population were evaluated by HSAG. Figure 1-1 displays the health plans' performance compared to the national Medicaid percentiles.

[1-5] Since national Medicaid benchmarks are not available for the *Medication Reconciliation Post-Discharge* measure, this measure was compared to national Medicare benchmarks. Caution should be exercised when comparing Medicaid rates to the corresponding Medicare percentiles.

[1-6] The *Inpatient Utilization-General Hospital/Acute Care* and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, national Medicaid percentiles do not exist for *Plan All-Cause Readmissions* and *Colorectal Cancer Screening*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

Figure 1-1—Comparison of QI Measure Indicators to HEDIS Medicaid National Percentiles



Please note: Percentages may not total 100% due to rounding.

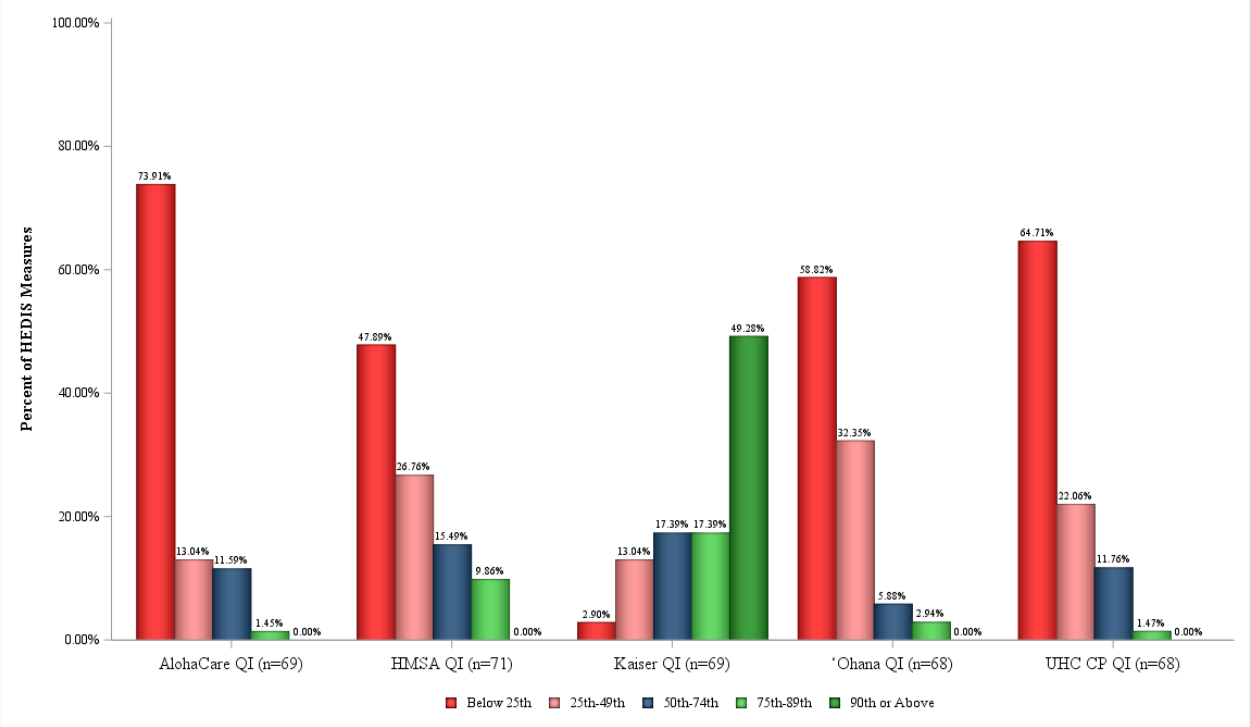
As presented in Figure 1-1, health plan performance was diverse for the QI population. The highest-performing health plan was Kaiser QI, with approximately 67 percent of its measure indicator rates ranking at or above the national Medicaid 75th percentile and 50 percent of these measures ranking at or above the national Medicaid 90th percentile. Conversely, the majority of the remaining health plans' QI population rates fell below the national Medicaid 25th percentile, with 50 percent of HMSA QI's and UHC CP QI's rates falling below the national Medicaid 25th percentile, roughly 53 percent of 'Ohana QI's rates falling below the national Medicaid 25th percentile, and approximately 69 percent of AlohaCare QI's rates falling below the national Medicaid 25th percentile.

In addition, all five health plans had reportable rates for the 18 measures with MQD Quality Strategy targets that were specific to the QI population. Thirteen of Kaiser QI's rates (72 percent) met or exceeded the MQD Quality Strategy targets. Five of UHC CP QI's rates (28 percent) met or exceeded the MQD Quality Strategy targets. Two of 'Ohana QI's rates (11 percent) met or exceeded the MQD Quality Strategy targets, and one of HMSA's QI rates (6 percent) met or exceeded the MQD Quality Strategy targets. None of AlohaCare QI's rates met the MQD Quality Strategy targets.

Non-ABD Performance Measure Results

The health plans reported and HSAG validated 95 performance measure indicators for the non-ABD population, of which up to 71 indicators were compared to national Medicaid percentiles.[1-7] Figure 1-2 displays the health plans' performance compared to the national Medicaid percentiles.

Figure 1-2—Comparison of Non-ABD Measure Indicators to HEDIS Medicaid National Percentiles



Please note: Percentages may not total 100 percent due to rounding.

Health plan performance varied for the non-ABD population, with Kaiser QI's performance exceeding that of the other QI health plans when compared to national Medicaid percentiles. Approximately 67 percent of Kaiser QI's rates ranked at or above the national Medicaid 75th percentile, with roughly 49 percent of these measure rates ranking at or above the national Medicaid 90th percentile. Conversely, most of the remaining health plans' QI population rates fell below the national Medicaid 25th percentile. Specifically, approximately 74 percent of AlohaCare QI's rates, 48 percent of HMSA QI's rates, 59 percent of 'Ohana QI's rates, and 65 percent of UHC CP QI's rates fell below the national Medicaid 25th percentile.

While the QI has 18 measures, the non-ABD had 17 measures. For the measures that were specific to the non-ABD population, all five health plans had reportable rates for the 17 measures with MQD Quality Strategy targets. Thirteen measure indicator rates reported by Kaiser QI (76 percent) met or exceeded

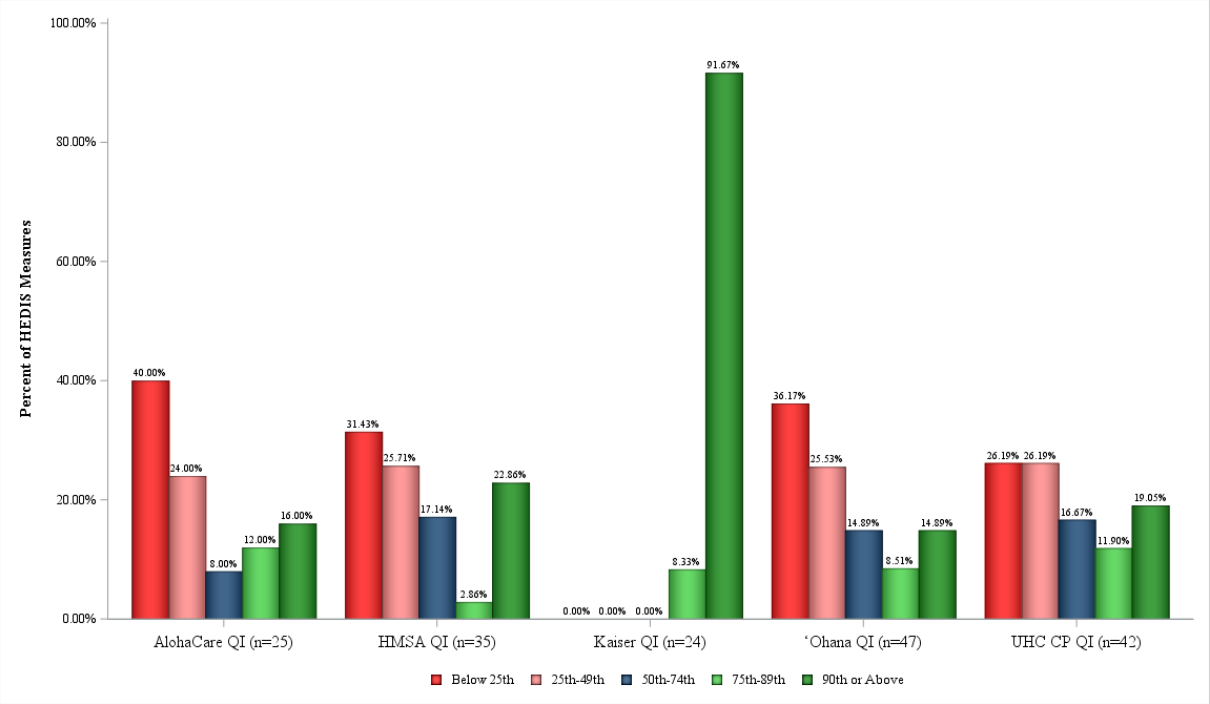
[1-7] The *Enrollment by Product Line, Inpatient Utilization-General Hospital/Acute Care,* and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, national Medicaid percentiles do not exist for *Plan All-Cause Readmissions* and *Colorectal Cancer Screening*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

the MQD Quality Strategy targets, and one of HMSA QI's reported rates (6 percent) met or exceeded the MQD Quality Strategy target. None of AlohaCare QI's, 'Ohana QI's, or UHC CP QI's rates met the MQD Quality Strategy targets.

ABD Performance Measure Results

The health plans reported and HSAG validated 100 ABD population performance measure indicators, of which up to 47 indicators were compared to national Medicaid percentiles.[1-8] Of note, HSAG evaluated ABD population rates for 'Ohana QI and UHC CP QI in 2015, but 2016 is the first year that HSAG evaluated ABD rates for the remaining health plans. Figure 1-3 displays the health plans' performance compared to the national Medicaid percentiles.

Figure 1-3—Comparison of ABD Measure Indicators to HEDIS Medicaid National Percentiles



Please note: Percentages may not total 100 percent due to rounding.

As presented in Figure 1-3, the highest-performing health plan was Kaiser QI, with all of its measure rates ranking at or above the national Medicaid 75th percentile and approximately 92 percent these measure rates ranking at or above the national Medicaid 90th percentile. Rates for the remaining health plans demonstrated mixed performance compared to the national Medicaid percentiles. Roughly one-third of UHC CP QI's rates ranked at or above the national Medicaid 75th percentile, but more than 50 percent fell below the national Medicaid 50th percentile, with approximately 26 percent of the rates

[1-8] The *Enrollment by Product Line*, *Inpatient Utilization—General Hospital/Acute Care* and *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, national Medicaid percentiles do not exist for *Plan All-Cause Readmissions*, *Care for Older Adults*, *Colorectal Cancer Screening*, and *Medication Reconciliation Post-Discharge*. For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

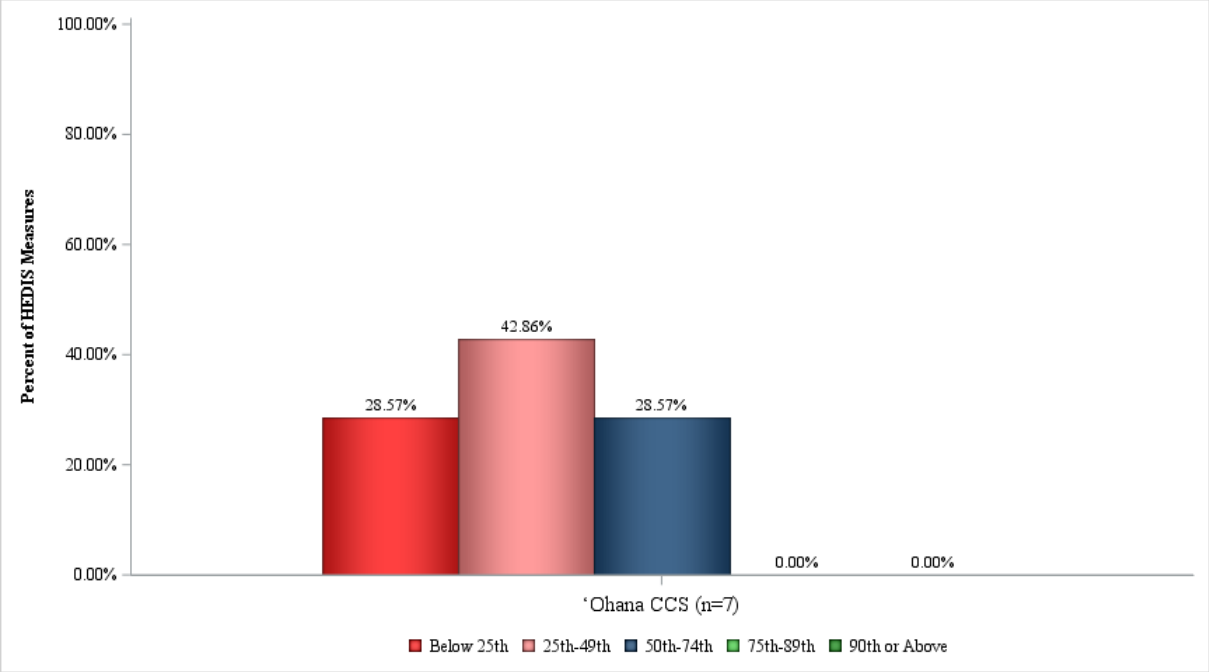
falling below the national Medicaid 25th percentile. Further, approximately one-quarter of AlohaCare QI's, HMSA QI's, and 'Ohana QI's rates ranked at or above the national Medicaid 75th percentile, but the majority of these health plans' rates fell below the national Medicaid 50th percentile.

While the QI has 18 measures, the ABD had 17 measures. Of the 17 ABD population measures with MQD Quality Strategy targets, Kaiser QI had reportable rates for 10 of these measure indicators, and nine of these rates (90 percent) met or exceeded the MQD Quality Strategy targets. Of the 17 measure indicators that were reportable for 'Ohana QI, four rates (24 percent) met or exceeded the MQD Quality Strategy targets. Of the 14 measure indicators that were reportable for UHC CP QI, three rates (21 percent) met or exceeded the MQD Quality Strategy targets. Of the 12 reportable rates for HMSA QI, one rate (8 percent) met or exceeded the MQD Quality Strategy targets. None of AlohaCare QI's rates met the MQD Quality Strategy targets.

CCS Performance Measure Results

'Ohana CCS reported and HSAG validated 16 indicator rates, of which seven indicators were compared to national Medicaid percentiles.[1-9] HSAG evaluated the CCS program rates for 'Ohana CCS in 2015 and 2016. Figure 1-4 displays 'Ohana CCS program performance compared to the national Medicaid percentiles.

Figure 1-4—Comparison of 'Ohana CCS' Rates to HEDIS Medicaid National Percentiles



Please note: Percentages may not total 100 percent due to rounding.

[1-9] The *Mental Health Utilization* measure results do not warrant comparisons to national benchmarks. Further, national Medicaid percentiles do not exist for *Plan All-Cause Readmissions* or the two non-HEDIS measures: *Behavioral Health Assessment* and *Follow-up with Assigned PCP Following Hospitalization for Mental Illness.* For these reasons, these measure results are presented for informational purposes and were not compared to national percentiles.

As presented in Figure 1-4, none of 'Ohana CCS' reported rates ranked at or above the national Medicaid 75th percentile. Conversely, approximately 71 percent of 'Ohana CCS' rates fell below the national Medicaid 50th percentile, with approximately 29 percent of these rates falling below the national Medicaid 25th percentile. 'Ohana CCS' did not meet the MQD Quality Strategy targets for *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days of Discharge* and *Follow-Up Within 30 Days of Discharge*. These were the only measures with MQD Quality Strategy targets for the CCS program.

Recommendations for improvement are presented in the population and health plan-specific results sections of this report. In general, HSAG recommends that each health plan focus on improving performance related to the measure indicators with rates that fell below the national Medicaid 25th percentile to determine if interventions are warranted, focusing efforts on identifying improvement strategies that could be leveraged to improve all rates for each population.

Validation of Performance Improvement Projects (PIPs)

Description

PIPs are designed as an organized way to assist health plans in assessing their healthcare processes, implementing process improvements, and improving outcomes of care. In 2016, HSAG validated two PIPs for each of the QI and CCS health plans, for a total of 12 PIPs. The five QUEST Integration plans were required by the MQD to conduct PIPs related to *All-Cause Readmissions* and a second topic to improve *Diabetes Care*. The *All-Cause Readmissions* PIP topic is a key focus of the MQD's quality strategy. CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment.*

The goal of HSAG's PIP validation is to ensure that the health plan and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP. In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes in order to determine the most effective strategies for achieving real improvement. To illustrate how the rapid-cycle PIP framework continued to meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-10] HSAG presented the crosswalk and new PIP framework components to CMS, and

[1-10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2016.

CMS agreed that with the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern PIPs within healthcare settings, a new approach was reasonable, approving HSAG's rapid-cycle PIP framework for validation of PIPs for the State of Hawaii.

Validation Overview

HSAG's methodology for evaluating and documenting PIP findings is a consistent, structured process that provides the health plan with specific feedback and recommendations for the PIP. HSAG uses this methodology to determine the PIP's overall validity and reliability, and to assess the level of confidence in the reported findings. HSAG's validation of rapid-cycle PIPs includes the following two key components of the quality improvement process:

- Evaluation of the technical structure to determine whether a PIP's initiation (i.e., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation through the use of PDSA cycles, and sustainability and spreading successful change. This component evaluates how well the health plan executed its quality improvement activities and whether the desired aim was achieved and sustained.

Findings, Conclusions, and Recommendations

All of the health plans progressed to testing interventions for the rapid-cycle PIPs in the 2016 annual validation cycle and submitted a Module 4 (PDSA cycle) for each intervention selected for testing. The health plans received recommendations from HSAG for the initial review of the Module 4 submissions. All of the health plans satisfactorily addressed HSAG's recommendations and feedback in the resubmitted Module 4s. The health plans had not yet progressed to reporting healthcare measure outcomes at the time of the validation. Following the review and validation of the health plans' 2016 PIPs, HSAG concluded that overall:

- The performance on the PIPs suggests that the health plans were able to successfully complete the first Module 4 submission (intervention testing using PDSA) for each PIP topic after receiving feedback from HSAG.
- The health plans should be cognizant of timing of interventions. If there are delays with beginning intervention testing, there may not be enough data points to determine meaningful and sustained improvement by the specific, measurable, attainable, relevant, and time-bound (SMART) Aim end date.
- The PIP process should be a learning experience that provides participating team members and organizations with new knowledge and skills that can be applied in ongoing quality improvement efforts.

- Module 5 (PIP conclusions) will be submitted within a few weeks of the SMART Aim end date (December 31, 2016). The conclusion of the PIP should be used as a springboard for sustaining improvement achieved and attaining new improvement.
- In Module 5, the health plans should provide an accurate summary of the overall key findings and interpretation of results.
- In Module 5, the health plans should document lessons learned and a plan for spreading successful interventions beyond the initial scope of the project.
- The health plans should request technical assistance from HSAG at any point in the process, if needed.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Plan-Specific Adult Medicaid Survey and Statewide CHIP Survey

Description

The CAHPS health plan surveys are standardized survey instruments which measure members' satisfaction levels with their healthcare. For 2016, HSAG administered the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members of the QI health plans, as well as a CHIP-eligible CAHPS 5.0 survey of members via a statewide sampling methodology, who met age and enrollment criteria. All members of sampled adult Medicaid and CHIP members completed the surveys from February to May 2016 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.[1-11] Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan and/or State-level CAHPS data.

For each survey, the results of 11 measures of satisfaction were reported. These measures included four global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and five composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*). In addition, two individual items were assessed (*Coordination of Care* and *Health Promotion and Education*).

Findings and Conclusions for the QI Health Plans

For the QI health plans and the statewide QI Program aggregate, 2016 scores were compared to the 2015 NCQA national adult Medicaid average, and the following results were noted:

- The QI Program aggregate scores exceeded the NCQA national adult Medicaid average on nine of the 11 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*,

[1-11] Please note that administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.0H Adult Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required in order to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.

Rating of Specialist Seen Most Often, *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.

- AlohaCare QI scored above the NCQA national adult Medicaid average on seven of the 11 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- HMSA QI scored above the NCQA national adult Medicaid average on seven of the 11 measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- Kaiser QI scored above the NCQA national adult Medicaid average on 10 of the 11 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- 'Ohana QI scored above the NCQA national adult Medicaid average on nine of the 11 measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.
- UHC CP QI scored above the NCQA national adult Medicaid average on eight of the 11 measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Customer Service*, *Shared Decision Making*, *Coordination of Care*, and *Health Promotion and Education*.

Figure 1-5 depicts the 2016 top-box scores for the statewide QI Program aggregate and the 2015 NCQA national adult Medicaid average for each of the global ratings.

Figure 1-5—QI Program Aggregate: Global Ratings

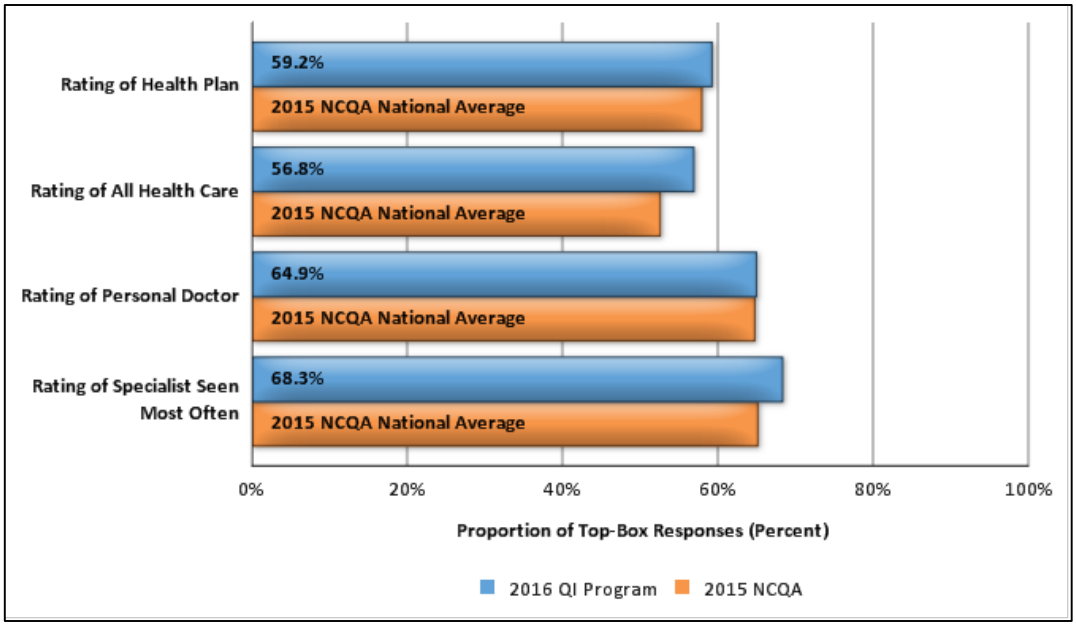


Figure 1-6 depicts the 2016 top-box scores for the statewide QI Program aggregate and the 2015 NCQA national adult Medicaid average for each of the composite measures.

Figure 1-6—QI Program Aggregate: Composite Measures

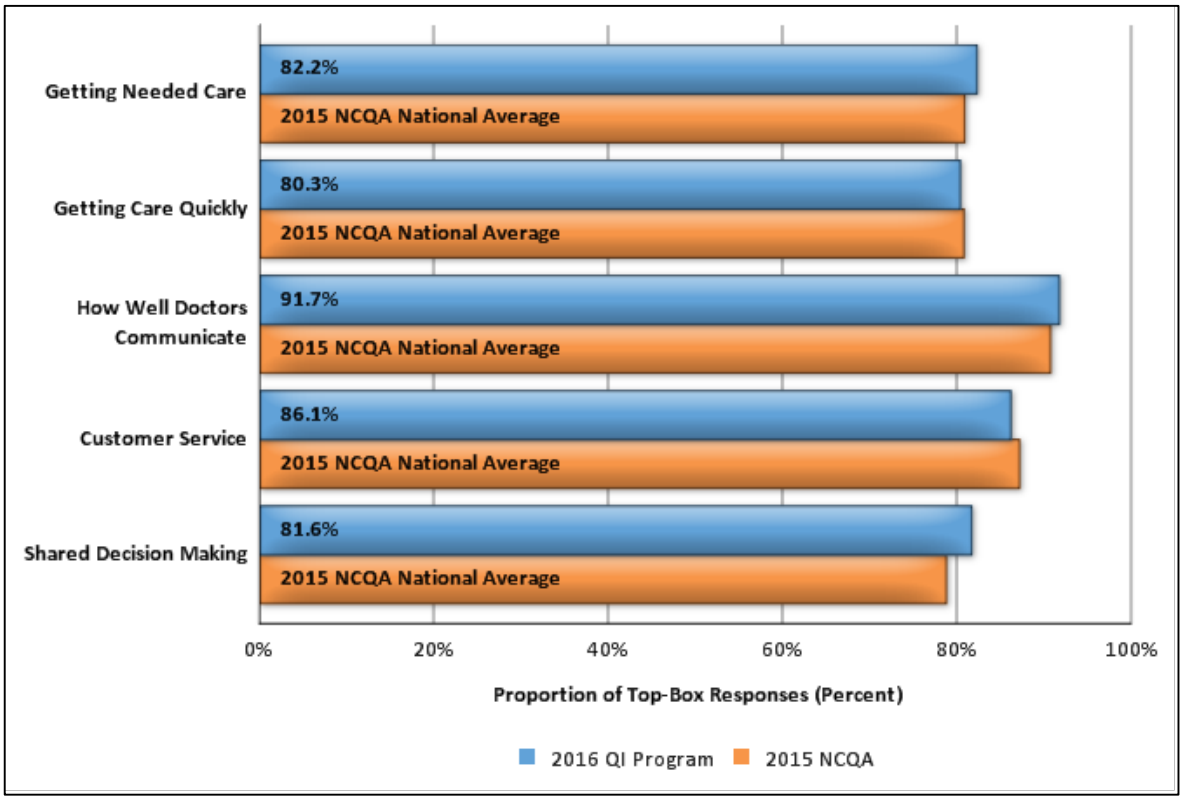
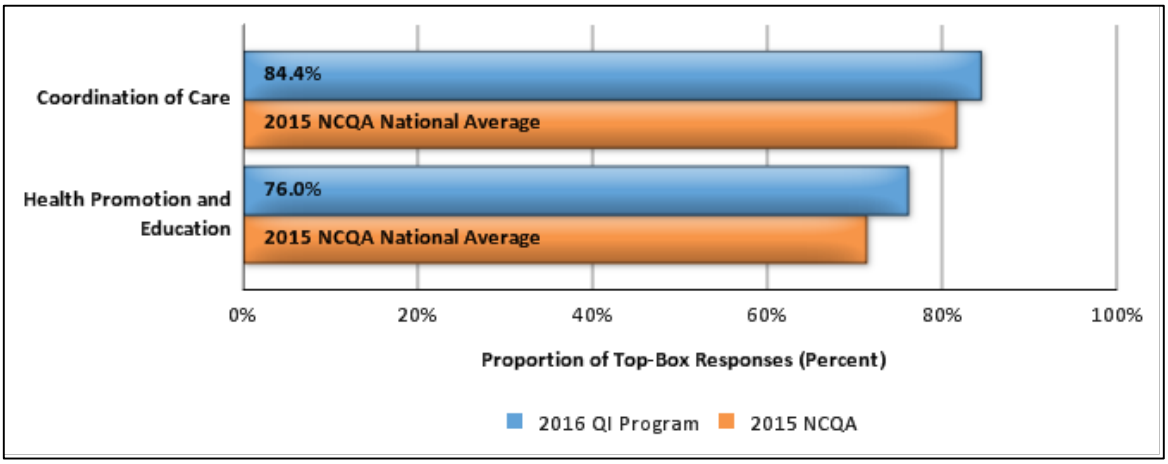


Figure 1-7 depicts the 2016 top-box scores for the statewide QI Program aggregate and the 2015 NCQA national adult Medicaid average for each of the individual item measures.

Figure 1-7—QI Program Aggregate: Individual Item Measures



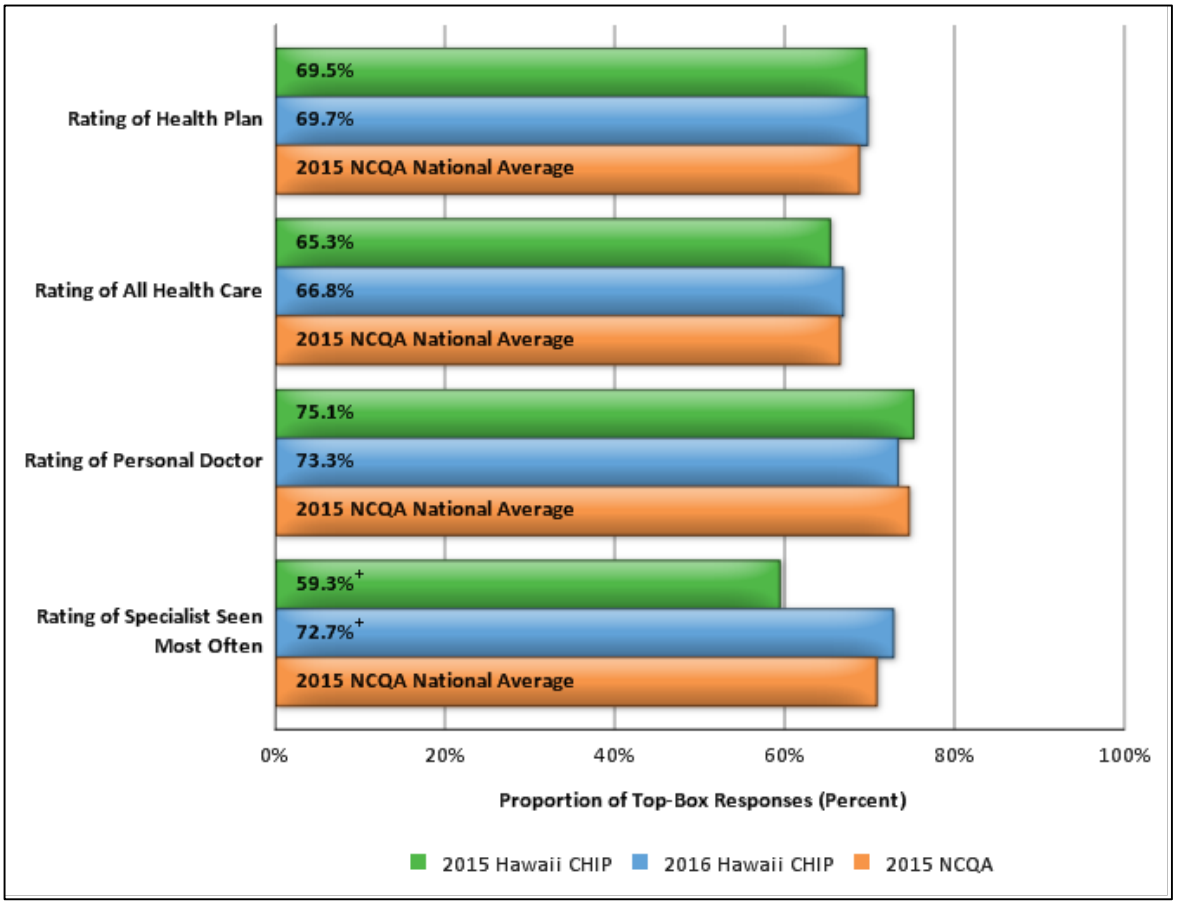
Findings and Conclusions for CHIP

As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparative purposes. As compared to the 2015 NCQA national child Medicaid average, the following results were noted for the CHIP population:

The 2016 CHIP Program scores were above the 2015 NCQA national child Medicaid average on six of the 11 reportable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Health Promotion and Education*.

Figure 1-8 depicts the 2015 and 2016 top-box scores for CHIP and the 2015 NCQA national child Medicaid average for each of the global ratings.

Figure 1-8—CHIP: Global Ratings



+ There were fewer than 100 respondents for the CAHPS measure; therefore, caution should be exercised when interpreting these results.

Figure 1-9 depicts the 2015 and 2016 top-box scores for CHIP and the 2015 NCQA national child Medicaid average for each of the composite measures.

Figure 1-9—CHIP: Composite Measures

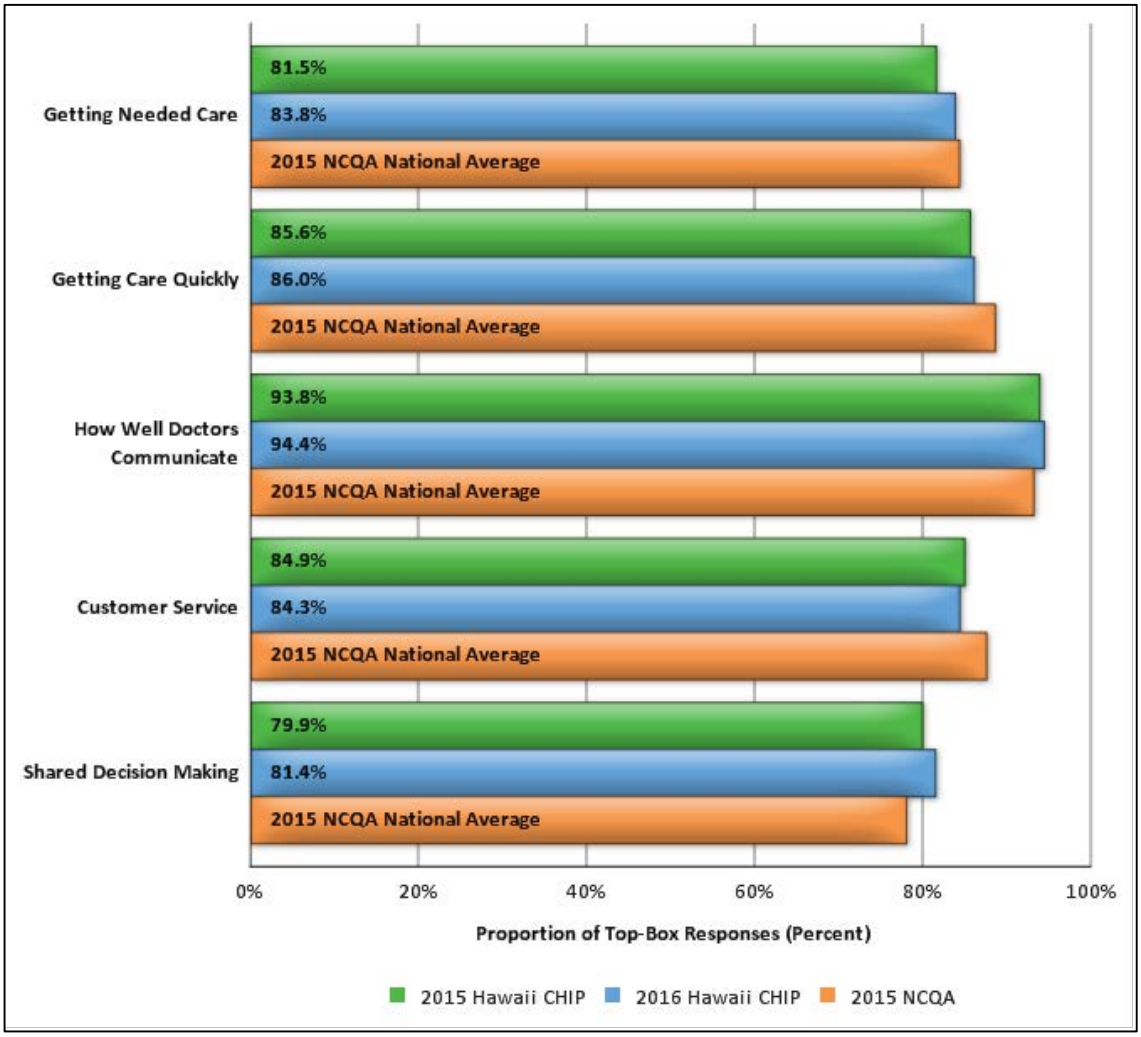
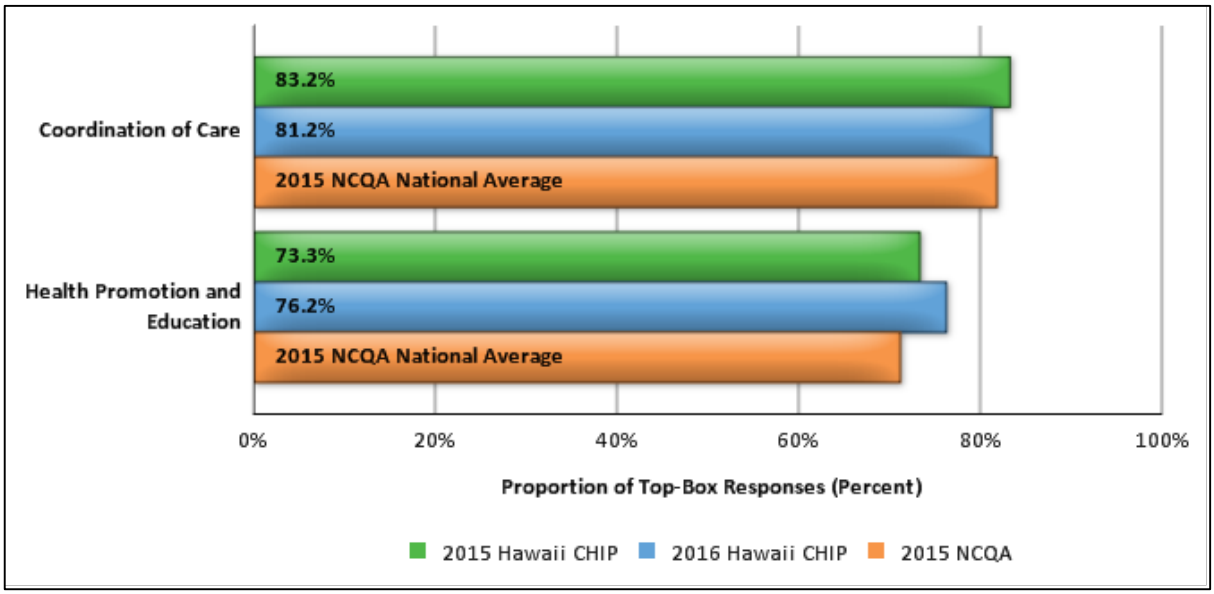


Figure 1-10 depicts the 2015 and 2016 top-box scores for the statewide CHIP aggregate and the 2015 NCQA national child Medicaid average for each of the individual item measures.

Figure 1-10—CHIP: Individual Item Measures



Provider Survey

HSAG conducted a provider survey during 2016 at the request of the MQD. The objective of this activity was to provide meaningful information to the MQD and the QI health plans about providers' perceptions of the QI health plans. The results of the 2016 Hawaii Provider Survey questions were presented by five domains of satisfaction related to general positions, providing quality care, non-formulary, service coordinators, and specialists.

Findings and Conclusions

Standard tests of statistical significance were conducted to determine if statistically significant differences in QI health plan performance existed between the QI health plans' 2016 top-box rates. As is standard in most survey implementations, a "top-box" rate is defined by a positive or satisfied response. Below is a summary of the statistically significant differences that existed between the 2016 "top-box" rates of the QI health plans.

- AlohaCare QI's 2016 top-box rate for adequacy of specialists (6.6 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- HMSA QI's 2016 top-box rates for compensation satisfaction and timeliness of claims payments (35.7 percent and 58.0 percent, respectively) were both higher than the aggregate rates of the other QI health plans, and the differences were statistically significant.

- HMSA QI's 2016 top-box rate for prior authorization process (16.8 percent) was higher than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- HMSA QI's 2016 top-box rate for adequacy of specialists (21.6 percent) was higher than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- Kaiser QI's 2016 top-box rates for compensation satisfaction and timeliness of claims payments (63.4 percent and 61.5 percent, respectively) were both higher than the aggregate rates of the other QI health plans, and the differences were statistically significant. Also, no providers were dissatisfied with the timeliness of claims payments from Kaiser QI.
- Kaiser QI's 2016 top-box rates for prior authorization process and formulary (32.4 percent and 56.3 percent, respectively) were both higher than the aggregate rates of the other QI health plans, and the differences were statistically significant. Also, no providers indicated that Kaiser QI's formulary negatively impacted their ability to provide quality care.
- Kaiser QI's 2016 top-box rate for adequate access to non-formulary drugs (72.9 percent) was higher than the aggregate rate of the other QI health plans, and the difference was statistically significant. Also, no providers were dissatisfied with the adequacy of Kaiser QI's access to non-formulary drugs.
- Kaiser QI's 2016 top-box rate for helpfulness of service coordinators (75.0 percent) was higher than the aggregate of the other QI health plans, and the difference was statistically significant. Also, no providers were dissatisfied with the adequacy of the help provided by Kaiser QI's service coordinators.
- Kaiser QI's 2016 top-box rates for adequacy of specialists and adequacy of behavioral health specialists (80.0 percent and 23.9 percent, respectively) were both higher than the aggregate rates of the other QI health plans, and the differences were statistically significant.
- 'Ohana QI's 2016 top-box rates for compensation satisfaction and timeliness of claims payments (12.6 percent and 24.0 percent, respectively) were both lower than the aggregate rates of the other QI health plans, and the differences were statistically significant.
- 'Ohana QI's 2016 top-box rate for formulary (6.1 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- 'Ohana QI's 2016 top-box rate for adequate access to non-formulary drugs (1.3 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- 'Ohana QI's 2016 top-box rate for helpfulness of service coordinators (9.2 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- 'Ohana QI's 2016 top-box rate for adequacy of specialists (5.0 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- UHC CP QI's 2016 top-box rates for compensation satisfaction and timeliness of claims payments (15.6 percent and 29.8 percent, respectively) were both lower than the aggregate rates of the other QI health plans, and the differences were statistically significant.
- UHC CP QI's 2016 top-box rate for formulary (8.4 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- UHC CP QI's 2016 top-box rate for adequate access to non-formulary drugs (1.3 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.

- UHC CP QI's 2016 top-box rate for helpfulness of service coordinators (10.3 percent) was lower than the aggregate rate of the other QI health plans, and the difference was statistically significant.
- UHC CP QI's 2016 top-box rates for adequacy of specialists and adequacy of behavioral health specialists (both 3.7 percent) were both lower than the aggregate rates of the other QI health plans, and the differences were statistically significant.

Recommendations

The Provider Survey revealed opportunities to improve provider satisfaction. Kaiser QI's rate was higher than the aggregate rate of the other plans on all domains, and the difference was statistically significant. Conversely, 'Ohana (WellCare) QI and UHC CP QI exhibited the most opportunity for improvement, with rates lower than the aggregate rate of the other plans on nearly all domains.

Based on these results, the following are general quality improvement recommendations that the plans and the MQD should consider to increase or maintain a high level of provider satisfaction.[1-12] The MQD and each plan should evaluate these general recommendations in the context of their own operational and quality improvement activities.

- HSAG recommends that the MQD evaluate 'Ohana (WellCare) QI's and UHC CP QI's performance on the various domains evaluated as part of the survey, based on the provider's feedback. The issues/concerns expressed by providers with these two plans may cause some providers to leave the Medicaid market, which would add to the provider shortage and provider access issue in the State of Hawaii.
- Providers consistently expressed concerns in getting adequate specialty care due to the immense lack of specialists. The process to refer patients to specialists was noted as especially difficult. The shortage of specialists on the island requires patients to travel to get care, but limitations related to availability and travel arrangements prevent many patients from being seen in a timely manner. Providers are becoming overwhelmed by the growing demand, while many members are being left with nowhere to go. HSAG recommends the MQD and the QI health plans collaborate on a solution to this issue, such as provider recruitment and retention, and focus on the patient-centered medical home (PCMH) model of care.
- Some providers indicated that the prior authorization process has a negative impact on their ability to provide quality care. QI health plans could work toward programming medical services and drugs that require prior authorization into their systems and workflows to automate the process (e.g., expand availability and interoperability of health information technology). The MQD can work with the QI health plans to support the simplification and standardization of the preauthorization forms and process.
- Providers' feedback indicated that opportunities still exist to ensure that QI health plans have adequate access to non-formulary drugs. QI health plans typically choose which drugs to include in

[1-12] Brodsky, Karen L. "Best Practices in Specialty Provider Recruitment and Retention: Challenges and Solutions." *HealthWorks Consulting, LLC*, 2005.

the formulary. The MQD should consider working with the QI health plans to establish standard policies and procedures to ensure adequate access to non-formulary drugs.

- Periodic provider focus groups could be implemented to gain further valuable information and insight into areas of poor performance as described in the survey feedback. Hearing about specific scenarios and examples of provider issues may help the QI health plans in understanding and targeting areas needing performance improvement. QI health plans could then use a performance improvement project approach to determine interventions and perform a targeted remeasurement of provider satisfaction at a later date.

Future Survey Administration Recommendations for the MQD

HSAG recommends continued administration of the provider survey every two years. This remeasurement would provide valuable trending information to the MQD, providers, the general public, as well as the QI health plans. Trending the data will allow QI health plans to determine which areas they have improved and which areas require direct improvement efforts. HSAG recommends that the MQD use the same survey instrument to allow for trending. HSAG also recommends that the MQD continue to oversample in order to increase the number of providers that participate in the survey.

HSAG recommends that the MQD continue to employ alternative approaches to increase provider participation in the survey. Increasing the overall number of respondents to the survey reduces the likelihood of nonresponse bias and increases the likelihood that the responses reflect those of all providers serving QI members. Some specific recommended strategies follow:

- Informing QI health plans and/or providers of a future survey can greatly increase the number of responses. A survey notification, in the form of a letter or an email, could be sent from the MQD prior to administering the survey to inform QI health plans and/or providers about the upcoming survey, estimated timeline for administration, and when and how the survey results will be made available. Additionally, to augment the cover letter included with the mailed survey, the MQD could stress the importance of provider participation in the reminder notice and encourage providers to complete the survey when it arrives. The MQD should continue its work with QI health plans and request that they send reminder notifications to providers or publish an announcement in provider newsletters, encouraging them to participate in the survey.
- HSAG recommends that the MQD collect email addresses for its QI providers to ensure this information is captured in the MQD's provider database system from which the provider survey sample is taken. Alternatively, the MQD could work with the QI health plans to obtain this email contact information.
- A web-based survey is an easy and convenient way for providers to respond to the survey. HSAG recommends that the MQD continue to use a mixed-mode approach (e.g., mail survey, email reminders, or web-based survey) to help yield higher response rates. An email with a direct link to the web-based survey and customized to include a provider's specific login promotes provider participation by allowing immediate and convenient access to the web-based survey. The potential for initial and follow-up distribution of the survey via provider email as opposed to only mailed paper copies would increase the likelihood of higher response rates by allowing ease of access to the web-based component of the survey.

State of Hawaii

Department of Human Services

Med-QUEST Division

2017 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

April 2018

HSAG HEALTH SERVICES ADVISORY GROUP

1. Executive Summary

Overview

The 2017 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) Health Plans and the Community Care Services (CCS) program is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR §438.364.[1-1] Health Services Advisory Group, Inc. (HSAG), is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), the single State agency responsible for the overall administration of Hawaii's Medicaid managed care program.

This report describes how data from activities conducted in accordance with 42 CFR §438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid recipients by the five QI health plans and the CCS program. The QI health plans were AlohaCare QUEST Integration Plan (AlohaCare QI), Hawaii Medical Service Association QUEST Integration Plan (HMSA QI), Kaiser Foundation Health Plan QUEST Integration Plan (KFHP QI), 'Ohana Health Plan QUEST Integration ('Ohana QI), and UnitedHealthcare Community Plan QUEST Integration (UHC CP QI). 'Ohana also has held the contract for the Community Care Services (CCS) program since March 2013. CCS is a carved-out behavioral health specialty services plan for individuals who have been determined by the MQD to have a serious mental illness.

Purpose of the Report

The Code of Federal Regulations requires that states use an EQRO to prepare an annual technical report that describes how data from activities conducted, in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that managed care organizations provide.

To comply with these requirements, the MQD contracted with HSAG to aggregate and analyze the health plans' performance data across mandatory and optional activities and prepare an annual technical report. HSAG used the Centers for Medicare & Medicaid Services' (CMS') November 9, 2012, update of its External Quality Review Toolkit for States when preparing this report.[1-2]

This report provides:

- An overview of the QI and CCS programs.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

[1-2] The Centers for Medicare & Medicaid Services. External Quality Review Toolkit, November 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-toolkit.pdf. Accessed on: Mar 1, 2018.

- A description of the scope of EQR activities performed by HSAG.
- An assessment of each health plan's strengths and weaknesses for providing healthcare timeliness, access, and quality across CMS-required mandatory activities for compliance with standards, performance measures, and performance improvement projects (PIPs). The report also includes an assessment of an optional consumer satisfaction child survey.
- Recommendations for the CMOs to improve member access to care, quality of care, and timeliness of care.

Scope of EQR Activities

This report includes HSAG's analysis of the following EQR activities.

- *Review of compliance with federal and state-specified operational standards.* HSAG evaluated the health plans' compliance with State and federal requirements for organizational and structural performance. The MQD contracts with the EQRO to conduct a review of one-half of the full set of standards in Year 1 and Year 2 to complete the cycle within a three-year period. HSAG conducted on-site compliance reviews in May and June 2017. The health plans submitted documentation that covered a review period of April 1, 2016, through March 31, 2017. HSAG provided detailed, final audit reports to the health plans and the MQD in September 2017.
- *Validation of performance improvement projects (PIPs).* HSAG validated PIPs for each health plan to ensure the health plans designed, conducted, and reported projects in a methodologically sound manner consistent with the CMS protocol for validating PIPs. Each health plan submitted two state-mandated PIPs for validation. All PIPs were based on the rapid-cycle PIP framework, which includes five modules that were submitted by the health plans for each PIP, reviewed by HSAG, and used to provide feedback from HSAG to the health plans throughout the 12-month PIP cycle. HSAG assessed all PIPs for real improvements in care and services to validate the reported improvements. In addition, HSAG assessed the health plans' PIP outcomes and impacts on improving care and services provided to members. The CMOs submitted Modules 4 and 5 for each PIP at varying times throughout calendar year (CY) 2017. HSAG provided final, CMO-specific PIP reports to the health plans and the MQD in September 2017. A new round of rapid-cycle PIPs began in 2017 focused on completion of Module 1 through Module 3; however, these results will not be ready until CY 2018.
- *Validation of performance measures (PMs).* HSAG validated the HEDIS and non-HEDIS state-defined measure rates required by the MQD to evaluate the accuracy of the results. HSAG assessed the PM results and their impact on improving the health outcomes of members. HSAG conducted validation of the PM rates following the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] Compliance Audit™ [1-4] timeline, typically from January 2017 through July 2017. The final PM validation results generally reflect the measurement period of January 1, 2016, through December 31, 2016. HSAG provided final audit reports to the health plans and the MQD in July 2017.

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-4] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys.[1-5] The MQD conducted the CAHPS surveys of the QI child and Children's Health Insurance Program (CHIP) populations to learn more about member satisfaction and experiences with care. The standardized survey instrument selected was the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with chronic conditions [CCC] measurement set). The parents and caretakers of child members enrolled in the QI and CHIP program completed the surveys from February to May 2017. HSAG aggregated and produced a final report in September 2017.

Overall Summary of Health Plan Performance

Compliance Monitoring Review

CY 2017 began the second year of a three-year cycle of compliance reviews for all the QI health plans and the CCS program that included two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs, using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the CFR for six areas of review, or standards.[1-6] A pre-on-site desk review, on-site review with interview sessions, system and process demonstrations, and record reviews were conducted.

The second compliance review activity in 2017 involved HSAG's and the MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to its 2016 compliance review, which were all addressed by the end of 2016 or early 2017.

Findings, Conclusions, and Recommendations

Table 1-1 summarizes the results from the 2017 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the six compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-6] CY 2017 standards included the following: *Provider Selection, Subcontracts and Delegation, Credentialing, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines.*

Table 1-1—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I Provider Selection	100%	100%	100%	100%	100%	100%	**100%**
II Subcontracts and Delegation	94%	100%	56%	100%	100%	100%	**92%**
III Credentialing	94%	95%	88%	93%	91%	94%	**93%**
IV Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	94%	**99%**
V Health Information Systems	100%	100%	100%	100%	100%	100%	**100%**
VI Practice Guidelines	100%	100%	100%	100%	100%	100%	**100%**
Totals	**96%**	**97%**	**88%**	**96%**	**95%**	**96%**	**95%**

***Total Compliance Score*:** The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. Three of the standards were found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—i.e., *Provider Selection*, *Health Information Systems*, and *Practice Guidelines*. The *Subcontracts and Delegation* and *Credentialing* standards were identified as having the greatest opportunity for improvement with statewide compliance scores of 92 percent and 93 percent, respectively. However, while the *Subcontracts and Delegation* standard exhibited the lowest overall performance (i.e., 92 percent), this statewide compliance score was largely driven by KFHP QI's low score (i.e., 56 percent). Conversely, lower performance on the *Credentialing* standard was consistent across all health plans, with individual health plan scores ranging from 88 percent (i.e., KFHP QI) to 95 percent (HMSA QI).

Individual health plan performance revealed the following:

- AlohaCare QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - AlohaCare QI had a total compliance score of 96 percent with four of the standards scoring 100 percent: *Provider Selection*, *Quality Assessment and Performance Improvement*, *Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.
  - AlohaCare QI was required to develop a corrective action plan (CAP) to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.
- HMSA QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - HMSA QI had a total compliance score of 97 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance*

Improvement, Health Information Systems, and *Practice Guidelines.* None of the standards or elements were noncompliant.
  - HMSA QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor HMSA's QI CAP activities until the health plan is found to be in full compliance.
- KFHP QI's performance across all standards was moderate, meeting or exceeding the statewide compliance score for four of the six standards.
  - KFHP QI had the lowest performance with a total compliance score of 88 percent and four of the standards scoring 100 percent: *Provider Selection, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines.* Three elements across the *Subcontracts and Delegation* and *Credentialing* standards were noncompliant.
  - KFHP QI's total compliance score was driven by low compliance noted in the *Subcontracts and Delegation* (56 percent) and *Credentialing* (88 percent) standards.
  - KFHP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor KFHP's QI CAP activities until the health plan is found to be in full compliance.
- 'Ohana QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - 'Ohana QI had a total compliance score of 96 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines*. None of the standards or elements were noncompliant.
  - 'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana QI's CAP activities until the health plan is found to be in full compliance.
- UHC CP QI's performance across all standards was moderate, meeting or exceeding the statewide compliance score for all standards except *Credentialing*.
  - UHC CP QI had a total compliance score of 95 percent with five of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Quality Assessment and Performance Improvement, Health Information Systems,* and *Practice Guidelines.* None of the standards or elements were noncompliant.
  - UHC CP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor UHC CP's CAP activities until the health plan is found to be in full compliance.
- 'Ohana CCS' performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards except *Quality Assessment and Performance Improvement*.
  - 'Ohana CCS had a total compliance score of 96 percent with four of the standards scoring 100 percent: *Provider Selection, Subcontracts and Delegation, Health Information Systems,* and *Practice Guidelines.* None of the standards or elements were noncompliant.

- 'Ohana CCS was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and the MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

With the completion of these reviews, the health plans and CCS have demonstrated their structural and operational compliance and ability to provide quality, timely, and accessible services.

The QI health plans' and CCS' CAP implementation resulting from HSAG's 2016 compliance review was also monitored by HSAG and the MQD in CY 2017. All health plans successfully closed out their CAPs by February 2017, with most interventions focusing on policies, procedures, and forms. Deficiencies from the CY 2017 reviews are currently under CAPs and continue to be monitored by HSAG and the MQD.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG performed independent audits of the performance measure results calculated by the QI health plans and CCS program according to the *2016 NCQA HEDIS Compliance Audit Standards, Policies, and Procedures, HEDIS Volume 5.* The audit procedures were also consistent with the CMS protocol for performance measure validation: *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[1-7] The health plans that contracted with the MQD during the current measurement year for QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit incorporated a detailed assessment of the health plans' information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information, including a review of the specific reporting methods used for the HEDIS measures. HSAG also conducted an NCQA HEDIS Compliance Audit to evaluate the CCS program's IS capabilities in reporting on a set of HEDIS and non-HEDIS measures relevant to behavioral health. The measurement period was CY 2016 (January 1, 2016, through December 31, 2016), and the audit activities were conducted concurrently with HEDIS 2017 reporting.

During the HEDIS audits, HSAG reviewed the performance of the health plans on state-selected HEDIS or non-HEDIS performance measures. The health plans were required to report on 33 measures, yielding a total of 96 measure indicators, for the QI population. 'Ohana CCS was required to report on 10 measures, yielding a total of 27 measure indicators, for the CCS program. The measures were organized into categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services. These domains included:

- Access to Care
- Children's Preventive Care
- Women's Health

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Apr 17, 2018.

- Care for Chronic Conditions
- Behavioral Health
- Utilization and Health Plan Descriptive Information

Findings, Conclusions, and Recommendations

NCQA HEDIS Compliance Audit

HSAG evaluated each QI health plan's compliance with NCQA information system (IS) standards during the 2017 NCQA HEDIS Compliance Audit. All QI health plans were *Fully Compliant* with the IS standards applicable to the measures under the scope of the audit except for AlohaCare QI (IS 5.0 = *Partially Compliant*). Overall, the health plans followed the NCQA HEDIS 2016 specifications to calculate their rates for the required HEDIS measures. All measures received the audit designation of *Reportable* except for two measures reported by UHC CP QI, which received a *Biased Rate* designation for the *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence* measures.

Performance Measure Results

HSAG analyzed the performance measure results for each health plan, and where applicable, HSAG compared the results to the NCQA national Medicaid HEDIS 2016 means and percentiles. For the inverse measure indicators, where a lower rate indicates better performance (i.e., *Comprehensive Diabetes Care—HbA1c Poor Control [>9.0%], Well-Child Visits in the First 15 Months of Life—0 Visits, Plan All-Cause Readmissions, Frequency of Prenatal Care—<21 Percent,* and *Ambulatory Care—ED Visits/1,000),* HSAG reversed the order of the national percentiles for performance level evaluation to be consistently applied.[1-8]

In the following figures, "N" indicates, by health plan, the total number of indicators in the QI and CCS performance measures that were compared to the HEDIS 2016 national Medicaid percentiles. Rates representing a population too small for reporting purposes (i.e., "*Not Applicable*," or *NA*) or for which comparisons to national percentiles were not appropriate, were not included in the following summary results.

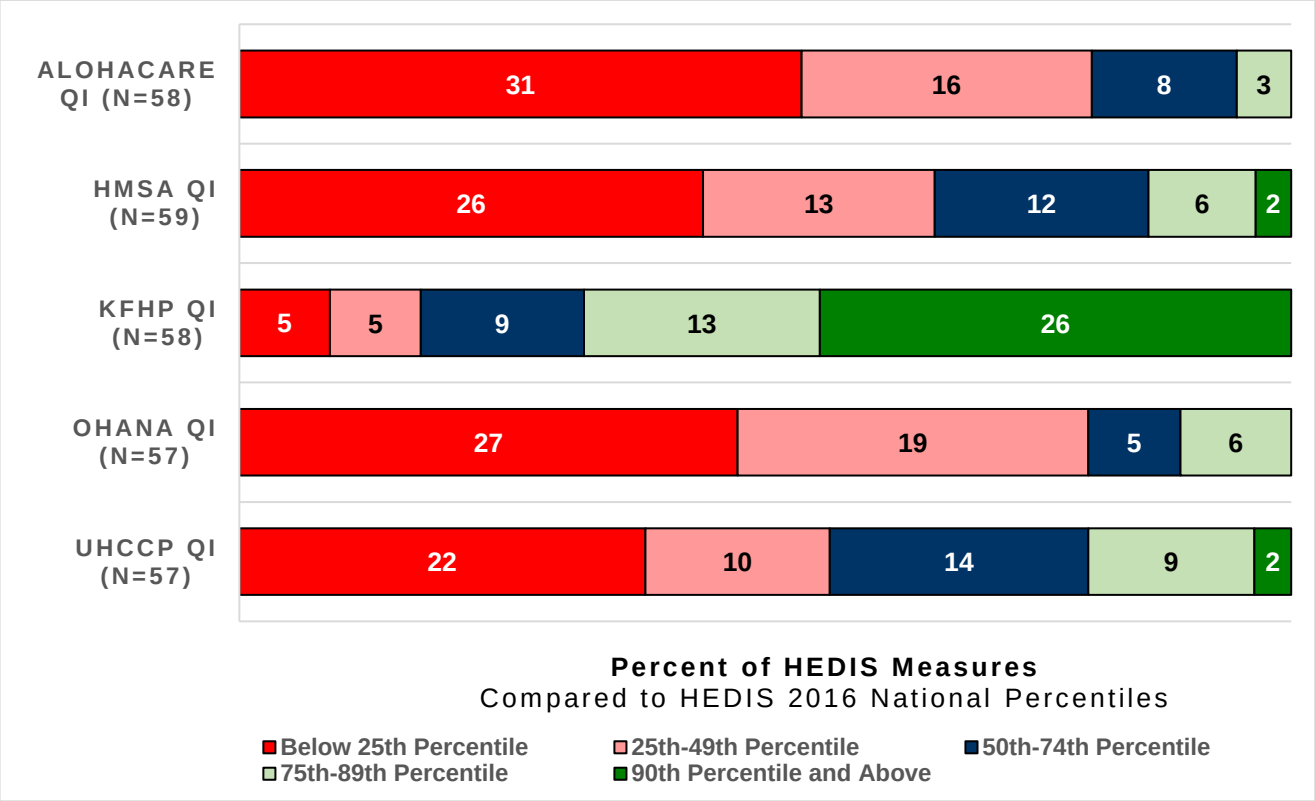
For QI health plans, HSAG validated 33 HEDIS 2017 performance measures, resulting in a total of 96 separate indicator rates reported across all audited measures, of which 60 indicators were compared to national Medicaid HEDIS 2016 percentiles.[1-9] None of the plans reported all 60 indicators. AlohaCare QI had two indicators, HMSA QI had one indicator, KFHP QI had two indicators, 'Ohana QI had three indicators, and UHC CP QI had five indicators with denominator(s) less than 30 for which valid rates could not be reported. For those indicators, the plans received an audit result of *NA* (small denominator).

[1-8] For example, because the value associated with the national 10th percentile reflects better performance, HSAG reversed the percentile to the measure's 90th percentile. Similarly, the value associated with the 25th percentile was reversed to the 75th percentile.

[1-9] Star ratings are not reported if benchmarks are not available, or for measures of utilization where benchmark comparisons are not appropriate. For these reasons, some measure results are presented for informational purposes only and are not compared to national percentiles.

Figure 1-1 shows the plans' performance on those measure indicators that could be compared to the national percentiles.

Figure 1-1—Comparison of QI Measure Indicators to HEDIS Medicaid National Percentiles



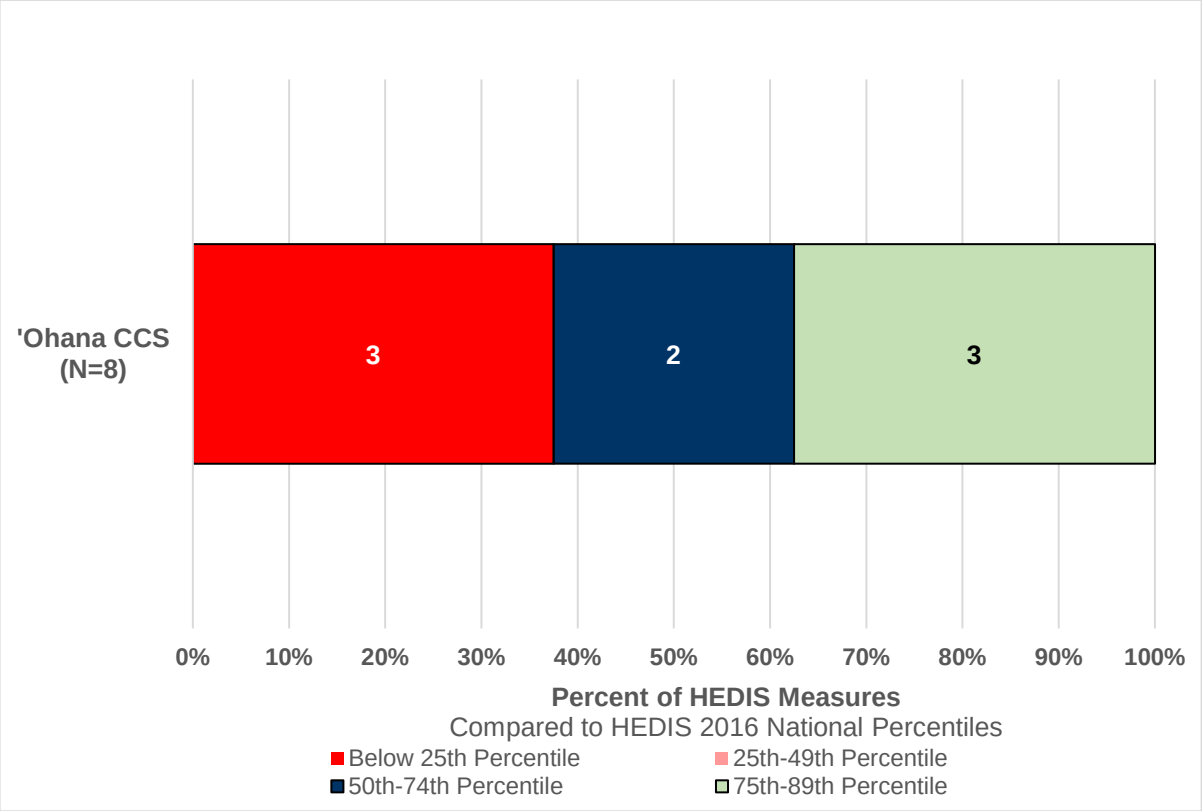
As presented in Figure 1-1, the plans were diverse in their performance. KFHP QI, the best-performing plan for HEDIS 2017, reported 26 of 58 indicators (45 percent) at or above the HEDIS 2016 national Medicaid 90th percentile, along with 13 indicators (22 percent) at or above the national 75th percentile but below the 90th percentile. UHC CP QI performed moderately with just under half of the measure rates reporting at or above the 50th percentile (i.e., 25 of 57 indicators), and about one-fifth of the measure rates reporting at or above the 75th percentile (i.e., 11 of 57 indicators). UHC CP QI and HMSA QI each had two measure rates that met or exceeded the 90th percentile. AlohaCare QI, HMSA QI, and 'Ohana QI were the lowest-performing plans compared to the national percentiles, each with more than two-thirds of their measure rates below the national 50th percentile (i.e., 47 of 58 indicators, 39 of 59 indicators, and 46 of 57 indicators, respectively). Moreover, 31 of AlohaCare QI's measure rates (53 percent), 26 of HMSA QI's measure rates (44 percent) and 27 of 'Ohana QI's measure rates (47 percent) were below the 25th percentile, indicating considerable room for improvement. Neither AlohaCare QI or 'Ohana QI had rates that met or exceeded the 90th percentile.

Additionally, all five health plans had reportable rates for 16 measures with MQD Quality Strategy targets. KFHP QI met or exceeded 12 (75 percent) of the MQD Quality Strategy targets, followed by UHC CP QI, which met or exceeded the MQD Quality Strategy targets for seven measure rates (44

percent). HMSA QI and ‘Ohana QI met or exceeded three and two of the MQD Quality Strategy targets, respectively. AlohaCare QI did not meet any of the targets. These results, in combination with overall HEDIS measure rates, suggest considerable room for improvement for AlohaCare QI, HMSA QI, and ‘Ohana QI.

Figure 1-2 shows the CCS’ performance on those measure indicators that could be compared to the national percentiles. CCS had two measures with denominators less than 30 for which valid rates could not be reported.

Figure 1-2—Comparison of CCS Measure Indicators to HEDIS Medicaid National Percentiles



As presented in Figure 1-2, ‘Ohana CCS’ program performance was strong, with five of the eight measure rates ranking at or above the 50th percentile (63 percent). The remaining three indicators fell below the 25th percentile. There is one measure in this domain with an MQD Quality Strategy target for HEDIS 2017 (i.e., *Follow-Up After Hospitalization for Mental Illness)*, and ‘Ohana CCS met or exceeded the established target, the 75th percentile.

Recommendations for improvement are presented in the plan-specific results sections of this report. In general, HSAG recommends that each plan target the lower-scoring measures/indicators for improvement. Each plan should conduct a barrier analysis to determine why plan performance was low, coupled with data analysis and drill-down evaluations of noncompliant cases.

Performance Improvement Projects

PIPs are designed as an organized way to assist health plans in assessing their healthcare processes, implementing process improvements, and improving outcomes of care. In 2016, HSAG validated two PIPs for each of the QI and CCS health plans, for a total of 12 PIPs. The five QUEST Integration plans were required by the MQD to conduct *All-Cause Readmissions* and *Diabetes Care* PIPS. The *All-Cause Readmissions* PIP topic is a key focus of the MQD's Quality Strategy. 'Ohana CCS conducted two PIPs: *Follow-up After Hospitalization for Mental Illness* and *Initiation of Alcohol and Substance Abuse Treatment*.

The goal of HSAG's PIP validation is to ensure that the health plan and key stakeholders can have confidence that any reported improvement is related and can be linked to the quality improvement strategies and activities conducted during the life of the PIP. In 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement. To illustrate how the rapid-cycle PIP framework continued to meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[1-10] HSAG presented the crosswalk and new PIP framework components to CMS, and CMS agreed that with the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern PIPs within healthcare settings, a new approach was reasonable, approving HSAG's rapid-cycle PIP framework for validation of PIPs for the State of Hawaii.

For this new PIP framework, HSAG developed five modules, each with a companion guide. Each module includes validation criteria necessary for successful completion of a valid PIP. Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

- *High confidence* = the PIP was methodologically sound, achieved meaningful improvement for the SMART (specific, measurable, achievable, relevant, and time-bound) Aim measure, and the demonstrated improvement was clearly linked to the quality improvement processes conducted.
- *Confidence* = the PIP was methodologically sound; achieved meaningful improvement for the SMART Aim measure; and some of the quality improvement processes were clearly linked to the demonstrated improvement, but there was not a clear link between all quality improvement processes and the demonstrated improvement.

[1-10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Mar 1, 2018.

- *Low confidence* = (1) the PIP was methodologically sound, but improvement was not achieved for the SMART Aim measure; or (2) improvement was achieved for the SMART Aim measure, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Findings, Conclusions, and Recommendations

Health plan performance on the two PIPs continued to demonstrate the continued need for improvement around the application and documentation of the rapid-cycle PIP process, especially in intervention testing through PDSA cycles. Well-planned, appropriately executed, and clearly documented PDSA cycles are necessary to achieve a *High Confidence* level in a PIP and drive sustainable improvement.

Overall, the five QI health plans achieved the SMART Aim goal for all PIPs, except for AlohaCare QI on its *All-Cause Readmissions* PIP, which failed to meet the SMART Aim goal. These findings demonstrate that, in general, the health plans defined attainable goals as part of the rapid-cycle PIP process, and the goals were achieved during the life of the PIP.

However, while the health plans were successful in achieving the outcomes defined by the SMART Aim goals, they had considerable difficulty achieving a *High Confidence* level for most PIPs. AlohaCare QI was the only health plan that received a level of *High Confidence* for any PIPs. KFHP QI and UHC CP QI each achieved a moderate *Confidence* level for their *All-Cause Readmissions* and *Diabetes Care* PIPs, respectively, while the remaining PIPs all received an assignment of *Low Confidence* due to the inability to clearly link the interventions tested to the outcomes.

Similarly, 'Ohana CCS achieved the SMART Aim goal for both of its PIPs, demonstrating that the health plan defined attainable goals as part of its rapid-cycle PIP process and that the goals were achieved during the life of the PIP. However, both PIPs received an assessment of *Low Confidence* due to the inability to clearly link the interventions tested to the outcomes.

The health plans' performance regarding PIPs suggested opportunities for improvement in many areas of the rapid-cycle PIP process, such as ensuring a sound measurement methodology for the PIP outcomes; maintaining the integrity of approved measurement methodology throughout the PIP process; identifying the true root causes of barriers to improvement; and planning and executing effective PDSA cycles to test and refine interventions that will result in meaningful, sustained, and spreadable improvement strategies. Many of these opportunities for improvement applied consistently across all health plans and topics. Specific recommendations related to improving PIP performance are detailed in the plan-specific results sections of this report. In general, HSAG recommends that the health plans seek technical assistance as needed to further develop their capacity to apply sound improvement science in the rapid-cycle PIP process.

CAHPS—Child Survey

The CAHPS health plan surveys are standardized survey instruments which measure members' satisfaction levels with their healthcare. For 2017, HSAG administered the Child Medicaid Health Plan

Survey instrument (without the CCC measurement set) to child Medicaid and CHIP members of the QI health plans who met age and enrollment criteria. All members of sampled child Medicaid and CHIP members completed the surveys from February to May 2017 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.[1-11] Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan and/or state-level CAHPS data.

For each survey, the results of 11 measures of satisfaction were reported. These measures included four global ratings (*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*) and five composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*). In addition, two individual items were assessed (*Coordination of Care* and *Health Promotion and Education*).

Findings, Conclusions, and Recommendations

Table 1-2 presents the question summary rates and global proportions for the QI Program aggregate compared to the 2017 NCQA national child Medicaid average, as well as the results from HSAG's comparison to NCQA's HEDIS benchmarks.[1-12, 1-13]

Table 1-2—2017 QUEST Integration Child CAHPS Results

	QI Program Aggregate	NCQA Comparison
Global Ratings		
Rating of Health Plan	69.1%	★★★
Rating of All Health Care	65.0%	★★★★
Rating of Personal Doctor	74.1%	★★★★
Rating of Specialist Seen Most Often	72.9%	★★★★★
Composite Measures		
Getting Needed Care	82.8%	★★
Getting Care Quickly	86.4%	★
How Well Doctors Communicate	94.4%	★★★★
Customer Service	86.9%	★
Shared Decision Making	82.7%	—

[1-11] Please note that administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.0H Child Medicaid Health Plan Survey is made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.

[1-12] The QI Program aggregate results were derived from the combined results of the five participating QI health plans.

[1-13] National Committee for Quality Assurance. *HEDIS Benchmarks and Thresholds for Accreditation 2017*. Washington, DC: NCQA, May 4, 2017.

	QI Program Aggregate	NCQA Comparison
Individual Item Measures		
Coordination of Care	83.8%	★★
Health Promotion and Education	75.8%	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.
(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.
Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th
★★ 25th–49th ★ Below 25th

Comparison of the QI Program aggregate, AlohaCare QI, HMSA QI, KFHP QI, ‘Ohana QI, and UHC CP QI scores to the 2016 NCQA national child Medicaid average revealed the following:

- The QI Program aggregate scores were at or above the NCQA national child Medicaid average on six measures: *Rating of Health Plan, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.
- AlohaCare QI scored at or above the NCQA national child Medicaid average on three measures: *Customer Service, Shared Decision Making,* and *Health Promotion and Education.*
- HMSA QI scored at or above the NCQA national child Medicaid average on nine measures: *Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.
- KFHP QI scored at or above the NCQA national child Medicaid average on 11 measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.
- ‘Ohana QI scored at or above the NCQA national child Medicaid average on three measures: *Rating of Specialist Seen Most Often, Shared Decision Making,* and *Health Promotion and Education*.
- UHC CP QI scored at or above the NCQA national child Medicaid average on five measures: *Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making, Coordination of Care,* and *Health Promotion and Education*.

Comparison of the QI Program aggregate to the 2017 NCQA HEDIS benchmarks for accreditation revealed the following:

- The QI Program scored at or above the 75th percentile on four measures, with one of these measures scoring at or above the 90th percentile: *Rating of All Health Care, Rating of Personal Doctor, How Well Doctors Communicate,* and *Rating of Specialist Seen Most Often,* respectively. Four measures scored below the 50th percentile, two of which scored below the 25th percentile: *Getting Needed Care, Coordination of Care, Getting Care Quickly, and Customer Service,* respectively. Of the three MQD Quality Strategy targets, only the QI Program’s member satisfaction rating met or exceeded the 75th percentile for *How Well Doctors Communicate*.

As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparative purposes. Table 1-3 presents the question summary rates and global proportions for the Hawaii CHIP population.

Table 1-3—Comparison of 2017 CHIP CAHPS Results

	CHIP Aggregate Ratings	NCQA Comparison
Global Ratings		
Rating of Health Plan	72.2%	★★★★★
Rating of All Health Care	69.1%	★★★★★
Rating of Personal Doctor	73.8%	★★★★★
Rating of Specialist Seen Most Often	72.1%	★★★★★
Composite Measures		
Getting Needed Care	82.3%	★
Getting Care Quickly	87.1%	★★
How Well Doctors Communicate	95.5%	★★★★★
Customer Service	85.2%	★
Shared Decision Making	80.3%	—
Individual Item Measures		
Coordination of Care	82.5%	★
Health Promotion and Education	79.7%	—

Cells highlighted in yellow represent rates and proportions that are equal to or greater than the 2016 NCQA national child Medicaid average.
(—) indicates that NCQA does not publish national benchmarks and thresholds for these CAHPS measures; therefore, overall member satisfaction ratings could not be derived.

Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th
★★ 25th–49th ★ Below 25th

Comparison of the CHIP scores to the 2016 NCQA national child Medicaid average revealed the following:

- Hawaii's CHIP scored at or above the NCQA national child Medicaid average on six measures: *Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, How Well Doctors Communicate, Shared Decision Making,* and *Health Promotion and Education*.

Comparison of the CHIP scores to the 2017 NCQA national child Medicaid average revealed the following:

- The Hawaii CHIP population scored at or above the 90th percentile on five measures: *Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often,* and *How Well Doctors Communicate*. The four remaining ratings fell below the 50th percentile, with three of these measures scoring below the 25th percentile: *Getting Care Quickly,*

Getting Needed Care, *Coordination of Care*, and *Coordination of Care*, respectively. Of the three MQD Quality Strategy targets, the Hawaii CHIP population's member satisfaction rating met or exceeded the 75th percentile on two measures: *Rating of All Health Care* and *How Well Doctors Communicate*.

Attachment B

Hawai‘i QUEST Integration
§1115 Waiver Interim Evaluation

State of Hawai‘i, Department of Human Services,

Med-QUEST Division

July 27, 2018

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Introduction

The State of Hawai‘i implemented QUEST on August 1, 1994. QUEST was a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery system. QUEST stands for:

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

The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditure. The State combined its Medicaid program with its then General Medical Assistance Program and its State Children's Health Insurance Program. Low-income women, children, and adults who had been covered by the two programs were enrolled into fully capitated managed care plans throughout the State. This program virtually closed the coverage gap in the State.

Since its implementation, CMS has renewed the demonstration five times. Over the years, the State has made significant changes to the demonstration, including several eligibility expansions and a renewal in 2007 that authorized managed long-term services and supports.

The current section 1115 demonstration for the State of Hawai‘i is entitled "QUEST Integration" (Project Number 11-W-00001/9). The QUEST Integration demonstration began in October 2013 and is effective through December 2018. This evaluation covers the CY2014 to CY2016 time period, which falls under the waiver extension period. Some metrics in the evaluation use data from CY2017 and CY2018 for illustrative purposes.

The demonstration integrated the demonstration's eligibility groups and benefits within the context of the Affordable Care Act and accomplished several programmatic changes, including:

- Streamlining eligibility pathways by transitioning low-income childless adults and former foster care children from demonstration expansion populations to state plan populations, adding former adoptive and kinship guardianship children as demonstration expansion populations, and decreasing retroactive eligibility period to 10 days for non-long-term services and supports population;
- Consolidating QUEST, QUEST-Net, QUEST-ACE, and QExA into a single QUEST Integration program;
- Removing QUEST-ACE enrollment-related benchmarks from the uncompensated care cost (UCC) pool, evaluating UCC costs, and winding down federal financial participation for UCC pool payments in June 2016; and
- Providing additional benefits like certain specialized behavioral health services, cognitive rehabilitation, and habilitation.

QUEST Integration has five (5) health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, ‘Ohana Health Plan, and UnitedHealthcare Community Plan

Evaluation Questions and Hypotheses

The goals of the QUEST Integration renewal demonstration were laid out in the Special Terms & Conditions and were as follows:

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

The goals of the demonstration were grouped into three broad areas for measurement to serve the purpose of "evaluation hypotheses." The first area was centered on access to care and beneficiary engagement. The area specifically addressed the following goals:

- Align the demonstration with Affordable Care Act;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system; and
- Expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS.

The second area was centered on improving health, ensuring high-quality care, and managing costs. It specifically addressed how the QUEST Integration's managed care program and the focus on pay-for-performance and alternative payment methodologies could address the following goals of the demonstration:

- Improve the health care status of the member population;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP); and
- Continue the predictable and slower rate of expenditure growth associated with managed care.

The third area was centered on health plan and provider accountability and addressed the following goals:

- Maintain a managed care delivery system that assures access to high- quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations; and
- Establish contractual accountability among the contracted health plans and health care providers.

Methodology

MQD has devised a number of different measurement strategies for the evaluation. Several measurement strategies used measures developed by the National Committee for Quality Assurance (NCQA). The source for data contained in this publication is Quality Compass® 2015, 2016, and 2017 and is used with the permission of NCQA. Quality Compass 2015, 2016, and 2017 includes certain Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Access to Care and the Beneficiary Experience Methods and Limitations

For the first area, MQD presented a qualitative narrative and analysis on activities to demonstrate how the program aligned with the Affordable Care Act; CAHPS survey results to measure access to care and beneficiary engagement, and enrollment and encounter data to measure utilization for institutional services, HCBS, and at-risk population services.

The CAHPS measures are based on annual surveys conducted by the External Quality Review Organization (EQRO) entity under contract with, and under the direction of, MQD. The method of these surveys and the definitions of the various CAHPS measures strictly adhere to required national standard CAHPS specifications. The surveys were sent to a random sample of recipients. The overall survey response rate was 39.9 percent in 2014, 19.6 percent in 2015, 31.6 percent in 2016, and 23.5 percent in 2017. A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. Because the populations surveyed are different between the Adult and Child surveys, these surveys are analyzed separately as the data allows.

Improving Health, Ensuring High-Quality Care, and Managing Costs Methods and Limitations

For the second area, Healthcare Effectiveness Data & Information Set (HEDIS) measures are included in this report to measure improvement in the health care status of QUEST Integration (QI) beneficiaries and improvement in care coordination. Specifically, HEDIS measures from the 2018 CMS Adult and Child Core Sets were picked, as well as the measures MQD used for its P4P Program.

The HEDIS measures mostly involve ratios of a target behavior over the entire population that is eligible for that behavior. Occasionally ratios are reported on a sample of the population instead of the entire population, but on these occasions, there are intensive internal claim audits applied to a sample of the claims. The HEDIS measures are based on self-reported HEDIS reports received from the five individual QUEST plans.

HEDIS reports from the plans are based on a calendar year period, a twelve- month period beginning in January 1 and ending on December 31 of the report year, and are due to MQD on approximately June 30 of the following year. These are weight-averaged to create composite HEDIS measures for the entire

Med-QUEST population for a single year. The plans are required to report on most of the HEDIS measures in each year. The definitions of the various HEDIS measures reported by the plans are no different from the national standard HEDIS definitions – we do not have any HEDIS-like measures. All five plans are concurrently audited by the EQRO vendor.

Annual audits on how the plans calculate and report their HEDIS scores are conducted by the HEDIS-certified EQRO entity under contract with, and under the direction of, Med-QUEST. Typically, these audits involve a sample of three to six HEDIS measures.

A longitudinal analysis is completed on the statewide QUEST rates to determine if there are broad trends in the measure over a period of several years. For most measures scores are reported for each year from HEDIS year 2015 to 2017 (CY2014 to CY2016). A comparison is made to the corresponding year's National Medicaid Average Rate and the Median 75th Percentile score to bring perspective to where MQD scores on a national level.

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

Provider and Health Plan Accountability Methods and Limitations

For the third area, MQD measured provider and health plan accountability by reviewing qualitative data it gained from providers.

In calendar year (CY) 2016, MQD required the administration of surveys to health care providers who serve QI members through one or more QI health plan. MQD and a vendor developed a survey instrument designed to acquire meaningful provider information and gain providers' insight as it relates to the QI health plans' performance and potential areas of performance improvement. A total of 1,500 providers were sampled for inclusion in the survey administration: 200 Kaiser providers and 1,300 non-Kaiser providers (i.e., AlohaCare QI, HMSA QI, 'Ohana (WellCare) QI, and/or UHC CP QI providers). Providers completed the surveys from August to October 2016.

The State was interested in surveying Federally Qualified Health Center (FQHC) providers and increasing responses from primary care physicians (PCPs). Therefore, for non-Kaiser plans, all FQHC providers were surveyed, with the remaining sample size consisting of PCPs and non-PCPs. Since there were no FQHC providers for Kaiser, the sampling consisted of PCPs and non-PCPs. FQHC providers made up 17 percent of the sample size for the non-Kaiser plans.

The response rate is the total number of completed surveys divided by all eligible providers within the sample. Eligible providers included the entire sample minus ineligible surveys, which included any providers that could not be surveyed due to incorrect or incomplete mailing address information or had no current contracts with any of the QI health plans. A total of 267 Hawai`i providers completed the survey, including 50 providers from the Kaiser sample and 217 providers from the non-Kaiser sample.

The response rate for the non-Kaiser sample was considerably lower than the Kaiser sample (18.0 percent and 28.2 percent, respectively). The low response rates increased potential for non-response bias and likelihood that provider responses are not reflective of all providers serving QI members.

Results

Strengthening Access to Care and Beneficiary Engagement

Activities to Align with the Affordable Care Act

MQD started determining eligibility for Medicaid individuals using new Modified Adjusted Gross Income (MAGI) criteria on October 1, 2013. In addition, MQD fine-tuned its work within its eligibility system called Kauhale (community) On-Line Eligibility Assistance System (KOLEA). MQD encouraged applicants to apply on-line at its mybenefits.hawaii.gov website.

MQD implemented other Affordable Care Act (ACA) requirements in October 1, 2013. This included the FQHCs becoming navigators with the Hawai‘i Health Connector, the state’s original state-based exchange. Hawai‘i became a state-based exchange using the federal platform for the individual market in 2015, and switched to a fully-federally-run exchange in 2017. FQHCs were able to submit applications for Hawai‘i Medicaid through the KOLEA system as well.

In addition to encouraging applicants to apply through the KOLEA system, MQD established a new branch in December 2015. The Health Care Outreach Branch (HCOB) was created in response to a demonstrated community need for additional application assistance for some of the hardest to reach populations. The program focused its outreach and enrollment assistance efforts on those individuals and families who experience significant barriers to health care access due to various social determinants of health such as homelessness, lack of transportation, language/cultural barriers and justice-involved populations. Due to the multiple challenges faced by these individuals/families, they were traditionally less likely to proactively enroll themselves in health insurance. Having an outreach team in the field that met people where they congregate and offered on-the spot application assistance was helpful in serving this high-risk population.

Beneficiary Engagement

MQD had a varied experience with Child CAHPS measures from CY2015 to CY2017 as described in the table below. The QI program showed improvement on all composite measures, but showed a drop in three out of the four global ratings and both individual item measures.

Table 1: Child CAHPS

Child CAHPS		
Global Ratings	CY2015	CY2017
Rating of Health Plan	68.7%	69.1%
Rating of All Health Care	65.5%	65.0%
Rating of Personal Doctor	76.0%	74.1%
Rating of Specialist Seen Most Often	72.5%	72.9%

Composite Measures		
Rating of Health Plan	80.3%	82.8%
Rating of All Health Care	85.8%	86.4%
Rating of Personal Doctor	93.9%	94.4%
Rating of Specialist Seen Most Often	83.1%	86.9%
Shared Decision Making	82.4%	82.7%
Individual Item Measures		
Coordination of Care	86.6%	83.8%
Health Promotion and Education	77.1%	75.8%

From CY2014 to CY 2016, MQD showed improvement in all adult CAHPS composite and individual item measures, and all the global ratings except for the rating of personal doctor. Of particular note, the QI program showed over a 30 percentage point increase on the Shared Decision Making composite measure.

Table 2: Adult CAHPS

Adult CAHPS		
Global Ratings	CY2014	CY2016
Rating of Health Plan	56.2%	59.2%
Rating of All Health Care	52.7%	56.8%
Rating of Personal Doctor	65.1%	64.9%
Rating of Specialist Seen Most Often	61.3%	68.3%
Composite Measures		
Rating of Health Plan	75.8%	82.2%
Rating of All Health Care	76.5%	80.3%
Rating of Personal Doctor	90.3%	91.7%
Rating of Specialist Seen Most Often	82.6%	86.1%
Shared Decision Making	50.9%	81.6%
Individual Item Measures		
Coordination of Care	81.1%	84.4%
Health Promotion and Education	72.9%	76.0%

The At-Risk Expansion

One of the goals of the demonstration was to expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS. MQD sought to accomplish this by opening up HCBS to individuals at-risk of deteriorating to institutional level of care.

Coverage was intended to prevent a decline in health status and maintain individuals safely in their homes and communities. During the current demonstration, the at-risk population had access to a set of HCBS that included personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS) and skilled nursing.

For the at-risk population, Hawai‘i has seen some positive results in the numbers of individuals that receive care in a nursing home in relation to those that receive HCBS. The number of individuals

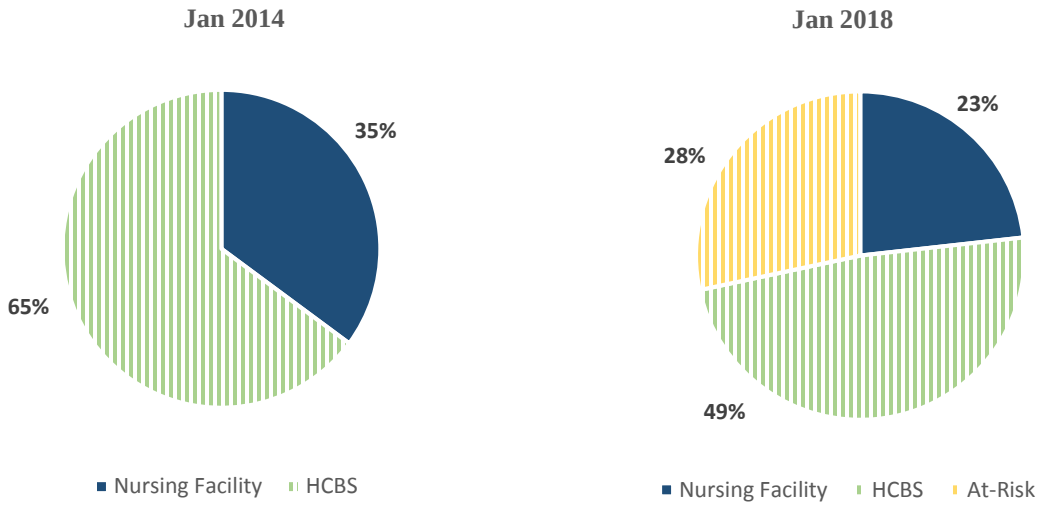
receiving care in a nursing home decreased 17.6 percent between January 2014 and January 2018. The number of individuals meeting an institutional level of care receiving HCBS also decreased 7 percent. These shifts happened at the same time as more beneficiaries received at-risk services.

While the term of this evaluation is CY2014 through CY2016, enrollment data up to January 2018 has been included in this table to show enrollment trends over time.

Table 3: Nursing Facility, HCBS, and At-Risk Service Enrollment over Time

	January 2014	July 2014	January 2015	July 2015	January 2016	July 2016	January 2017	July 2017	January 2018
Nursing Facility	2,584	2,605	2,479	2,442	1,917	2,148	2,356	2,250	2,129
HCBS	4,770	4,765	4,556	4,829	4,062	4,846	4,194	4,493	4,434
At-Risk					1,403	1,587	2,379	2,530	2,599

Figure 1: Proportion of Individuals Receiving LTSS in NF and HCBS Settings - Jan 2014-Jan 2018



It should be noted that beneficiaries in Hawai‘i must meet a relatively high standard in order to receive HCBS or nursing facility services through a nursing facility level-of-care assessment. If the at-risk population were to be removed from the analysis, MQD still reduced the percentage of those receiving LTSS in a nursing facility from 35.1 percent to 32.4 percent from January 2014 to January 2018.

Improving Health, Ensuring High-Quality Care, and Managing Costs

The rationale for the implementation of managed care is improved access, quality, and cost-efficiency. Under this theory, using managed care systems improves the care delivered to Medicaid beneficiaries by improving coordination of care, consistent application of managed care principles, strong quality assurance programs, partnership with providers, emphasis on the medical home, and achieving cost-effective service delivery.

The HEDIS measures below show how the QI program performed in both improving health outcomes and its performance in aspects of providing a medical home – namely, the use of primary and preventive care, chronic care management, and behavioral health. Three rates are depicted graphically – the statewide aggregate rate for the QI program, the average Medicaid rate, and the 75th Medicaid percentile, which is typically MQD's quality target. The average Medicaid rate is depicted to give greater context to MQD's performance, specifically to show how far the statewide aggregate may be off from the national average when the QI program may not meet the 75th percentile.

Adult Core Set – Primary Care Access and Preventive Care

Cervical Cancer Screening

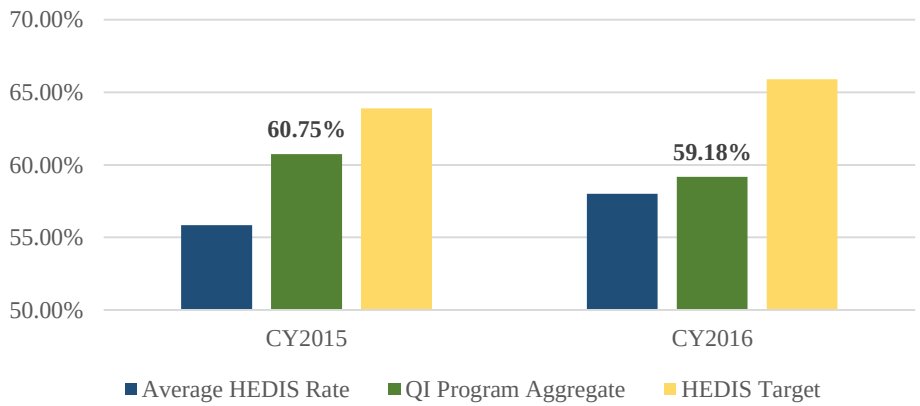
The QI program experienced a decrease in performance on the "Cervical Cancer Screening" measure during the measure period for the adult population. However, the QI program performed better than the average HEDIS rate.

The measure assesses women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed every 3 years; or
- Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

MQD began reporting this measure in CY2015, so only two years of data are available. Performance decreased by approximately 1.5 percentage points between CY2015 and CY2016.

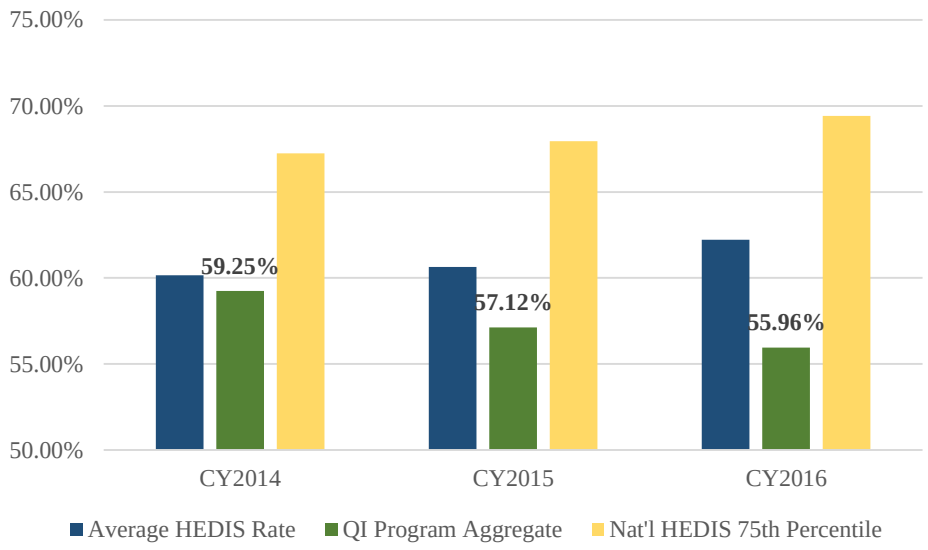
Figure 2: Cervical Cancer Screening



Chlamydia Screening in Women

The QI program experienced a decrease in performance on the "Chlamydia Screening in Women" measure between CY2014 and CY2016. The measure assesses women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. MQD reported on two age breakouts – 16-20 years of age and 21-24 years of age. The results for women age 21-24 years are shown below. Performance went down 3.25 percentage points between CY2014 and CY2016.

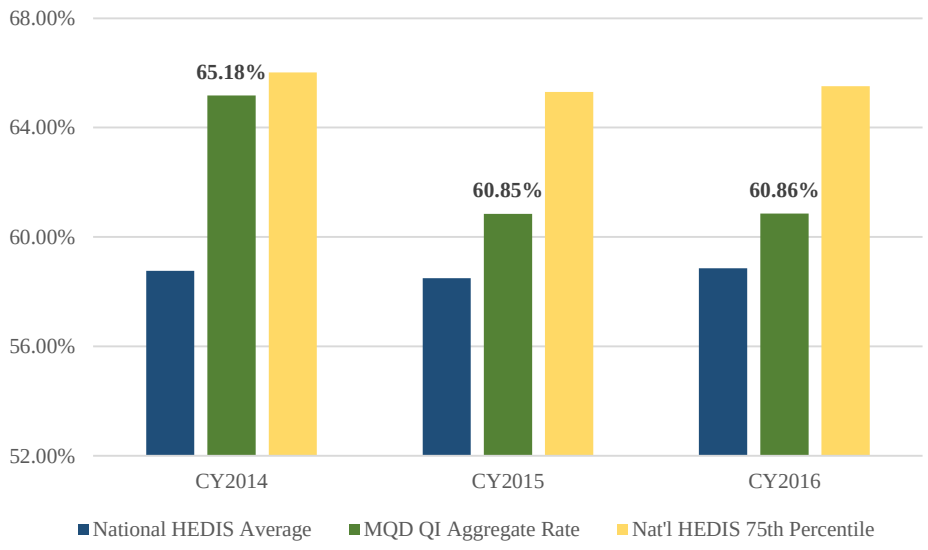
Figure 3: Chlamydia Screening in Women - 21 to 24 Years of Age



Breast Cancer Screening

The QI program experienced a decline in its performance on the "Breast Cancer Screening" measure. The measure assesses women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. However, the QI program performed better than the national HEDIS average for all years measured. Performance decreased by approximately 4.25 percentage points between CY2014 and CY2016.

Figure 4: Breast Cancer Screening

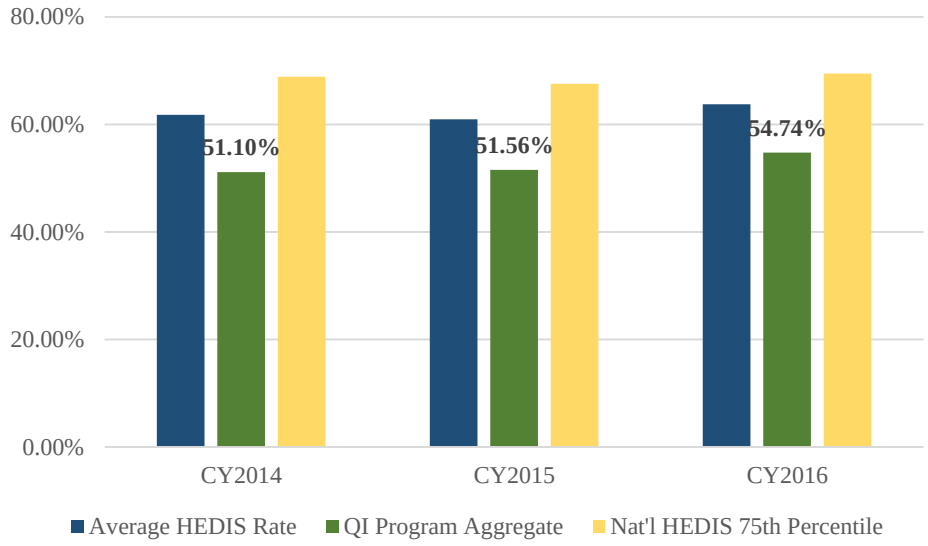


Adult Core Set - Maternal and Perinatal Health

Postpartum Care

"Postpartum Care" is defined as the percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. The QI program improved performance on this measure by approximately .5 percentage points between CY2014 and CY2015, and about 3 percentage points between CY2015 and CY2016.

Figure 5: Prenatal and Postpartum Care - Postpartum Care

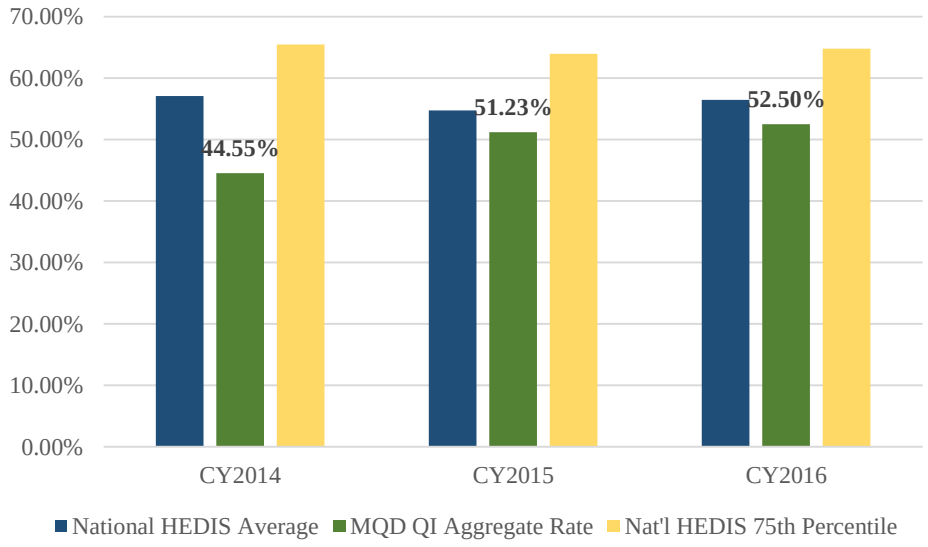


Adult Core Set - Care of Acute and Chronic Conditions

Controlling High Blood Pressure

The QI Program experienced improvement in the "Controlling High Blood Pressure" measure. The measure is defined as adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled based on the following criteria: adults 18-59 years of age whose blood pressure was <140/90 mm Hg; adults 60-85 years of age, with a diagnosis of diabetes, whose blood pressure was <140/90 mm Hg; and adults 60-85 years of age, without a diagnosis of diabetes, whose blood pressure was <150/90 mm Hg. Between CY2014 and CY2016, performance increased by about 8 percentage points.

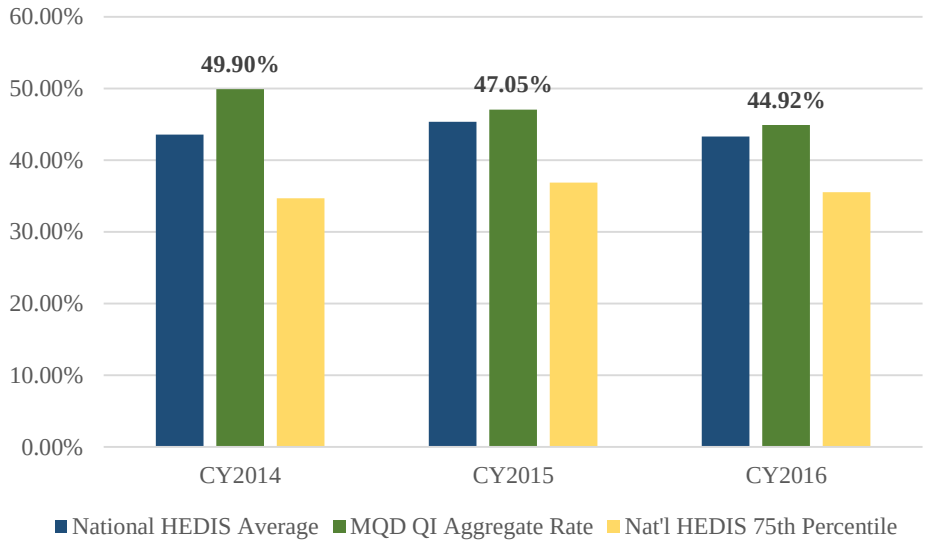
Figure 6: Controlling High Blood Pressure



Comprehensive Diabetes Care

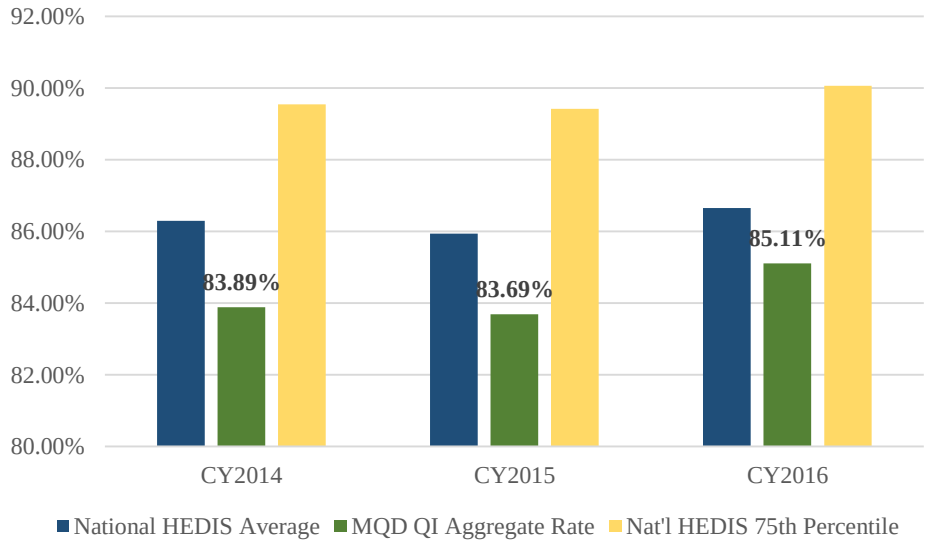
The QI experienced variation in the "Comprehensive Diabetes Care" measures during the waiver extension period. The "Hemoglobin A1c Poor Control" is defined as the percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. A lower rate reflects better performance. The QI program improved its performance by 2.85 percentage points between CY2014 and CY2015, and then over 2 percentage points between CY2015 and CY2016.

Figure 7: Hemoglobin A1c Poor Control



The "Hemoglobin A1c Testing" measures the percentage of beneficiaries ages 18-75 with diabetes (type 1 and 2) who had a hemoglobin A1C test. The QI performance dipped by .2 percentage points between CY2014 and CY2015, but improved by nearly 1.5 percentage points between CY2015 and CY2016.

Figure 8: HbA1c Testing



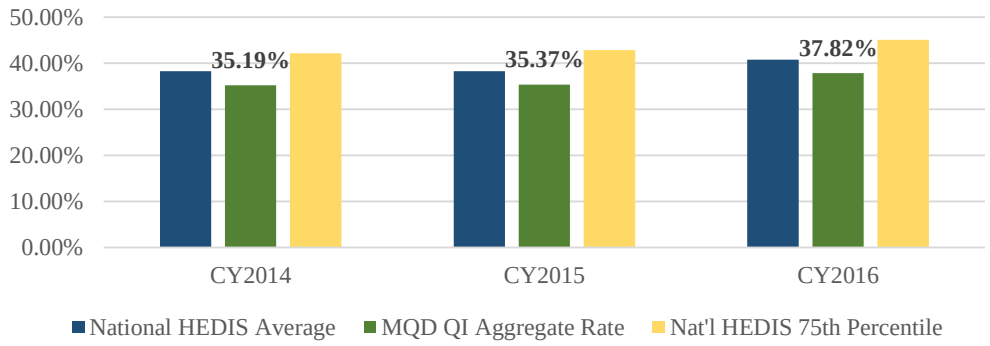
Adult Core Set – Behavioral Health Care

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

The QI program experienced variation with this measure. The measure assesses the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) dependence who received the following care. The QI program improved on Initiation over the extension period, and while the engagement results have varied, QI is still performing above the national HEDIS average.

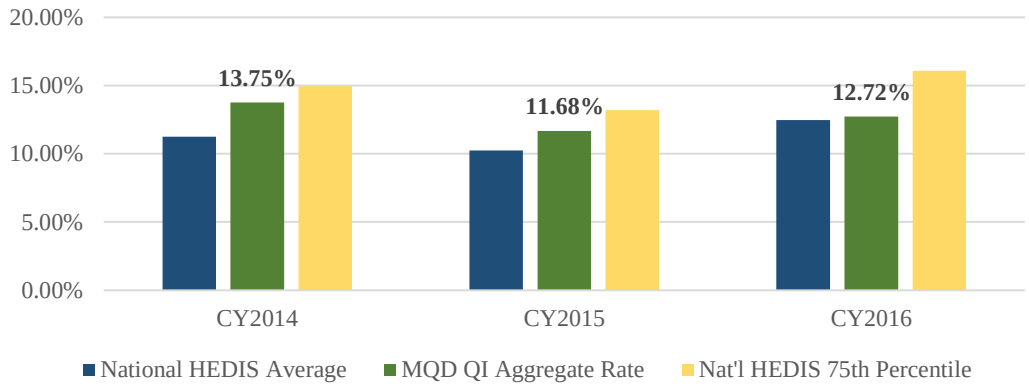
Initiation of AOD Treatment: Adolescents and adults who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Figure 9: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation of AOD Treatment



Engagement of AOD Treatment: Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

Figure 10: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – Engagement of AOD Treatment



Antidepressant Medication Management

The QI program experienced variation with this measure. The measure assesses adults 18 years of age and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on their antidepressant medications.

Two rates are reported:

- Effective Acute Phase Treatment: Adults who remained on an antidepressant medication for at least 84 days (12 weeks).
- Effective Continuation Phase Treatment: Adults who remained on an antidepressant medication for at least 180 days (6 months)

Figure 11: Antidepressant Medication Management - Effective Acute Phase Treatment

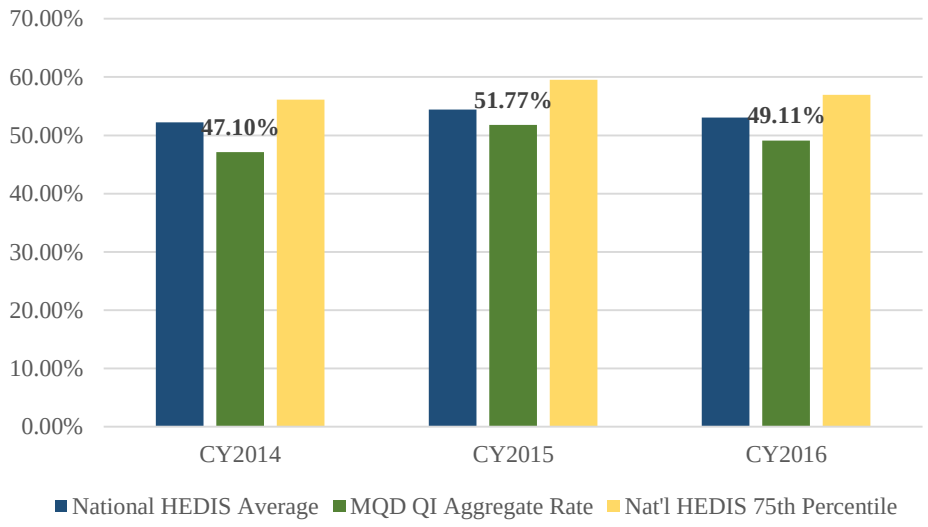
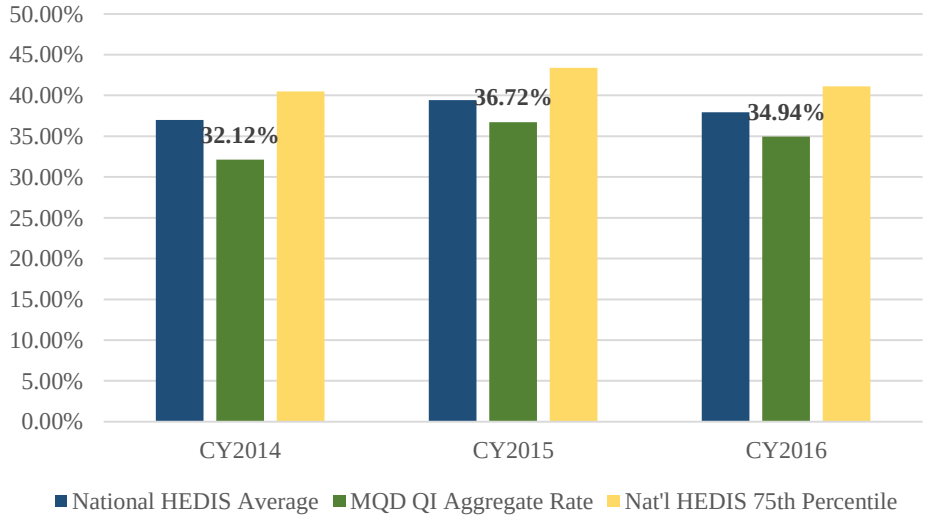


Figure 12: Antidepressant Medication Management - Effective Continuation Phase Treatment

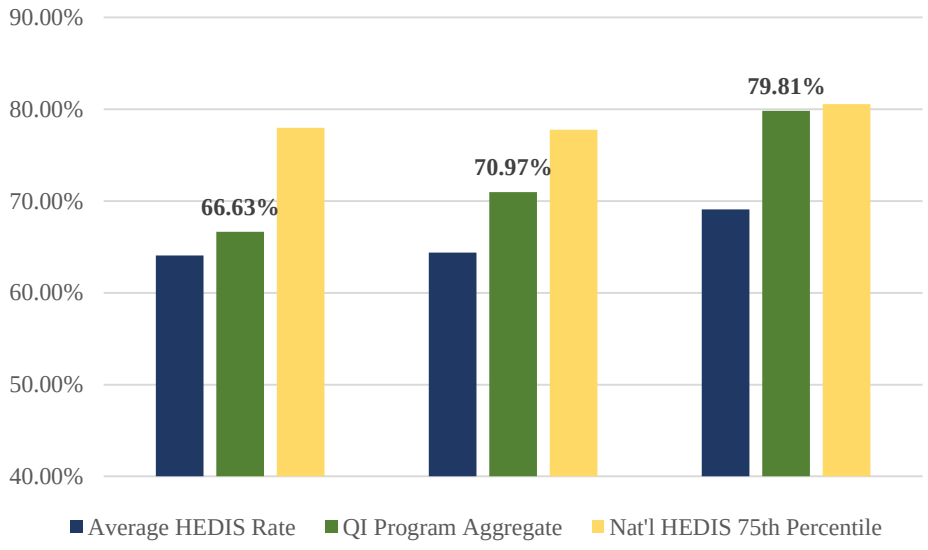


Child Core Set – Primary Care Access and Preventive Care

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile

The QI program experienced improvement in the "Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile" measure. The measure is the percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of patients with documentation for height, weight, and body mass index (BMI) percentile. Performance increased by about 13 percentage points between CY2014 and CY2016.

Figure 13: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile



Children and Adolescents' Access to Primary Care Practitioners

The QI program experienced variation in the "Children and Adolescents' Access to Primary Care Practitioners" measure. The measure assesses children and young adults 12 months–19 years of age who had a visit with a primary care practitioner (PCP). The measure reports on four separate percentages:

- Children 12–24 months who had a visit with a PCP during the measurement year.
- Children 25 months–6 years who had a visit with a PCP during the measure year.
- Children 7–11 years who had a visit with a PCP during the measure year or the year prior to the measurement year.
- Adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Figure 14: Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months of Age

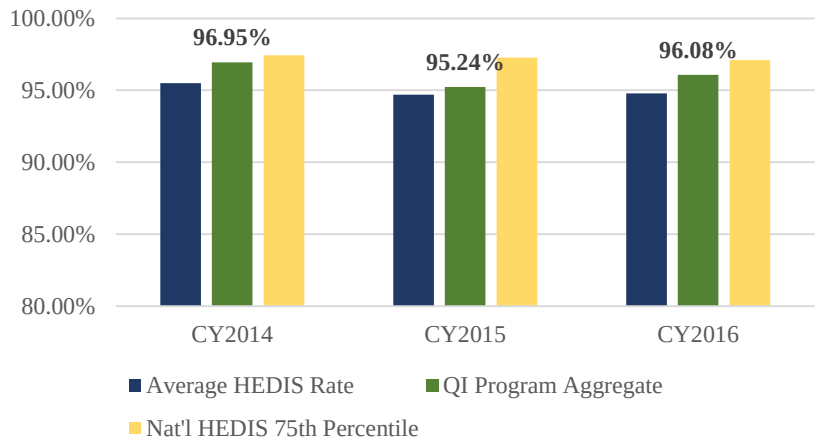


Figure 15: Children and Adolescents' Access to Primary Care Practitioners - 25 months to 6 years

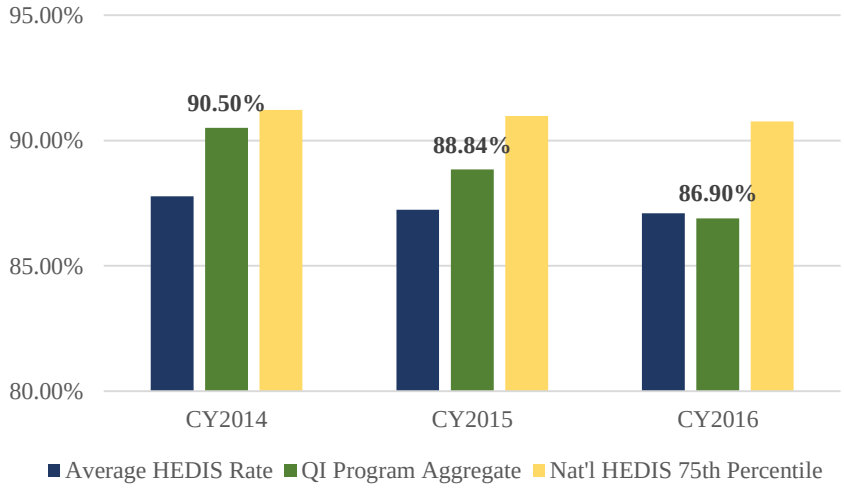


Figure 16: Children and Adolescents' Access to Primary Care Practitioners - 7 to 11 years

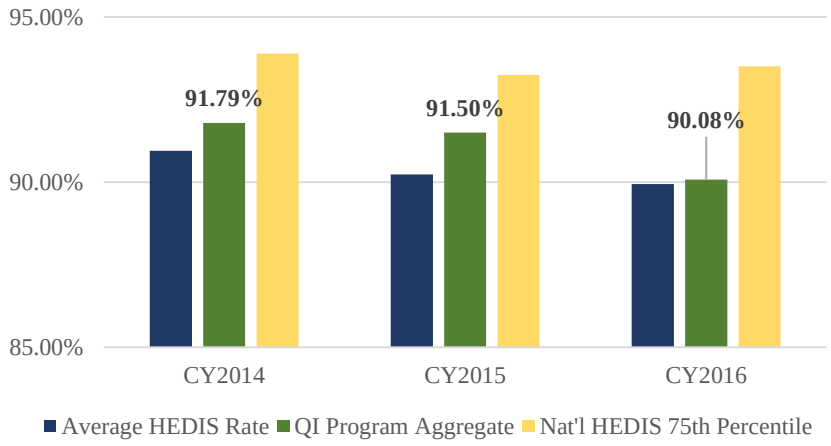
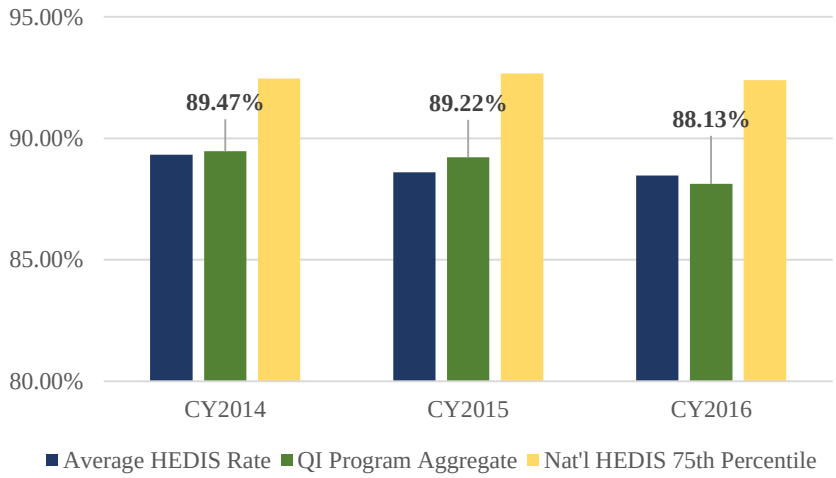


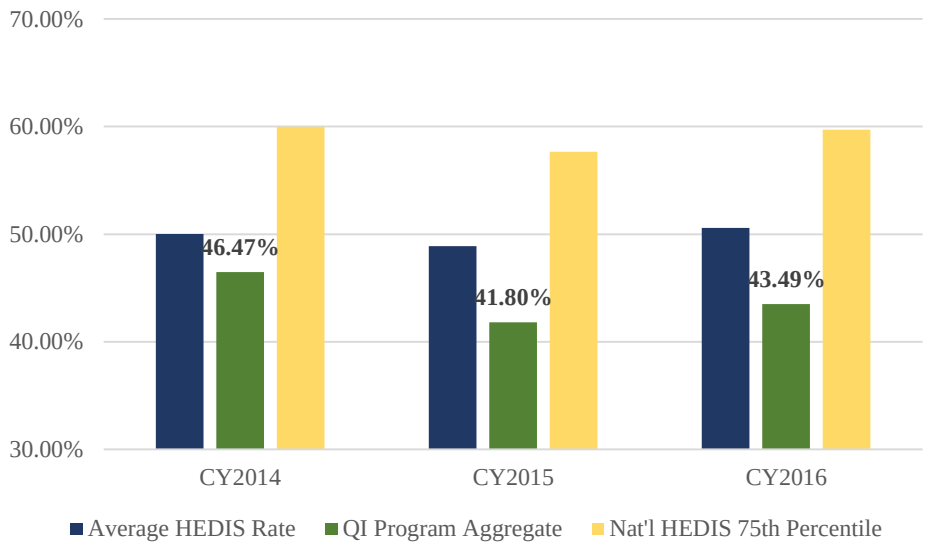
Figure 17: Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years of Age



Adolescent Well-Care Visits

The QI program experienced variation with the "Adolescent Well-Care Visits" measure. The measure assesses adolescents and young adults 12–21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Overall, performance decreased from CY2014 and CY2016 by about 3 percentage points.

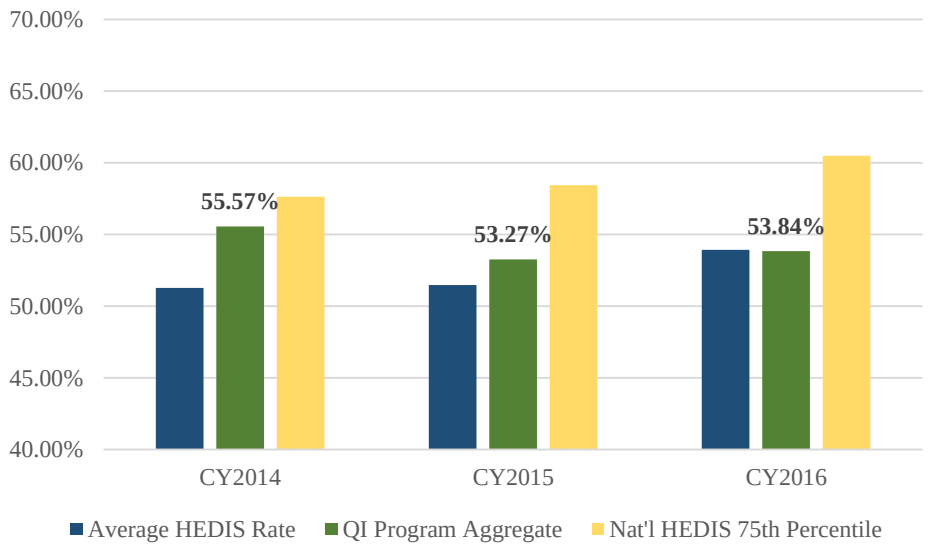
Figure 18: Adolescent Well-Care Visits



Chlamydia Screening in Women

The QI program experienced variation in the "Chlamydia Screening in Women" measure. Assesses women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. MQD reported on two age breakouts – 16-20 years of age and 21-24 years of age. Overall, there was about a decrease of 2 percentage points between CY2014 and CY2016.

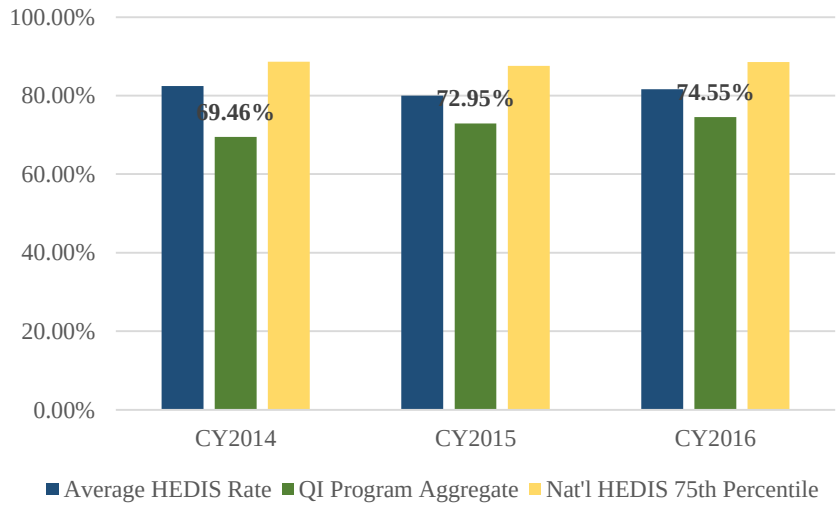
Figure 19: Chlamydia Screening in Women - 16 to 20 Years of Age



Child Core Set – Maternal and Perinatal Health

"Timeliness of Prenatal Care" is defined as the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. The QI program improved its performance by nearly 3.5 percentage points from CY2014 to CY2015 and approximately 1.5 percentage points from CY2015 to CY2016.

Figure 20: Prenatal and Postpartum Care - Timeliness of Prenatal Care

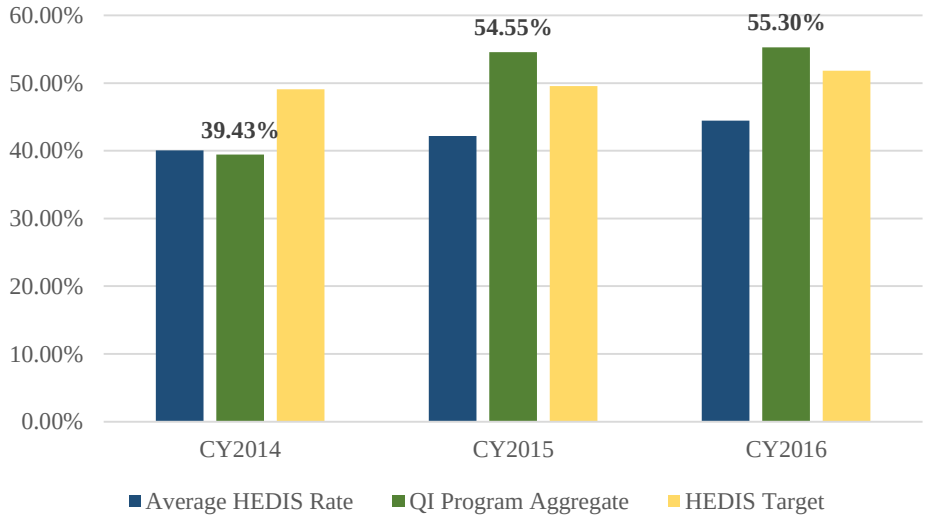


Child Core Set – Behavioral Health Care

Follow-Up Care for Children Prescribed ADHD Medication

The QI program experienced progress in the HEDIS "Follow-Up Care for Children Prescribed ADHD Medication" measure. The measure is defined as the percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care.

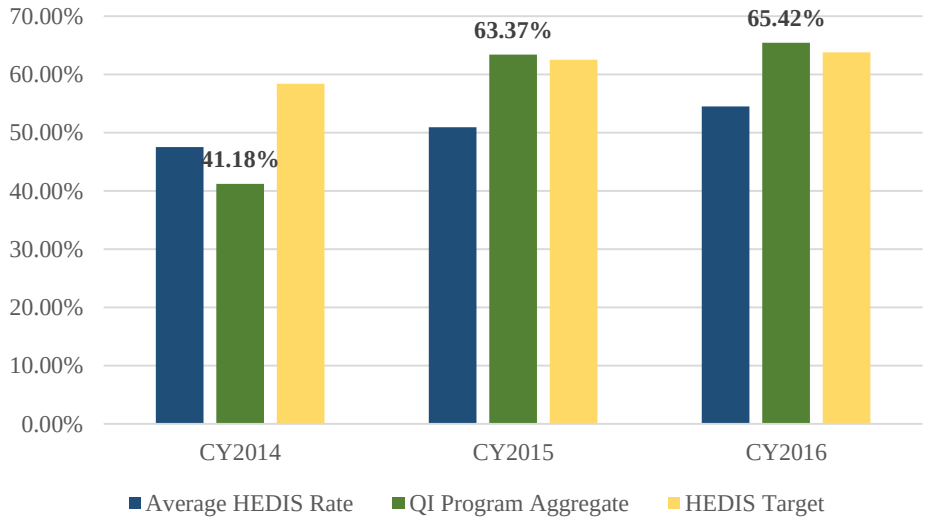
Figure 21: Follow-Up Care for Children Prescribed ADHD Medication - Initiation



Two rates are reported: the percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase; and the percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

For both components of the measure, the QI program rate was below the average HEDIS rate in calendar year 2014, but was above the national HEDIS 75th percentile in calendar years 2015 and 2016.

Figure 22: Follow-Up Care for Children Prescribed ADHD Medication - Continuation Phase



Pay for Performance Results

During this waiver term, beginning in CY2015 and continuing into CY2016, the QI health plans had a withhold of $2.00 PMPM for the non-ABD population and $1.00 PMPM for the ABD population. These entire withhold amounts were available for both the CY 2015 and CY 2016 Pay for Performance (P4P) Program. The MQD generally improved its P4P Program in the QI program, but there were also decreases in performance on some measures.

The following were improvements made to the QI P4P Program beginning CY 2015:

- Expanded measure set – increased number of measures from six (6) to nine (9)
- Recognized both improvement and goal achievement of individual measure scores – added incremental achievement targets to the current excellence target, with corresponding additional percentage incentives
- Weighted the measures differently based on the percentage of ABD enrollment each health plan served during the time period

The result of these P4P changes has been broader participation achievement of intermediate goals by a broader spectrum of the QI health plans. Whereas in past years a maximum of only two QI health plans in any year achieved any P4P payout, in the first two years of the new P4P Program, each and every QI health plan participated in the P4P payout. The intent was to keep each QI health plan engaged in the quality improvement process no matter where they are on the performance spectrum.

The QI program improved performance on seven of the nine measures included in the P4P Program, but only met two of its HEDIS targets. In addition to this longitudinal improvement, the QI program also narrowed the distance between the Hawai‘i rate and the national HEDIS target rate for the seven measures. However, Med-QUEST also saw decreases in performance in measures on well-child visits and immunizations.

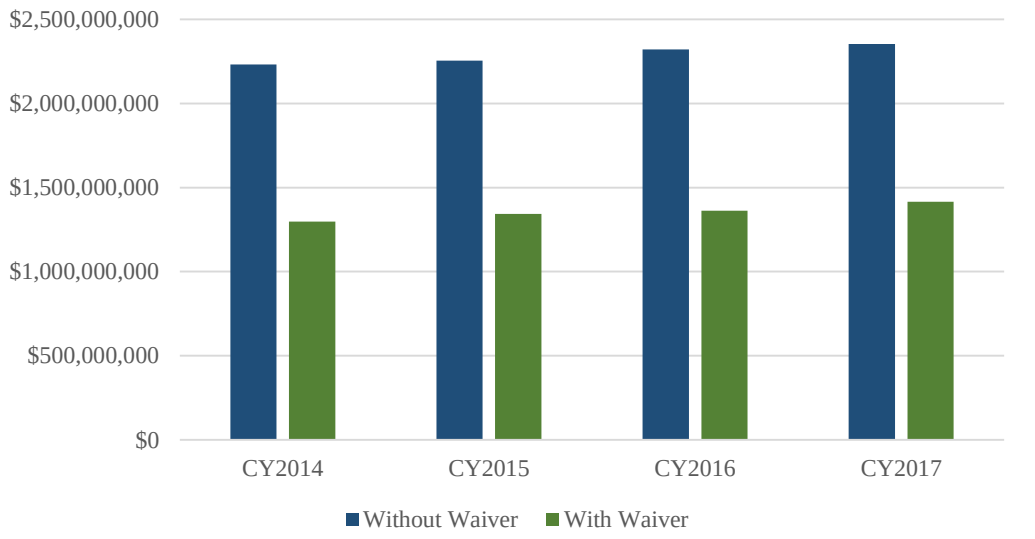
Table 4: P4P Results CY2014-CY2016

		CY2014			CY2015			CY2016		
		Hawai'i Rate	Target Percent	Difference Between Rates	Hawai'i Rate	Target Percent	Difference Between Rates	Hawai'i Rate	Target Percent	Difference Between Rates
Comprehensive Diabetes Care	Eye Exam (Retinal) Performed	58.57%	63.23%	-4.66%	58.48%	61.50%	-3.02%	61.72%	63.33%	-1.61%
Comprehensive Diabetes Care	HbA1c Control (<8.0%)	40.37%	54.01%	-13.64%	43.59%	52.55%	-8.96%	45.80%	53.65%	-7.85%
Childhood Immunization Status	Combination 3	57.81%	76.50%	-18.69%	64.63%	75.60%	-10.97%	57.92%	75.91%	-17.99%
Follow-Up After Hospitalization for Mental Illness	7-Day Follow-Up	29.69%	56.78%	-27.09%	34.89%	55.34%	-20.45%	38.63%	56.22%	-17.59%
Plan All-Cause Readmissions*	Total	12.15%		12.15%	13.76%	13.17%	-.49%	13.14%	13.55%	.41%
Prenatal and Postpartum Care	Postpartum Care	51.10%	68.85%	-17.75%	51.56%	67.53%	-15.97%	54.74%	69.44%	-14.70%
Prenatal and Postpartum Care	Timeliness of Prenatal Care	69.46%	88.66%	-19.20%	72.95%	87.56%	-14.61%	74.55%	88.59%	-14.04%
Well-Child Visits in the First 15 Months of Life	Six or More Well-Child Visits	72.91%	66.24%	6.67%	67.59%	67.76%	-0.17%	71.32%	68.66%	2.66%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	75.80%	78.46%	-2.66%	72.39%	77.57%	-5.18%	71.51%	78.51%	-7.00%

The source for data contained in the table above is Quality Compass® 2015, 2016, and 2017 and is used with the permission of NCQA. Quality Compass 2015, 2016, and 2017 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Financial Performance

One of the goals of the demonstration is to "[c]ontinue the predictable and slower rate of expenditure growth associated with managed care." One measure for that goal is the budget neutrality test the waiver must meet under waiver rules. Budget neutrality savings is a reflection of the fiscal performance of the waiver. Specifically, it compares the expenditures with the waiver in place – inclusive of all the demonstration group costs -- against the hypothetical expenditures if the waiver were not in place at all. If the "With Waiver" expenditures are less than the "Without Waiver" expenditures, then Budget Neutrality Savings will result. Over the waiver term, Hawai'i continued its historical performance under the budget neutrality cap.



	CY2014	CY2015	CY2016	CY2017
Without Waiver	$2,232,453,994	$2,253,542,582	$2,321,791,532	$2,353,515,633
With Waiver	$1,298,373,371	$1,343,314,944	$1,361,491,708	$1,415,242,078

The numbers above do not include the Group VIII population as those numbers are not part of the savings calculation under budget neutrality. The table below illustrates expenditures if those numbers were to be included.

	CY2014	CY2015	CY2016	CY2017
Without Waiver	$2,865,706,000	$3,125,921,334	$3,372,492,772	$3,506,857,163
With Waiver	$1,707,340,410	$1,846,705,244	$1,961,265,188	$2,091,241,239

Provider and Health Plan Accountability

One of the hypotheses tested in the QUEST 1115 waiver renewal is "[e]stablish contracted accountability among the contracted health plans and health care providers" and "[m]aintain a managed care delivery system that assures access to high- quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations." MQD has attempted to realize this goal through a number of vehicles. A good proxy measure for performance is provider opinion on how QI programs are able to support providers in their work to serve QI beneficiaries. The tables below describe provider attitudes toward health plan accountability, by QI plan.

It should be noted again that the response rate for the non-Kaiser sample was considerably lower than the Kaiser sample (18.0 percent and 28.2 percent, respectively). The low response rates increased potential for non-response bias and likelihood that provider responses are not reflective of all providers serving QI members. Furthermore, FQHC providers did make up 17 percent of the non-Kaiser sample, but were not included in the Kaiser sample.

General Positions

Providers were asked to rate their satisfaction with the rate of reimbursement or compensation they receive from their contracted QI health plans. In 4 of 5 plans, at least one-third of providers reported being very dissatisfied/dissatisfied with the reimbursement rate or compensation received.

Table 5: Provider Survey - General Positions

	Very Dissatisfied/Dissatisfied	Neutral	Very Satisfied/Satisfied	N
AlohaCare	41.9%	37.1%	21.0%	186
HMSA	30.0%	34.3%	35.7%	207
Kaiser	12.2%	24.4%	63.4%	41
'Ohana	57.1%	30.2%	12.6%	182
UHC	54.3%	30.1%	15.6%	186

Providing Quality Care

Providers were also asked two questions focusing on the impact QI health plans have on their ability to provide quality care. Areas rated included: prior authorization process and formulary. Responses for the prior authorization process are described below:

Table 6: Provider Survey - Providing Quality Care

	Negative Impact	Neutral Impact	Positive Impact	N
AlohaCare	55.0%	32.8%	12.2%	186
HMSA	46.7%	36.5%	16.8%	207
Kaiser	8.8%	58.8%	32.4%	41
'Ohana	65.0%	26.6%	12.6%	182
UHC	61.1%	30.3%	15.6%	186

Service Coordinators

Providers were asked to rate the adequacy of the help provided by the QI health plans' service coordinators. In 4 of 5 plans, more than one-third of providers reported dissatisfaction with the adequacy of help provided by service coordinators.

Table 7: Provider Survey - Service Coordinators

	Very Dissatisfied/Dissatisfied	Neutral	Very Satisfied/Satisfied	N
AlohaCare	41.0%	42.3%	16.7%	156
HMSA	31.3%	47.3%	21.4%	182
Kaiser	0%	25.0%	75.0%	48
'Ohana	54.2%	36.6%	9.2%	153
UHC	49.0%	40.6%	10.3%	155

Specialists

A majority of providers were dissatisfied with the adequacy of the number of specialists for three QUEST plans; were neutral in one plan; and were satisfied in the fifth plan.

Table 8: Provider Survey - Specialists

	Dissatisfied	Neutral	Satisfied	N
AlohaCare	60.8%	32.5%	6.6%	166
HMSA	34.2%	44.2%	21.6%	190
Kaiser	2%	18.0%	80.0%	50
'Ohana	72.5%	22.5%	5.0%	160
UHC	60.7%	35.6%	3.7%	163

In regard to the plans' behavioral health networks, approximately two-thirds of providers surveyed reported dissatisfaction with the availability of behavioral health providers in three plans. For the two other plans, close to 50 percent of providers surveyed reported being dissatisfied with the availability of behavioral health providers.

Table 9: Provider Survey - Behavioral Health Specialists

	Dissatisfied	Neutral	Satisfied	N
AlohaCare	66.7%	27.5%	5.8%	138
HMSA	49.7%	38.8%	11.5%	165
Kaiser	47.8%	28.3%	23.9%	46
'Ohana	69.9%	24.8%	5.3%	133
UHC	66.2%	30.1%	3.7%	136

Findings, Conclusions & Recommendations

The QUEST Integration is the continuation of a mature managed care program that serves approximately 99 percent of Medicaid beneficiaries in Hawai‘i. The information presented in this evaluation demonstrates that the QI program achieved success on the goals outlined in the STCs, but there may be room for improvement.

MQD grouped the following goals under Access to Care and Beneficiary Engagement:

- Align the demonstration with Affordable Care Act;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system; and
- Expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS.

The QI program demonstrated success in meeting these goals. The demonstration was aligned with the Affordable Care Act. Data from the CAHPS survey showed improved ratings for all composite measures and individual item measures for the adult population. The program also improved on the child CAHPS composite measures, however declines in performance on the global ratings and individual items suggest that more attention may be needed on the provision of services to children, such as care coordination and health education.

Service utilization data for nursing home, HCBS, and at-risk services show fewer people received nursing home services and HCBS in 2018 than 2014 if they qualified for those services by meeting the nursing home level of care in Hawai‘i – a high standard. If at-risk services are added to the analysis, the percentage of individuals receiving HCBS rather than nursing home services increases from 65 percent to 77 percent.

MQD grouped the next three goals into Improving Health, Ensuring High-Quality Care, and Managing Costs

- Improve the health care status of the member population;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP); and
- Continue the predictable and slower rate of expenditure growth associated with managed care.

The evaluation shows mixed results as it pertains to improving health care outcomes and quality of care in the QI program. In looking at the Adult Core Set measures, screenings for cervical cancer, breast cancer, and chlamydia decreased in the QI program during the measurement period, but breast and cervical cancer screening rates exceeded the national Medicaid average. For postpartum care, the QI program saw an increase in performance the measure, but fell below the national average. The QI program's performance for acute and chronic care conditions and behavioral health was mixed, but rates on three of the four behavioral health measures below the national HEDIS average which may suggest a need for improvement in the quality of care for adults in the QI program with behavioral health diagnoses.

For the Child Core Set measures, the QI program experienced variation across the domains. The program notably experienced strong performance on the Follow-Up Care for Children Prescribed ADHD Medication measure.

QI performance in the measures in the P4P Program similarly showed mixed results. While the state aggregate score improved on 7 out of 9 measures, the State only met the target for 2 out of 9 measures from CY2014 through CY2016.

MQD grouped the following goals into Provider and Health Plan Accountability:

- Maintain a managed care delivery system that assures access to high- quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations; and
- Establish contractual accountability among the contracted health plans and health care providers.

The provider survey shows evidence that providers believe there is a shortage of mental health providers in the QI program. This reflects workforce shortages that affect other payers and health systems in Hawai'i. As noted above, however, performance on behavioral health HEDIS measures for adults and children were mixed. QI plan performance on service coordination also had mixed results according to providers.

The QI program will continue to monitor performance on the measures found in this evaluation and in other quality monitoring activities and use them to inform policy and operations. MQD does not recommend particular policy changes at this time as it is presently embarking on a major evolution of the QUEST waiver.

In the next 1115 renewal period, MQD will continue the current QUEST program, but will adopt policies to invest in primary care, prevention, and health promotion, improve outcomes for high-need, high-cost individuals, engage in payment reform and alignment, and support community driven initiatives to improve population health in line with the Hawai'i 'Ohana Nui Project Expansion (HOPE) initiative. MQD will use the evaluation report findings to help inform the direction and the design of the HOPE initiative in the next renewal. In particular, findings related to primary care and prevention, chronic care management, behavioral health, and value-based purchasing will be useful in program design under the HOPE initiative.

QUEST Integration
Evaluation Design

Submitted by the State of Hawaii, Department of Human Services,
Med-QUEST Division

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Overview and Brief History of the Demonstration

Hawaii's QUEST Integration is a Med-QUEST Division (MQD) wide comprehensive section 1115 (a) demonstration that expands Medicaid coverage to children and adults. The demonstration creates a public purchasing pool that arranges for health care through capitated-managed care plans. The State of Hawaii implemented the first QUEST demonstration on August 1, 1994. The extension period for this evaluation design is from October 1, 2013 through to December 31, 2018.

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

As QUEST was originally conceived, a second phase was planned that would have enrolled the ABD populations into managed care. CMS approved the second phase on February 1, 2008 and implemented on February 1, 2009 as the QUEST Expanded Access (QExA) program. A third planned phase would have combined the purchasing power of QUEST with that of the State employees' health benefits to further increase the cost efficiencies of the program. However, for a variety of reasons, phase three was never implemented.

A class action lawsuit under the Americans with Disabilities Act (ADA) was filed against the State in 1995 alleging that disabled individuals with incomes above 100 % of the FPL were kept out of the program based solely on their disability status. To address this issue, the State reduced its coverage of the uninsured under QUEST to those uninsured adults with incomes at or below 100 % FPLand uninsured children with family incomes at or below 200 percent FPL. In addition, a new program, QUEST-Net, was developed in 1995 for individuals who are no longer eligible for QUEST or Medicaid fee-for-service due to an increase in income or assets. For a reasonable premium share, QUEST-Net provided full Medicaid benefits for children from 201 to 300 % FPL and a limited benefit package for adults with incomes from 101 to 300 % FPL. QUEST eligibles who are self-employed were previously assessed a premium. These individuals were allowed to opt for QUEST-Net as a source of insurance coverage.

Below is a summary of changes to the QUEST program since its inception.

Timeframe	Summary of Change to QUEST program
July 1995	Changes to eligibility requirements Establish a fee-for-service window prior to QUEST health plan enrollment
September 1995	Cap QUEST enrollment at 125,000 expansion-eligibles participants
May 1996	Reinstate asset test and add a premium for QUEST-Net participants
March 1997	Changes to eligibility requirements for AFD-related covered groups
June 2001	Expand QUEST-Net program
July 2005	Significant changes to QUEST program
February 2008	Develop a managed care program for Aged, Blind, and Disabled population
May 2010	Development of Hawaii Premium Plus (HPP) program

Timeframe	Summary of Change to QUEST program
October 2010	Changes to HPP program Add pneumonia vaccine as a covered immunization
July 2012	Change eligibility and benefits for QUEST-ACE and QUEST- Net programs Eliminate QUEST enrollment limit for childless adults Eliminate HPP program Changes to uncompensated care (UC) payments
December 2012	Approval of a one-year waiver extension
October 2013	Consolidated programs Transitioned former programs (i.e., QUEST-ACE and QUEST-Net) into the new low-income adult group Added new populations Increased retroactive eligibility period to ten (10) days Added new benefits Changes to the UC pool

Refer to the information below for details regarding the summary table above. Since its implementation, the State has made several changes to the QUEST program.

- The first amendment, approved July 11, 1995, allowed the State to deem parental income for tax dependents up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing for expansion populations, impose a premium for self-employed individuals, and require the State to pay for State Plan services received prior to the date of enrollment in a QUEST health plan on a Fee-For-Service basis for an eligible QUEST client.

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

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

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

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

- In January 2006, the federal government approved a new Section 1115 waiver for Hawaii, QUEST Expanded (QEx) which incorporated the existing QUEST program with some significant changes including:
  - The addition of a dental benefit for adults of up to $500 a year;
  - Coverage was extended to all Medicaid-eligible children in the child welfare system;

- Coverage was extended to adults up to 100% of the FPL who meet Medicaid asset limits;
- Premium contributions for children with income at or below 250% of FPL were eliminated;
- The requirement that children have prior QUEST coverage was eliminated as a condition to qualifying for QUEST-Net; and
- Increased SCHIP eligibility from 200% of FPL to 300% of FPL.

In all, about 9,000 children and another 20,000 adults who were previously uninsured, were made eligible for the program. In addition, the waiver amendment authorized federal match on payments made by the State to its state-owned hospitals.

The current waiver for the Hawaii program was approved by CMS on January 31, 2006 with a retroactive start date of July 1, 2005. The waiver will require renewal on or before June 30, 2008. The waiver currently being negotiated for the ABD population was submitted as an amendment to the existing waiver.

- In February 2007, the State requested to renew the QUEST demonstration, and the State reaffirmed its 2005 request to CMS to amend the Demonstration to advance the State's goals to develop a managed care delivery system for the Aged, Blind, and Disabled (ABD) population. This amendment was effective on February 1, 2008.

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

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

- On July 28, 2010, the State of Hawaii submitted a proposal for a section 1115 Medicaid demonstration amendment to eliminate the unemployment insurance eligibility requirement for the Hawaii Premium Plus (HPP) program. The HPP program was recently created to encourage employment growth and employer sponsored health insurance coverage in the State. This amendment was effective October 15, 2010.

- On August 11, 2010, Hawaii submitted an amendment proposal to add the pneumonia vaccine as a covered immunization. In addition to the July 28 and August 11, 2010 proposed amendments, several technical corrections were made regarding expenditure reporting for both Title XIX and XXI Demonstration populations. This amendment was effective October 15, 2010.

- On July 7, 2011, Hawaii submitted an amendment proposal to reduce QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL, including the elimination of the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. QUEST- Adult Coverage Expansion (QUEST-ACE) was an eligibility expansion category for non-pregnant childless adults with income not exceeding 133% and for adults with children who have income 101-133%.

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

- In the July 7, 2011 amendment, Hawaii also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the Demonstration; eliminate the QUEST enrollment limit for childless adults; provide QUEST Expanded Access (QExA) individuals with expanded primary and acute care benefits; remove the Hawaii Premium Plus program, a premium assistance program, due to a lack of Legislative appropriation to continue the program, and allow uncompensated cost of care payments (UC) to be paid to government-owned nursing facilities. The July 7, 2011 amendment was effective July 1, 2012.

- In June 2012, Hawaii requested to extend the QUEST demonstration under section 1115(e) of the Social Security Act. Revisions were made to the waiver and expenditure authorities to update the authorization period of the demonstration, along with a technical correction clarifying that the freedom of choice waiver is necessary to permit the state to mandate managed care, and updates to the budget neutrality trend rates. A one year renewal was approved in December 2012. In December 2012, the state requested to amend the demonstration to provide full Medicaid benefits to former foster children under age 26 with income up to 300 percent FPL with no asset limit.

- In September 2013, CMS approved a five-year extension of the demonstration from October 1, 2013 through December 31, 2018. This five year demonstration extension:
  - Consolidated the four (4) programs within the demonstration (QUEST, QUEST-ACE, QUEST Expanded Access (QExA) and QUEST-Net) into a single "QUEST Integration" program which, effective January 1, 2014, provided the full Medicaid state plan benefit package to all enrollees in the demonstration;
  - Transitioned the low-income childless adults and former foster care children from demonstration expansion populations to state plan populations (new adult group);
  - Added additional new demonstration expansion populations, including a population of former adoptive and kinship guardianship children;
  - Increased the retroactive eligibility period to ten (10) days for the non-long term services and supports population;

- Provided additional benefits, including cognitive rehabilitation, habilitation, and certain specialized behavioral health services;
- Eliminated state enrollment limits;
- Removed the QUEST-ACE enrollment-related benchmarks from the UC pool; and
- Required additional evaluation on UC costs after January 1, 2014 and a June 2016 sunset date for UC authority.

Current Enrollment and Delivery System

QUEST Integration or QI is a melding of both the QUEST and QExA programs. QI is a patient-centered approach with provision of services based upon clinical conditions and medical necessity. QUEST Integration combines QUEST and QUEST Expanded Access (QExA) programs into one and eliminates the QUEST-ACE and QUEST-Net programs. In addition, beneficiaries remain with same health plan upon turning 65 or when changes occur in their health condition. In QUEST Integration, health plans will provide a full-range of comprehensive benefits including long-term services and supports. MQD has lowered its ratios for service coordination.

QUEST Integration has five (5) health plans: AlohaCare, Hawaii Medical Services Association (HMSA), Kaiser Permanente, ʻOhana Health Plan, and UnitedHealthcare Community Plan. See information in Table 1 that includes populations by eligibility groups, health plan enrollment, and eligibility by island.

Summary of QUEST Expanded Demonstration Evaluation-January 2014

The demonstration evaluation period for this report was from January 1, 2008 to September 30, 2013. This report concluded the 19th demonstration year for the QUEST Expanded Medicaid section 1115 demonstration waiver. The demonstration evaluation period saw several significant initiatives for the QUEST Expanded program:

- **Development and implementation of the QUEST Expanded Access (QExA) program on February 1, 2009.**
  Effective February 1, 2009, the majority of the fee-for-service (FFS) population was transitioned into managed care in the QUEST Expanded Access (QExA) program. The Medicaid population in QExA consists of beneficiaries 65 years or older or with a disability of any age. The QExA program has two health plans: ʻOhana Health Plan and UnitedHealthcare Community Plan. As of September 30, 2013, the QExA program has approximately 46,000 beneficiaries. The QExA health plans provide a continuum of services to include primary, acute care, standard behavioral health, and long-term care services. The goals of the QExA program are:
  - Improve the health status of the member population;
  - Establish a "provider home" for members through the use of assigned primary care providers (PCPs);
  - Establish contractual accountability among the State, the health plan and healthcare providers;
  - Expand and strengthen a sense of member responsibility and promote independence and choice among members;

- Assure access to high quality, cost-effective care that is provided, whenever possible, in a member's home and/or community;
- Coordinate care for the members across the benefit continuum, including primary, acute and long-term care benefits;
- Provide home and community based services (HCBS) to persons with neurotrauma;
- Develop a program that is fiscally predictable, stable and sustainable over time; and
- Develop a program that places maximum emphasis on the efficacy of services and offers health plans both incentives for quality and sanctions for failure to meet measurable performance goals.

- **Reprocurement of the QUEST program.**
  The QUEST program is for Medicaid beneficiaries under the age of 65 without a disability. As of September 30, 2013, the QUEST program has approximately 243,000 beneficiaries. Through the demonstration evaluation period, the QUEST program had three health plans from July 1, 2008 to June 30, 2012: AlohaCare, Hawaii Medical Services Association (HMSA), and Kaiser Permanente. In August 2011, the Med-QUEST Division (MQD) reprocured the QUEST program and added two additional health plans on July 1, 2012: 'Ohana Health Plan and UnitedHealthcare Community Plan.

  In the new procurement effective July 1, 2012, MQD added or expanded on several new initiatives. These include:
  - Value-based purchasing (e.g., patient centered medical homes and accountable care organizations);
  - Financial incentives for improving quality to their members;
  - Integration of medical and behavioral health services;
  - Auto-assign algorithm based upon quality instead of cost; and
  - Standardization of capitation payments amongst health plans.

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

  On July 1, 2012, the MQD changed the benefit package from a limited package of benefits to the same benefits as provided under the QUEST program. By changing the benefits from a limited to a full benefit package, the enrollment in the QUEST-ACE program more than doubled (from approximately 13,850 on June 30, 2012 to 28,800 on September 30, 2013).

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

- **Implementation of Pay for Performance through financial incentives in the QUEST program.**
  MQD implemented a Pay for Performance program that provides financial incentives to QUEST health plans based upon improved quality results. MQD utilizes improvement of both Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to measure improved quality results. For calendar years 2010 to 2012, health plans had access to a financial incentive of $1.00 per member per month (pmpm) withhold. For calendar years 2010 to 2012, the quality measures were:
  - Childhood Immunization
  - Emergency Department (ED) Visits/1000
  - LDL Control in Comprehensive Diabetes Care
  - Chlamydia Screening
  - Getting Needed Care (from CAHPS survey)

  Health plans needed to either meet the Medicaid 75th percentile rate for each of the measures listed above or meet/exceed an improvement of 50% of the difference between the current rate and the rate the year before. The only exception to these measures is ED visits/1000. For this measure, health plans needed to meet or exceed the Medicaid 10th percentile.

  In the QUEST procurement that was implemented on July 1, 2012, MQD increased the financial incentive withhold described above to $2.00 pmpm and included the following measures:

  - Childhood Immunization
  - Chlamydia Screening
  - Controlling High Blood Pressure
  - Comprehensive Diabetes Care:
    - HBA1C Control (<8%);
    - LDL-C Control (<100 mg/dl); and
    - Systolic and Diastolic blood pressure levels (<140/90).
  - Getting Needed Care (from CAHPS survey)

  Below is a chart that describes the number of quality measures of the five (5) potential measures each year that each health plan met.

	AlohaCare	HMSA	Kaiser
HEDIS/CAHPS 2010 (CY 2009)	2	2	4
HEDIS/CAHPS 2011 (CY 2010)	1	2	4
HEDIS/CAHPS 2012 (CY 2011)	1	1	5
HEDIS/CAHPS 2013 (January to June 2012)	1	2	5
HEDIS/CAHPS 2013 (July to December 2012)	0	1	5

Neither ‘Ohana Health Plan or UnitedHealthcare Community Plan was able to participate in incentives for July to December 2012 due to QUEST data only from July 1 to December 31, 2012.

The implementation of these initiatives has occurred to decrease the uninsured population in

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

Recommendations of QUEST Expanded Demonstration Evaluation-January 2014

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

1. Improve process for gathering information from providers

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

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

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

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

3. Increase the Pay for Performance withhold from health plans

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

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

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

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

Goals and Objectives

Hawaii's goals and objectives in the extension of this demonstration are to:

1. Improve the health care status of the member population;
2. Continue the predictable and slower rate of expenditure growth associated with managed care;
3. Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations, with a focus on preventative care;
4. Improve care coordination and decrease provider administrative burden by establishing a Patient Centered Medical Home (PCMH); and
5. Expand access to home and community based services (HCBS) and allow LTSS individuals to have a choice between institutional services and HCBS.

Hypotheses

Hawaii's hypotheses in the extension of this demonstration are to test the following:

- **Hawaii will both improve health care quality and reduce costs, by holding MCOs to outcomes and performance measures, and adjusting the financial pay-for-quality (P4Q) model to reward both improvement and excellence (relates to goal #1 and #2):** Hawaii understands that an 1115 waiver is an opportunity to both provider better care as well as show cost savings. We propose to do both by revamping our financial pay-for-quality (P4Q) model to achieve these twin goals. By having a diverse set of measures that evaluates different segments of our Medicaid population such as children/adults/LTSS/women of childbearing age/etc.; by being intentional in partnering with our MCOs to create some alignment among Medicare/Commercial and Medicaid product lines and increases alignment with MCOs P4Q efforts with their providers; by increasing the amounts that are at risk in the P4Q model; and by rewarding both improvement and excellence in the P4Q model; we expect the sum of these efforts to show cost savings and improved population health statistics. Results of the adjusted P4Q model will be posted on the Med-QUEST website. Some of the measures we will focus on are:
  - Improving the overall health of members with diabetes mellitus;
  - Improving the overall health of our keiki by boosting immunization and well-child visit rates;
  - Improving the overall health of our mothers by improving prenatal and postpartum

visit rates;
    - Improving the overall health of members that suffer from mental illness; and
    - Improving the delivery of care in the inpatient setting.
- **Hawaii will deliver improved quality of care and access to care in the community by offering cutting edge screening tools and collaborating with partner agencies (relates to goal #3)**: Hawaii agrees with current literature that says focusing on preventative care will lead to a healthier Medicaid population at a lower overall spend. Altering our delivery system to enhance and promote cutting edge screening tools is one way to achieve this focus. Policy changes including expanding the use of One Key Question, expanding access to Long Acting Reversible Contraceptives (LARC) for our maternity population, and expanding the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services will serve to enhance the screening available and boost preventative care for Hawaii's Medicaid individuals. Access to Medicaid can be disrupted by certain events that force a loss of Medicaid eligibility, which include being admitted to the Hawaii State Hospital and becoming incarcerated in the prison system. And often times when the individual returns to normal society, the Medicaid eligibility gaps and puts the individual at risk for returning to some form of incarceration. Hawaii sees collaborating with partner agencies as an effective way to prevent any disruption of coverage once the individual returns to normal society and is again eligible for Medicaid. Some of the opportunities are working with the Department of Health/Adult Mental Health Division to smooth member transition in and out of the State Hospital, and working with Department of Public safety to smooth member transition in and out of the prison system. Hawaii sees working with Department of Health/Alcohol & Drug Abuse Division to train providers on conducting SBIRT as fulfilling the twin goals of improving preventative care and collaborating with partner agencies.
- **Hawaii will improve coordination of care, increase appropriate utilization of the health care system and decrease administrative burdens of providers, by encouraging the development of PCMHs and implementing value-based purchasing (VBP) reimbursement methodologies to support PCMHs (relates to goal #4)**: Hawaii concurs with the many studies that show that coordinated and supportive care delivery leads to high quality medical care and continued independence for the individual. Hawaii also recognizes that non-clinical support services are often needed to assist individuals with complying with clinical guidelines. Often times these support services are not directly reimbursed in the current healthcare financing models. So Hawaii is strongly encouraging our MCOs to use VBP models, both with and without the use PCMHs, to change the delivery system in favor of the individual. are an integral piece in making the PCMH model viable to the provider community. By paying not on a per service basis but on a per patient basis, and combining this with additional reimbursement when specific quality metrics are met, VBP will free up the physicians to practice the medicine they were trained for and allow for funds to be redirected to surround the individual with support staff that will ensure that clinical guidelines are followed. All this to the benefit of the individual, increasing their wellness and independence.
- **Hawaii will continue to reduce the percentage of beneficiaries in institutional settings by initially offering the choice of HCBS to individuals with hospitalization discharges, continuing to support beneficiaries' ability to move out of an institutional setting, and expanding the provision of some HCBS to an 'at risk' population (relates to goal #5)**:

Hawaii recognizes that when an individual needing LTSS has choice and control over how care is delivered and in what setting, then the individual is more satisfied and can lead a more independent life. To that end Hawaii will continue to initially offer the choice of HCBS to individuals being discharged from acute care hospitalization and to those declining in the community. Also, Hawaii will continue to support individuals' ability and choice to transition out of an institution and into a home and community based setting. Finally, there are many individuals that are currently living independently but are one incident away from needing LTSS. To slow or prevent the progression to institutional level of care for those individuals that are not yet receiving LTSS and to further support their independent lifestyle, Hawaii will expand the provision of some HCBS to a population at risk of deteriorating to institutional level of care (called "at risk" population). These individuals will be determined 'at risk' by scoring at a lower acuity than those determined institutional level of care, using the same assessment tool. Metrics documenting the results of these efforts will be posted on the Med-QUEST website.

Population Groups Impacted

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

- Pregnant women in families whose income is up to 185 percent of the FPL.
- Infants and children in families whose income is up to 300 percent of the FPL.
- Adults whose income is up to 133 percent of the FPL.
- Individuals 65 years or older receiving long-term services and supports (LTSS).
- Individuals with a disability of any age receiving LTSS.
- Uninsured individuals in general.

Outcome Measures

Current Measures

Hawaii has identified a number of outcome measures that we will use to evaluate the demonstration. These measures include the following:

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

- Frequency of Ongoing Prenatal Care (FPC): Increase performance on the state aggregate HEDIS Frequency of Ongoing Prenatal Care measure to meet/exceed the Medicaid 75th percentile.

- Timeliness of Prenatal Care (PPC): Increase performance on the state aggregate HEDIS Timeliness of Prenatal Care (Total) measure to meet/exceed the Medicaid 75th percentile.

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

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

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services: Increase participant ratio on the state aggregate Participant Ratio to meet/exceed 80 percent for children of all ages.

- Comprehensive Diabetes Care (CDC):

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

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

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<8) to meet/exceed below the HEDIS 75th percentile.

    - Increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<140/90) to meet/exceed the 2010 HEDIS 75th percentile.

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

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

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

- Reduce the percent of asthma related Emergency Department visits for Medicaid beneficiaries ages 0 to 20: Decrease the percent of asthma related Emergency Department visits to less than or equal to 6%.

- Follow-Up After Hospitalization for Mental Illness (FUH): Increase performance on the state aggregate HEDIS Follow-Up After Hospitalization for Mental Illness measure to meet/exceed the HEDIS 75th percentile.

- Medication Reconciliation Post-Discharge (MRP): Increase performance on the state aggregate Medication Reconciliation Post-Discharge measure to meet/exceed the HEDIS 75th percentile.

- Plan All-Cause Readmission (PCR): Improve performance on the State aggregate HEDIS acute readmissions for any diagnosis within 30-days to meet/exceed HEDIS 75th percentile.

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

- Well-Child Visits in the First 15 Months of Life (W15): Improve performance on the State aggregate HEDIS Well-Child Visits in the First 15 Months of Life to meet/exceed HEDIS 75th percentile.

- Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life (W34): Improve performance on the State aggregate HEDIS Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life to meet/exceed HEDIS 75th percentile.

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

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

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

- Providing Quality Care: Prior Authorization Process: Increase performance on the State aggregate Provider Survey measure 'Providing Quality Care: Prior Authorization Process' to 75% of providers are either neutral or positive impact.

- Providing Quality Care: Formulary: Increase performance on the State aggregate Provider Survey measure 'Providing Quality Care: Formulary' to 75% of providers are either neutral or positive impact.

- Specialists: Adequacy of Specialists: Increase performance on the State aggregate Provider Survey measure 'Specialists: Adequacy of Specialists' to 70% of providers are either neutral or positive impact.

- Specialists: Adequacy of Behavioral Health Specialists: Increase performance on the State aggregate Provider Survey measure 'Specialists: Adequacy of Behavioral Health Specialists' to 50% of providers are either neutral or positive impact.

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

Future Measures

All measures will be evaluated each year against national lists (CMS Child and Adult Core Set measures) and updates will be made as necessary. This evaluation will also include determining

measures that may need to be phased out (nearly all health plans nearing 75th percentile target) or phased in (new measures that might be more appropriate or effective), and to address changing MQD strategic initiatives.

Hawaii has identified a number of initiatives and measures that we will not be used to evaluate the current demonstration evaluation, but will be initiated during this demonstration to inform and progress toward the subsequent demonstration evaluation.

- Decreasing the percentage of discharges from the Hawaii State Hospital (HSH) and/or Department of Public Safety (DPS) that have Medicaid ineligible days post-discharge.
- Expanding the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in both the physician office and hospital settings.
- Expanding the use of One Key Question during the delivery of professional maternity services.
- Expanding access to Long Acting Reversible Contraceptives (LARC) for our maternity population by requiring separate and distinct reimbursement in the inpatient setting for LARC devices.
- Expanding the provision of Intensive Behavioral Therapy (IBT) services to populations with an Autism Spectrum Disorder (ABA) diagnosis.
- Expanding the settings that nursing services can be delivered to Medicaid clients, to include the Department of Education (DOE) school system.
- Expanding the use of tele-medicine.

Evaluation Design

Management and Coordination of Evaluation

Organization Conducting the Evaluation

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

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

- Research Officer- primary lead
- MQD Medical Director
- Home & Family Access Program Manager

- Contract and Compliance Section Administrator
- Health Care Services Branch Administrator
- Finance Officer

Evaluation Timeline

Summary of Timeline for Annual Quality Activities

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

Summary of Timeline for Biennial Quality Activities

Time Frame	Activity
April	Mail survey to Medicaid health plan providers
June	Close survey to Medicaid health plan providers
October	EQRO releases final provider survey results to MQD
December	Release the provider survey for public reporting

Summary of Timeline for Annual Deliverables

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

Summary of Timeline for Compilation of Demonstration Evaluation Report

July to November 2013	Analyze data from previous demonstration years

December 2017	Compile information into final demonstration evaluation report for demonstration ending December 31, 2018
August 2018	Submit final demonstration evaluation report to CMS for demonstration ending December 31, 2018
120 days prior to expiration of demonstration	Submit draft evaluation report

Process

Data Sources

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

- Administrative data (i.e., claims; encounters, enrollment in Hawaii Prepaid Medical Management Information System (HPMMIS), health plan reports, etc.);
- Electronic Health Records; and
- Member and provider feedback (EQRO-conducted surveys, grievances, Ombudsman reports).

Measures were chosen for the evaluation design by focusing on the QUEST Integration goals and objectives established as part of Hawaii's Special Terms and Conditions. In addition, the evaluation design includes existing measures reviewing a range of ages, populations and programs in order to provide a broad representation of QUEST Integration. Existing reports include the following:

- Quantitative, performance measure reports using administrative and electronic health records, include the following:
  - Healthcare Effectiveness Data and Information Set (HEDIS®);
  - Health plan reporting on LTSS utilization;
  - Electronic Health Record reviews;
  - Performance Improvement Project (PIP) findings report;
  - Enrollment reports; and
  - Financial reports.
- Qualitative reports using surveys, and other forms of self-reported data including:
  - Consumer Assessment of Health Plans Study (CAHPS®);
  - Provider Survey; and
  - Grievance reports.

Given the length of this Demonstration, sources for the data and the entity responsible for calculation may change; the information provided in the measurement table reflects current data sources and entities responsible for calculation.

Encounter data will be used as input data to perform provider-specific HEDIS reporting. Determining the completeness and accuracy of our encounter data is an evolving process that is currently driven by the new rules around 42 CFR §438.242 Health information systems & 42 CFR §438.818 Enrollee encounter data. Steps toward complying with these regulations include:

- Revisiting and redesigning the monthly encounter review, validation, and reconciliation process, with the goal of obtaining a complete and accurate representation of the services provided to the enrollees under the contract between MQD and the health plans

- Working with our health plans to reconcile and resubmit ongoing differences in encounter submissions
- Working with our actuaries to catalog encounter differences between MMIS and actuary files directly from our health plans
- Engaging our EQRO in conducting an Encounter Data Validation study in 2018

Integration of the State Quality Improvement Strategy
MQD's goal continues to ensure that our beneficiaries receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and transparent outcomes. We have adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable. MQD identified an initial set of ambulatory care measures based on this framework. MQD reviews and updates HEDIS measures annually that the health plans report to us.

MQD continues to update its quality oversight of home and community based services, which will affect mostly our QI health plans, the DDID program, and the Going Home Plus program. MQD uses quality grid based upon the HCSB Quality Framework for monitoring the DDID program. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. We have also updated behavioral health monitoring and quality improvement.

Our quality approach aspires to 1) have collaborative partnerships among the MQD, health plans, and state departments; 2) advance the patient-centered medical home; 3) increase transparency- including making information (such as quality measures) readily available to the public; 4) being data driven; and 5) use quality-based purchasing- including exploring a framework and process for financial and non-financial incentives.

MQD updated its quality strategy and submitted a draft version to CMS on December 18, 2014. MQD received feedback from CMS on July 16, 2015. An updated version of the quality strategy was submitted to CMS on September 30, 2015. MQD received final approval for this quality strategy on July 8, 2016. The revised quality strategy is consistent with the previously approved 2010 version.

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

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

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

related to the measure calculation.

MQD will review its analysis plan to isolate the effects of the QUEST Integration demonstration from other initiatives in Hawaii. MQD will first complete a cataloguing of the various related initiatives occurring in Hawaii. MQD will contact various provider associations and other State agencies to identify, at a minimum, initiatives with potential to affect Medicaid populations in Hawaii. MQD will collect the following information about the other initiatives to help determine overlap with QUEST Integration initiatives:

- Member and provider populations impacted;
- Coverage by location/region;
- Available performance measure data; and
- Start dates and current stage of the initiative.

The evaluation will include baseline and cross-year comparisons. The first year of the QUEST Integration demonstration, calendar year (CY) 2014, will serve as a baseline year. If no major overlapping initiatives are identified for a particular measure and statistical improvement is identified when compared to prior Hawaii demonstration evaluations, or first year baseline rates, evaluation results will indicate the improvement is due to the effect of QUEST Integration. Examples include assessing outcomes related to the health plans value-based purchasing reimbursement and improved emphasis on positive health outcomes for individuals in QUEST Integration. See Figure 1 for examples of measurement of positive health outcomes.

When substantial overlapping initiatives are identified, MQD will determine whether control comparisons are possible. Since QUEST Integration is a statewide demonstration and Hawaii has been utilizing managed care since 1994, control groups may not be accessible.

If there is overlap with other initiatives within the state, MQD will determine whether the populations and areas impacted are distinct enough to warrant comparison between available performance measure results in the other initiatives, compared to the related QUEST Integration initiative. One example is the various initiatives regarding health homes and person centered medical home initiatives (PCMH). The MQD will be proposing implementation of a health home initiative outside of managed care. These health homes will be separate from the PCMH initiatives that the health plans are implementing as part of their value-based purchasing programs. If these settings and consumers served are distinctly different enough from the PCMH related initiatives in the State, it may be possible to compare rates of improvement, to help determine the effect of the health home initiative.

Additional analysis will we conducted on a plan specific basis to include longitudinal analysis on a single plan as well as single year comparisons across all plans, among other comparisons. Year-over-year trends will be noted and compared across plans. Differences in performance between plans will be used to inform evaluation objectives and possible conclusions. Root causes of positive differences will be determined as a best practice and then disseminated to other plans for cross-plan improvement.

Provider level analysis will also be conducted on selected measures. Hospital and FQHCs are two of the providers types that may be measured, with comparisons across different providers within the provider type in the same year, as well as longitudinal comparisons by provider.

Level of Analysis

The following table (Figure 1) includes design specifications for the Outcome Measures that are based upon the QUEST Integration goals, objectives, and hypotheses. The table includes the following elements:

- Goals and Objectives;
- Hypotheses;
- Measurement;
- Outcome;
- Type of measurement;
- Measurement crosswalk, if applicable;
- Source of data;
- Population/Stratifications;
- Comparison for determining effectiveness of the demonstration; and
- Evaluation frequency.

Table 1: QUEST Integration Enrollment

Eligibility Categories	**March 2017**
Children	116,915
CHIP	24,511
Current & Former Foster Care	6,047
Pregnant Women & Parent/Caretakers	39,502
Low Income Adults	120,095
Medical Assistance ABD	49,176
State Funded ABD	2,339
Others	89
Total	**358,674**
Health Plan	
AlohaCare Non-ABD	65,946
HMSA Non-ABD	160,355
Kaiser Non-ABD	29,425
‘Ohana Non-ABD	23,745
UnitedHealthcare Non-ABD	24,761
AlohaCare ABD	4,581
HMSA ABD	7,516
Kaiser ABD	1,490
‘Ohana ABD	19,722
UnitedHealthcare ABD	21,133
Total	**358,674**
Island	
Oahu	217,465
Kauai	21,410

Eligibility Categories	**March 2017**
Hawaii	74,985
Maui	40,145
Molokai	3,821
Lanai	848
Total	**358,674**

Figure 1

Measurement Table

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
Goal #1: Improve the health care status of the member population **Goal #2:** Continue the predictable and slower rate of expenditure growth associated with managed care.	**Hypothesis:** Hawaii will both improve health care quality and reduce costs, by holding MCOs to outcomes and performance measures, and adjusting the financial pay-for-quality (P4Q) model to reward both improvement and excellence.	Effectiveness of Care						
		Childhood Immunization (CIS) Combination 3	NCQA Quality Compass Medicaid 75th ile	• P4P • Quantitative	• NQF 0038 • CMS Child Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Children who turn two (2) years of age • Medicaid • CHIP	Annually
		Frequency of Ongoing Prenatal Care (FPC)	NCQA Quality Compass Medicaid 75th ile	• P4P (up thru 2014) • Quantitative	• NQF 1391 • CMS Child Core Set • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Pregnant Women • CHIP	Annually
		Timeliness of Prenatal Care (PPC)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quality auto-assign • PIP • Quantitative	• NQF 1517 • CMS Child Core Set • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Pregnant Women • CHIP	Annually
		Postpartum Care (PPC)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • PIP • Quantitative	• NQF 1517 • CMS Child Core Set • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from	• Pregnant Women • CHIP	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
						encounter data		
		Breast Cancer Screening (BCS)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0031 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Women 50 to 74 years • Medicaid	Annually
		Cervical Cancer Screening (CCS)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0032 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• Women 21 to 64 years • Medicaid	Annually
		Early and Periodic Screening, Diagnostic and Treatment (EPSDT) participant ratio	80 percent for children of all ages	• Quality auto-assign • Quantitative	• CMS 416	ESPDT reports from health plan	• Children under 21 years of age	Annually
		Comprehensive Diabetes Care (5 measures)-CDC						
		CDC- HgA1c testing	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0057 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from	• 18 to 75 years • Medicaid	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
						encounter data		
		CDC- HgA1c poor control (>9)	NCQA Quality Compass Medicaid 25th ile	• Quantitative	• NQF 0059 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 to 75 years • Medicaid	Annually
		CDC- HgA1c control (<8)	NCQA Quality Compass Medicaid 75th ile	• P4P • Quantitative	• NQF 0575	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 to 75 years • Medicaid	Annually
		CDC- Blood Pressure Control (<140/90)	NCQA Quality Compass Medicaid 75th ile	• P4P (up thru 2014) • Quantitative	• NQF 0061 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 to 75 years • Medicaid	Annually
		CDC- Retinal screening	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quantitative	• NQF 0055	• HEDIS reports from health plan • HEDIS reports from	• 18 to 75 years • Medicaid	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
						encounter data		
		Controlling High Blood Pressure (CBP)	NCQA Quality Compass Medicaid 75th ile	• P4P (up thru 2014) • Quantitative	• NQF 0018 • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 to 85 years • Medicaid	Annually
		Use of appropriate medications for people with asthma (ASM)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0036	• HEDIS reports from health plan • HEDIS reports from encounter data	• 5 to 67 years • Medicaid • CHIP	Annually
		Asthma related Emergency Department visits	Decrease the percent of asthma related Emergency Department visits to less than or equal to 6%.	• Quantitative		• MQD Data Warehouse	• 0 to 20 years • Medicaid • CHIP	Annually
		Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quality auto-assign • Quantitative	• NQF 0576 • CMS Child Core Set • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 6 years and older • Medicaid • CHIP	Annually

Commented [FJ1]: Addresses asthma measure questions in 4.f of 3/9/2017 letter.

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
		Medication Reconciliation Post-Discharge (MRP)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF 0554	• HEDIS reports from health plan • HEDIS reports from encounter data	• >=18 years • Medicaid	Annually
		Utilization						
		Plan All-Cause Readmission (PCR)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quantitative	• NQF TBD • CMS Adult Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 18 years and older • Medicaid • CHIP	Annually
		Emergency department visits (AMB) per 1000	NCQA Quality Compass Medicaid 10th ile	• Quantitative		• HEDIS reports from health plan • HEDIS reports from encounter data	• All ages • Medicaid • CHIP	Annually
		Well-Child Visits in the First 15 Months of Life (W15)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quantitative	• NQF 1392 • CMS Child Core Set	• HEDIS reports from health plan • HEDIS reports from	• 0 to 15 months • Medicaid	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
						encounter data		
		Well-Child Visits in the 3rd, 4th, 5th & 6th Years of Life (W34)	NCQA Quality Compass Medicaid 75th ile	• P4P (2015 forward) • Quantitative	• NQF 1516 • CMS Child Core Set	• HEDIS reports from health plan • HEDIS reports from encounter data	• 3 to 6 years • Medicaid	Annually
Goal #3: Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations, with a focus on preventative care.	**Hypothesis:** Hawaii will deliver improved quality of care and access to care in the community by offering cutting edge screening tools and collaborating with partner agencies.	Access to Care						
		The percentage of discharges from the Hawaii State Hospital (HSH) and/or Department of Public Safety (DPS) that have Medicaid ineligible days post-discharge	Decreasing the percentage of discharges with post-discharge gaps of eligibility, year over year	• Quantitative		• Discharge files from HSH & DPS, and eligibility records from MMIS system	• 18 years and older • Medicaid	Annually
		Percent of identified hospital train-the-trainer staff that have been trained on SBIRT screenings	Training of at least 50% of identified train-the-trainer staff on SBIRT screenings	• Quantitative		• Training data from ADAD training partners, and hospital train-the-trainer lists	• Hospital train-the-trainer staff	Annually
		The percentage of Long Acting	Increasing the percentage of LARC devices	• Quantitative		• Encounter data from	• Women of child bearing age • Medicaid	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
		Reversible Contraceptives (LARC) delivered in the inpatient setting as a percentage of all LARC devices delivered	delivered in the inpatient setting by 50%			health plans	• CHIP	
Goal #4: Improve care coordination and decrease provider administrative burden by establishing a Patient Centered Medical Home (PCMH).	**Hypothesis:** Hawaii will improve coordination of care, increase appropriate utilization of the health care system and decrease administrative burdens of providers, by encouraging the development of PCMHs and implementing value-based purchasing (VBP) reimbursement methodologies to support PCMHs.	Access to Care						
		Percent of physicians that are a part of a PCMH	Increase the percent of physicians that are a part of a PCMH by 20% year over year	• Quantitative		• Utilization report from health plans	• Physicians	Annually
		Percent of PCMHs that are reimbursed in part using VBP methodology	Increase the percent of PCMHs that are reimbursed in part using VBP methodology by 20% year over year	• Quantitative		• Utilization report from health plans	• Physicians • PCMHs	Annually
		Providing quality care: Prior authorization process	75% or more of providers that respond to survey are either neutral or positive impact	• Qualitative		• Provider survey from EQRO	• All ages • Medicaid • CHIP	Biennially
		Providing quality care: Formulary	75% or more of providers that respond to	• Qualitative		• Provider survey	• All ages • Medicaid	Biennially

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
			survey are either neutral or positive impact			from EQRO	• CHIP	
		Specialists: Adequacy of Specialists	70% or more of providers that respond to survey are either neutral or positive impact	• Qualitative		• Provider survey from EQRO	• All ages • Medicaid • CHIP	Biennially
		Specialists: Adequacy of Behavioral Health Specialists	50% or more of providers that respond to survey are either neutral or positive impact	• Qualitative		• Provider survey from EQRO	• All ages • Medicaid • CHIP	Biennially
Goal #5: Expand access to home and community based services (HCBS) and allow LTSS individuals to have a choice between institutional services and HCBS.	**Hypotheses:** Hawaii will continue to reduce the percentage of beneficiaries in institutional settings by initially offering the choice of HCBS to individuals with hospitalization discharges, continuing to support beneficiaries' ability to move out of an institutional setting, and expanding the provision of some HCBS to an 'at risk' population.	Utilization						
		Members that receive long-term services and supports (LTSS) in a home and community based (HCBS) setting instead of an institutional setting	Increase the percent of individuals receiving LTSS in a HCBS setting by at least 5% over the demonstration	• Quantitative		• Utilization report from health plans	• All ages • Medicaid • CHIP	Quarterly
		Dollars spent on HCBS services as a percent of total dollars spent	Increase the percent of dollars spent on HCBS services year over year	• Quantitative		• Encounter data from health plans	• All ages • Medicaid • CHIP • Members receiving LTSS	Annually

Figure 1

Goals and Objectives	Evaluation Questions	Measurement	Outcome	Type of Measurement	Measurement Crosswalk, if applicable	Source of Data	Population/ Stratification	Frequency
		on LTSS services						
		Plan All-Cause Readmission (PCR)	NCQA Quality Compass Medicaid 75th ile	• Quantitative	• NQF TBD • CMS Adult Core Set	• HEDIS reports from encounter data	• 18 years and older • Medicaid • CHIP • Members receiving LTSS	Annually

Attachment C

QUEST Integration
Quality Strategy

Submitted by the State of Hawaii, Department of Human Services,
Med-QUEST Division

December 18, 2014
Revised July 7, 2016

HAWAII QUEST INTEGRATION QUALITY STRATEGY 2015

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

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○ External Quality Review (EQR) activities and technical report ○

Clinical standards and guidelines ○ Performance measures

- State Standards and Contract Compliance ○ Access to

  Care ○ Structure and Operations

  ○ Quality Measurement and Improvement

- Monitoring and Evaluation ○ Monitoring and Quality

  Improvement Flow Process ○ Sources for Monitoring

  and Quality Improvement

  MCO monitoring reports, EQRO technical report, Compliance audit report, CAHPS survey results/report, Provider survey results/report,
  HEDIS results, PIP reports, MCO consumer guide/'report card', Encounter data, Enrollment/Disenrollment data ○

  Non-duplication Strategy

  ○ HCBS Monitoring and Quality Improvement

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III. IMPROVEMENT AND INTERVENTIONS

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I. QUALITY STRATEGY INTRODUCTION AND OVERVIEW

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

The Quality Strategy is comprehensive, systematic, and continuous. MQD will amend the Quality Strategy as necessary to support the continuous quality improvement process, to reflect changes from legislated state, federal or other regulatory authority, and to respond to any significant changes in membership or provider demographic.

The purposes of the strategy include:

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

MISSION

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

The MQD will ensure that its beneficiaries receive high quality care by collaborating with managed care plans, providers, and the community to seek innovative ways to promote health, and provide effective oversight of managed care organizations (MCOs) and other contracted entities to promote accountability and transparency for improving health outcomes. MQD has adapted the Institute of Medicine's (IOM) framework of quality and strive for our beneficiaries to receive care that is:

- *Safe* – prevents medical errors and minimizes risk of patient harm
- *Effective* – evidence-based services consistently delivered to the population known to benefit from them
- *Efficient* – cost – effective utilization that avoids waste, including waste of equipment, supplies, ideas, and energy
- *Patient-centered* – respectful of and responsive to an individual's preferences, needs, and values
- *Timely* – medically appropriate access to care and healthcare decisions with minimal delay
- *Equitable* – without disparities based on gender, race, ethnicity, geography, and socioeconomic status.

This framework can be summarized in the Three-Part Aim of "Better Health, Better Care, Lower costs." In addition, MQD recognizes that much of "health" is beyond the clinic walls related to the social determinants of health. MQD is also focused on working with the larger community in improving health by focusing on healthy communities and healthy families.

GUIDING PRINCIPLES

The MQD's quality approach aspires to the following:

Collaborative Partnerships

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

Patient-Centered Medical Home

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

Transparency

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

Data Driven

MQD's Data Warehouse allows MQD to perform analysis on encounter/claims data related to eligibility and enrollment data. This information allows specific measurement and analysis. In addition, MQD receives data compilation from external

sources to include but not limited to its health plans, External Quality Review Organization (EQRO), and actuaries.

Value/Quality Based Purchasing

The MQD incentivizes the provision of care that improves health outcomes. MQD uses non-financial incentives that include MCO report cards, Dashboards, and public reporting. Financial incentives include increased payment to MCOs for high quality care. In addition, MQD uses quality-based auto-assign algorithms to health plan enrollment.

HISTORY OF MANAGED CARE

Hawaii's statewide comprehensive 1115(a) demonstration waiver began on August 1, 1994 with the QUEST program, that converted medical assistance coverage to people younger than 65 and not blind and/or disabled from fee-for-service to managed care. Beginning February 1, 2009, MQD converted medical assistance coverage for the population age 65 or older and disabled of all ages from fee-for-service (FFS) to managed care through the QUEST Expanded Access (QExA) program. Adults and children eligible for Medicaid received their healthcare through QUEST and QExA. Children and pregnant women eligible for the State Children's Health Insurance Program (SCHIP) were also enrolled in the QUEST program and receive the same benefits as QUEST members.

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

On January 1, 2015, the MQD combined its QUEST and QExA programs into one program called QUEST Integration (QI). The QUEST Integration program has five (5) health plans. The goals for the QUEST Integration program are:

- Improve the health care status of the member population;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Align the demonstration with Affordable Care Act;
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCP);

- Expand access to home and community based services (HCBS) and allow individuals to have a choice between institutional services and HCBS; • Maintain a managed care delivery system that assures access to high-quality, cost-effective care that is provided, whenever possible, in the members' community, for all covered populations;
- Establish contractual accountability among the contracted health plans and health care providers; • Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

The **rationale for the implementation of a managed care** is improved access, quality, and cost-efficiency. Using managed care systems improves the care delivered to Medicaid beneficiaries by improving coordination of care, consistent application of managed care principles, strong quality assurance programs, partnership with providers, emphasis on the medical home, and achieving cost-effective service delivery.

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

QUALITY STRATEGY DEVELOPMENT

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

EQRO Input

The annual technical report provides detailed information about MCO performance with respect to quality, access, and timeliness of care and services, which guides our

Quality Strategy. Specifically, we receive information on regulatory compliance, a set of validated Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and performance improvement projects (PIPs). The EQRO also administers and reports on provider satisfaction surveys as well as the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of beneficiary satisfaction, both of which inform the quality strategy. Furthermore, the EQRO assists MQD in the compiling of an MCO comparison guide of various performance measures. Importantly, the EQRO reviews and provides input on the Quality Strategy.

Beneficiary and Provider Input

Beneficiary and provider input most directly occur through the results of beneficiary and provider surveys that the EQRO administers and reports. In addition, MCOs submit information on Member Grievance and Appeals Reports as well as Provider Complaints Reports and guides our Quality Strategy. Finally, MQD conducts public forums to gather input from beneficiaries, providers, and other stakeholders.

Partner Government Agency and Stakeholder Input

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

Public Input

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

QUALITY STRATEGY IMPLEMENTATION

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

Quality Flow Process

The Health Care Services Branch (HCSB) at MQD receives and reviews all monitoring and quality reports from the MCOs, the DD/ID waiver, the Community Care Services (CCS) program (MQD's behavioral health program), the State of Hawaii Organ and Tissue Transplant (SHOTT) program, and the EQRO. The HCSB uses standardized reporting and review tools for all MCOs and programs to allow for improved oversight, plan-to-plan comparisons, and trending over time.

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

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

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

Figure 1: Quality Flow Process Diagram:

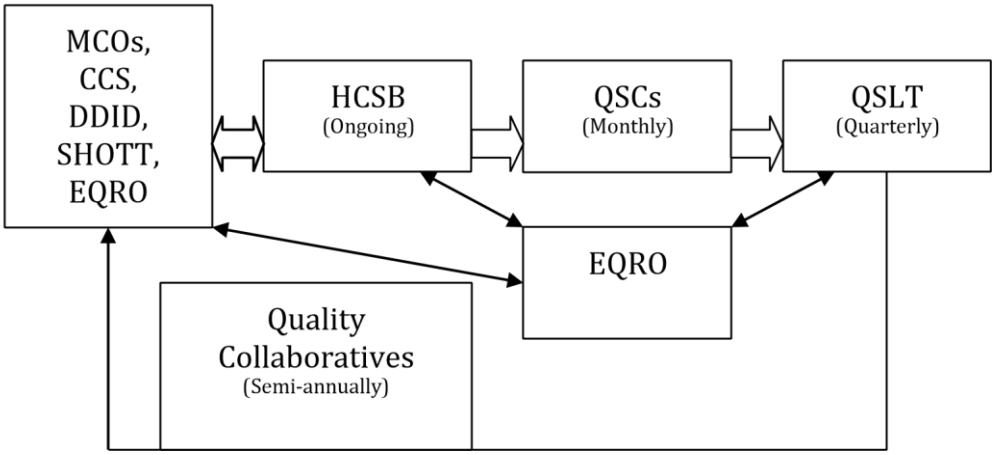

Table 1: Summary of the Quality Strategy Oversight:

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

Table 2: MQD Quality Flow Process Calendar of Events

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

Legend:

QSC	Quality Strategy Committee	QLST	Quality Strategy Leadership Team

GOALS AND OBJECTIVES

The MQD is focused on ensuring that its beneficiaries receive high quality care that is safe, effective, efficient, patient-centered, timely, and equitable, by providing effective oversight of health plans and other contracted entities to promote accountability and transparency for improving health outcomes. The chart below identifies the Medicaid populations that each goal in the quality strategy addresses.

Table 3: Performance measures by Medicaid populations

Goal	Children under 19 years of age	Former foster care children under 26 years of age	Pregnant Women	Parent or Caretaker Relatives	Adults (19 to 64 years of age)	Aged, Blind, or with a Disability (includes dual eligible individuals)

Improve preventative care for women and children	X	X	X	X	X	X
Improve healthcare for individuals who have chronic illnesses	X	X	X	X	X	X
Improve beneficiary satisfaction with health plan services	X	X	X	X	X	X
Improve costefficiency of health plan services	X	X	X	X	X	X
Expand access to Home and Community Based Service (HCBS) and assure that individuals have a choice of institutional and HCBS	X	X	X	X	X	X
Improve access to community living and the opportunity to receive services in the						X
Goal	Children under 19 years of age	Former foster care children under 26 years of age	Pregnant Women	Parent or Caretaker Relatives	Adults (19 to 64 years of age)	Aged, Blind, or with a Disability (includes dual eligible individuals)
most integrated setting appropriate for individuals receiving HCBS						

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

- Childhood Immunizations: For calendar year 2015 (HEDIS 2016) data, increase performance on the state aggregate HEDIS Childhood Immunization (combination 2) measure to meet/exceed the 2015 Medicaid 75th percentile.
  - Frequency of Ongoing Prenatal Care: For calendar year 2015 (HEDIS 2016) data, increase performance on the state aggregate HEDIS Frequency of Ongoing Prenatal Care measure to meet/exceed the 2015 Medicaid 75th percentile.
- Timeliness of Prenatal Care: For calendar year 2015 (HEDIS 2016) data, increase performance on the state aggregate HEDIS Timeliness of Prenatal Care measure to meet/exceed the 2015 Medicaid 75th percentile.
- Breast Cancer Screening: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Breast Cancer Screening measure to meet/exceed the 2015 Medicaid 75th percentile.
- Cervical Cancer Screening: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Cervical Cancer Screening measure to meet/exceed the 2015 Medicaid 75th percentile. • Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services: For federal fiscal year 15, increase participant ratio on the state aggregate Participant Ratio to meet/exceed 80 percent for children of all ages.

Goal 2: Improve healthcare for individuals who have chronic illnesses
Objectives:

- Comprehensive Diabetes Care Measures:
  ○ For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c testing to meet/exceed the 2015 HEDIS 75th percentile. ○ For calendar year 2015 (HEDIS 2016), improve performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (>9) to meet/exceed the 2015 HEDIS 50th percentile. ○ For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Diabetes Care Measure for A1c control (<8) to meet/exceed below the 2015 HEDIS 50th percentile. ○ For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Diabetes Care Measure for blood pressure control (<140/90) to meet/exceed the 2015 HEDIS 75th percentile. ○ For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS

Diabetes Care Measure for eye exams to meet/exceed the 2015 HEDIS 75th percentile.

- Blood Pressure Control in the General Population: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Blood Pressure Control (BP<140/90) measure to meet/exceed the 2015 HEDIS 75th percentile.
- Appropriate Medications in Asthma: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Asthma (using correct medications for people with asthma) measure to meet/exceed the 2015 HEDIS 75th percentile.
- Reduce the percent of asthma related Emergency Department visits for Medicaid beneficiaries ages 0 to 20: For calendar year 2015, decrease the percent of asthma related Emergency Department visits to less than or equal to 6%.

Goal 3: Improve beneficiary satisfaction with health plan services Objectives:

- For calendar year 2015, increase performance on the state aggregate CAHPS measure 'Getting Needed Care' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile.
- For calendar year 2015, increase performance on the state aggregate CAHPS measure 'Rating of Health Plan' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile.
- For calendar year 2015, increase performance on the state aggregate CAHPS measure 'How well doctors communicate' measure to meet/exceed CAHPS 2015 Child Medicaid 75th percentile.

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

- Monitor Plan All Cause Readmission annually to identify if improving from baseline that was established in calendar year 2013. MCOs will perform Performance Improvement Programs (PIPs) on Plan All Cause Readmission to improve this measure.
- Follow-Up After Hospitalization for Mental Illness: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate HEDIS Follow-Up After Hospitalization for Mental Illness measure to meet/exceed the 2015 HEDIS 75th percentile.
- Medication Reconciliation Post-Discharge: For calendar year 2015 (HEDIS 2016), increase performance on the state aggregate Medication Reconciliation Post Discharge measure to meet/exceed the 2015 HEDIS 75th percentile.

- Improve performance on the state aggregate for calendar year 2015 (HEDIS 2016) Emergency Department Visits/1000 rate to meet/fall below the HEDIS 2015 10th percentile.

Goal 5: Expand access to Home and Community Based Service (HCBS) and assure that individuals have a choice of institutional and HCBS Objectives:

- Increase the proportion of beneficiaries receiving HCBS instead of institutional-based long-term care services by 5% over the waiver demonstration (to 70%).

Goal 6: Improve access to community living and the opportunity to receive services in the most integrated setting appropriate for individuals receiving HCBS Objectives:

- Assure that settings are integrated and support full access to the greater community by each setting meeting/exceeding 85% compliance with the HCBS final rules.
- Optimize individuals' initiative, autonomy and independence in making life choices (including daily activities, physical environment, and with whom to interact) by beneficiaries confirming their setting meets/exceeds 85% compliance with the HCBS final rules.

In the upcoming year, additional goals focused on the Integration of Behavioral Health, and supporting Healthy Communities/Healthy Families will be developed.

II. ASSESSMENT

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

QUALITY AND APPROPRIATENESS OF CARE

Race, Ethnicity, and Primary Language

Consistent with Federal Regulations, the procedure for MQD obtaining data and communicating data to MCOs include the following: The eligibility workers at MQD, while processing the application and determining eligibility, obtain information about the beneficiary's race, ethnicity, and primary language. Either the eligibility worker or the applicant (through their Medicaid application) enters primary language (both

verbal and written) information into the Department of Human Services Kau'hale OnLine Eligibility Assistance (KOLEA) eligibility system. The information is transferred monthly to the MCOs through the health plan enrollment file (834 file). Any changes are updated and transferred to the MCOs daily via the 834 file format as well. The procedure is the same for beneficiaries receiving Supplemental Security Income.

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

Table 4: Primary Language Codes

Languages Obtained			
AR	Arabic	MA	Malay
AM	Aramaic	ML	Maltese
BE	Bengali	MO	Maori
BI	Bisayan	MR	Marquesan
BU	Bulgarian	MS	Marshallese
CE	Cebuano	MK	Mon-Khmer
CH	Chamorro	NA	Navaho
CU	Chuukese	NO	Norwegian
CZ	Czech	OA	Other Asian
DA	Danish	OI	Other Indo-European
DU	Dutch	ON	Other North American Indian
ES	Estonian	PW	Paiwan
FJ	Fijian	PP	Papuan
FN	Finnish	PE	Persian
FM	Formosan	PO	Pohnpeian
FR	French	PL	Polish
FC	French Creole	PR	Portuguese

GE	German	RA	Rapanui
GR	Greek	RO	Romanian
GU	Gujarathi	RU	Russian
HE	Hebrew	SE	Serbian
HI	Hindi	SN	Sinhalese
HM	Hmong	SL	Slovak
HU	Hungarian	SV	Slovenian
IB	Ibo	SW	Swedish
IN	Indonesian	TA	Tahitian
IR	Irish	TH	Thai
IT	Italian	TU	Turkish
KR	Kru	VS	Visayan
KU	Kurdish	YI	Yiddish
LT	Latvian	YO	Yoruba
LI	Lithuanian		

External Quality Review (EQR) Activities and Report

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

The EQRO and each of its subcontractors must meet the competency and independence requirements detailed in 42 CFR 438.354. Competency of its staff is demonstrated by experience and knowledge of: a) the Medicaid program; b) managed care delivery systems; c) quality assessment and improvement methods; and d) research design and methodology, including statistical analysis. The EQRO must have sufficient resources and possess other clinical and nonclinical skills to perform EQR activities and to oversee the work of any subcontractors. To maintain its independence, the EQRO must be governed by a board whose members are not government employees; and must not: a) review an MCO if the EQRO or the MCO exerts control over the other as evidenced by stock ownership, stock options, voting trusts, common management, and contractual relationships; b) furnish health care

services to Medicaid recipients; c) perform Medicaid managed care program operations related to the oversight of the quality of the MCO on the State's behalf, except for the activities specified in 42CFR 438.358; or d) have a financial relationship with the MCO that it will review.

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

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

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

Clinical Standards and Guidelines

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

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

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

Performance Measures

The MQD has identified a set of performance measures and PIP topics that address a range of priority issues for Medicaid beneficiaries. The measures have been identified through a process of analysis and trending of data within the Medicaid population, from MCO reports, and from the EQR technical report. Beneficiary and provider input, through results of beneficiary and provider surveys as well as member grievance and provider complaint reports, also guides the selection of performance measures. Reports from regular meetings with partner agencies and stakeholders also inform the selection of performance measures. Performance measures are updated each year.

The MQD favors measures whose results can be compared to national standards, and this is why we primarily report HEDIS and CAHPS measures. The MQD ensures that any HEDIS and CAHPS measures that are a part of the Child Core Set and Adult Core Set are included as a performance measures here in the Quality Strategy, and are also reported to CMS via the CARTS process.

Table 5: Selected HEDIS Performance Measures for 2015

	Non-Aged, Blind, Disabled (Non-ABD) HEDIS 2015 Measures		
I	**Effectiveness of Care**		HYBRID or ADMIN
	Adult BMI Assessment	ABA	H
	Childhood Immunization Status	CIS	H
	Immunization for Adolescents	IMA	H
	Human Papillomavirus Vaccine for Female Adolescents	HPV	H
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Counseling for	WCC	H
	Breast Cancer Screening	BCS	A
	Cervical Cancer Screening	CCS	H
	Colorectal Cancer Screening	COL	H
	Chlamydia Screening in Women	CHL	A
	Pharmacotherapy Management of COPD Exacerbation	PCE	A
	Use of Appropriate Medications for People with Asthma	ASM	A
	Medication Management for People with Asthma	MMA	A
	Controlling High Blood Pressure	CBP	H
	Persistence of B Blocker Treatment after a Heart Attack	PBH	A
	Comprehensive Diabetes Care	CDC	H
	Hemoglobin A1c (HbA1c) Tested		H
	HbA1c Poor Control (>9%)		H
	HbA1c Control (<8%)		H
	HbA1c Control (<7%)		H
	Eye Exam (Retinal) Performed		H
	Medical Attention for Nephropathy		H
	Systolic and Diastolic BP Levels < 140 / 90		H
	Antidepressant Medication Management	AMM	A
	Adherence to Antipsychotics for Individuals with Schizophrenia	SAA	A
	Follow-Up of Care for Children Prescribed ADHD Medication	ADD	A
	Follow-Up After Hospitalization for Mental Illness	FUH	A
	Annual Monitoring for Patients on Persistent Medications	MPM	A
II	**Access/Availability of Care**		
	Frequency of Ongoing Prenatal Care	FPC	H
	Adults' Access to Preventive/Ambulatory Health Services	AAP	A
	Children & Adolescents' Access to Primary Care Practitioners	CAP	A
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET	A
	Prenatal and Postpartum Care	PPC	H
	Timeliness of Prenatal Care		
	Postpartum Care		
III	**Use of Services**		
	Well-Child Visits in the First 15 Months of Life	W15	H
	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	W34	H
	Adolescent Well-Care Visits	AWC	H
	Inpatient Utilization -- General Hospital/Acute Care	IPUA	A
	Ambulatory Care	AMBA	A
	Mental Health Utilization	MPTA	A
	Plan All-Cause Re-Admissions (report applying the Commercial weighting tables)	PCR	A
IV	**Health Plan Descriptive Information**		
	Enrollment by Product Line	ENP	A

	Aged, Blind, Disabled (ABD) HEDIS 2015 Measures		
I	**Effectiveness of Care**		or ADMIN
	Adult BMI Assessment	ABA	H
	Childhood Immunization Status	CIS	H
	Immunization for Adolescents	IMA	H
	Human Papillomavirus Vaccine for Female Adolescents	HPV	H
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Counseling for	WCC	H
	Breast Cancer Screening	BCS	A
	Cervical Cancer Screening	CCS	H
	Colorectal Cancer Screening	COL	H
	Chlamydia Screening in Women	CHL	A
	Care for Older Adults	COA	H
	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	SPR	A
	Pharmacotherapy Management of COPD Exacerbation	PCE	A
	Use of Appropriate Medications for People with Asthma	ASM	A
	Medication Management for People with Asthma	MMA	A
	Controlling High Blood Pressure	CBP	H
	Persistence of B Blocker Treatment after a Heart Attack	PBH	A
	Comprehensive Diabetes Care	CDC	H
	Hemoglobin A1c (HbA1c) Tested		H
	HbA1c Poor Control (>9%)		H
	HbA1c Control (<8%)		H
	HbA1c Control (<7%)		H
	Eye Exam (Retinal) Performed		H
	Medical Attention for Nephropathy		H
	Systolic and Diastolic BP Levels < 140 / 90		H
	Antidepressant Medication Management	AMM	A
	Adherence to Antipsychotics for Individuals with Schizophrenia	SAA	A
	Follow-Up of Care for Children Prescribed ADHD Medication	ADD	A
	Follow-Up After Hospitalization for Mental Illness	FUH	A
	Annual Monitoring for Patients on Persistent Medications	MPM	A
	Medication Reconciliation Post-Discharge	MRP	H
II	**Access/Availability of Care**		
	Frequency of Ongoing Prenatal Care	FPC	H
	Adults' Access to Preventive/Ambulatory Health Services	AAP	A
	Children & Adolescents' Access to Primary Care Practitioners	CAP	A
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	IET	A
	Prenatal and Postpartum Care	PPC	H
	Timeliness of Prenatal Care		
	Postpartum Care		
III	**Use of Services**		
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	Inpatient Utilization -- General Hospital/Acute Care	IPUA	A
	Ambulatory Care	AMBA	A
	Mental Health Utilization	MPTA	A
	Plan All-Cause Re-Admissions (report applying the Medicare weighting tables)	PCR	A
IV	**Health Plan Descriptive Information**		
	Enrollment by Product Line	ENP	A

STATE STANDARDS AND CONTRACT COMPLIANCE

All standards for access to care, structure and operations, and quality measurement and improvement, listed in the table below are incorporated in the MCO contracts/requests for proposal (RFPs) and in accordance with Federal Regulations. The language in the MCO contracts for each standard is in alignment with the regulations, and in some cases, more stringent than the regulations. See ***Attachment 1*** for a detailed crosswalk. A link to the QUEST Integration contract (Request for Proposals link) can be found on the MQD website at http://www.medquest.us/Quest/QuestIntegration.html. Monitoring for each of these standards is achieved by a variety of methods, including required reporting and EQRO compliance reviews. This monitoring is more fully detailed in the next section.

MONITORING AND EVALUATION

Monitoring and Quality Flow Process

Staff of the MQD HCBS branch reviews monitoring and quality reports from the MCOs and programs. During regularly scheduled meetings, the QSCs review and analyze the data received, root causes, barriers, and improvement interventions. Feedback is provided to the MCOs and programs, and corrective action is requested if needed. The Committees also review and suggest changes to the reporting templates and monitoring mechanisms as needed. The QSLT in regular meetings review the findings

and recommendations from the various QSCs and focus on critical issues requiring systems changes. The Leadership Team regularly meets in collaboratives with the MCOs and programs to provide opportunity for dialogue, feedback, follow-up of corrective actions and PIPs, exchange of information, and identification of best practices. This flow process is fully detailed under the Quality Strategy Implementation Section.

Sources for Monitoring and Quality Improvement

MCO Monitoring Reports: These are contractual reporting required from MCOs. MQD is standardizing report templates as well as review tools for each required report. These include reports on Provider Network and Credentialing, Authorization Denials, Member Grievances, Provider Complaints, Timely Access, Availability of Services, Claims Payment, Call Center, Long-Term Services and Supports, Special Health Care Needs, among others. Individuals with Special Health Care Needs are: • Individuals under twenty-one (21) years of age who have a chronic physical, developmental, behavioral, or emotional condition and who requires health and related services of a type or amount beyond that generally required by children;

- Individuals who are twenty-one (21) years of age or older and have chronic physical, behavioral, or social conditions that requires health related services of a type or amount beyond that required by adults generally; and • Individuals of any age that are receiving long-term services and supports (both institutional and home and community based services (HCBS)).

MQD issues reporting calendars annually to the MCOs. The DD/ID program also has required reporting based upon their 1915(c) waiver that is in compliance with CMS HCBS Quality Framework.

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

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

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

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

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

Performance Improvement Project Reports: The EQRO validates two PIPS per MCO each year. The report summarizes the findings for each MCO on the validated PIPs. It contains the analysis of findings as well as recommendations for improvement. Technical assistance is provided to the MCOs for PIPs based on the report recommendations. The MQD chooses PIP topics (in collaboration with?....) to meet goals identified in this quality strategy. All QUEST Integration health plans participate in the same PIP topics to assure a greater impact on that population.

Public Summary Report: The MQD developed a public summary report that compiles health plan data on their overall performance. This document reports information in an easy to follow format that includes normalized data presented in both numbers and charts for ease of understanding. MQD obtained public input into the report format in June/July 2015. MQD designed this report to promote transparency with the daily functioning of the QI health plans. MQD will start posting this quarterly report on its website in September 2015.

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

Table 6: Monitoring Mechanisms and Frequency

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

Non-Duplication Strategy

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

Hawaii Revised Statute 432E-11 requires that managed care plans doing business in Hawaii are accredited by a national accrediting organization. The requirement for QUEST Integration is that National Committee accredits all health plans for Quality Assurance (NCQA).

The MQD implemented the non-duplication strategy for credentialing and recredentialing. However, MQD has chosen to require its EQRO to complete the credentialing and re-credentialing portion of compliance review going forward. MQD finds that with the implementation of the Affordable Care Act (ACA) requirements for provider enrollment, these functions are critical for provider oversight. In sum, going forward the MQD will not be using non-duplication for credentialing, re-credentialing, or other EQRO activities.

HEALTH INFORMATION TECHNOLOGY

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

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

Accuracy and Completeness – DHS will measure accuracy with the following measures: ○ Pended Rate for the latest month and the cumulative average for the past three (3) and six (6) months that is calculated based on new system pends for each encounter submission divided by the total encounter lines in that submission.

- Twelve (12) months new pends that is calculated based upon the last twelve month pended errors divided by total encounter lines (including resubmitted adjusted, void and denied encounters).
- Total Pended Rate that is calculated based on cumulative total pended errors divided by the sum of the total encounter lines in the past twelve (12) months' submissions.

The following accuracy targets apply:

- Current Pended Rate of less than five percent (5%);
- Current Pended Rate of less than five percent (5%) for cumulative averages for the past three (3) and six (6) months; and
- Cumulative twelve month pended rate less than ten percent (10%); and ○ Cumulative Total Pended Rate of twenty-five percent (25%).

Timeliness – Sixty percent (60%) of the encounter data shall be received by the DHS no more than one-hundred twenty (120) days from the date that services were rendered. Health plans shall have the goal of submitting one-hundred percent (100%) and shall submit no less than ninety-nine percent (99%) of encounter data within fifteen (15) months from the date of services. Adjustments and resubmitted encounters shall not be subject to the one-hundred twenty (120) day submission requirement. In addition, TPL related encounters shall not be subject to the one-hundred twenty (120) day submission deadline.

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

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

MQD uses information from HPMMIS to produce reports, which identify and aid in the investigation of provider abuse or misuse. The recent development of a Data Warehouse will enhance MQD's efforts in this area. The Data Warehouse also enhances efforts in quality improvement as it enables MQD to monitor HEDIS-like quality and utilization measures for specific populations (HCBS beneficiaries, DD/ID participants, beneficiaries over the age of 65, among others) outside of MCO annual HEDIS reporting. Through the Data Warehouse, the MQD can also monitor utilization and cost-efficiency.

In Hawaii, the use of health information technology has expanded to include an online EPSDT form, which provides a database of previous vaccines, screenings, and referrals, and will provide prompts and alerts for services that are due. This pilot project also encompasses the collection of all EPSDT data, whether submitted electronically or through a paper form, into the online database and allows MQD to track and trend clinical information associated with EPSDT exams. Connectivity between provider electronic health systems and the EPSDT database to facilitate submission of EPSDT data is actively being explored. Connectivity among the State's Vaccine for Children's program, the Immunization Registry, and the EPSDT database is also being pursued. This connectivity will prevent the duplication of providers entering immunization information into the EPSDT online system as well as the Immunization Registry and/or Vaccines for Children database.

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

III. IMPROVEMENT AND INTERVENTIONS

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

INTERVENTIONS

State Agency Collaboration

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

branches often work together on common issues, such as obesity, tobacco abuse, and early screening and intervention. MQD, DOH and the Department of Education are also regularly discussing the best ways to improve the collaboration of state agencies to better ensure access to and the quality of health services provided to children, regardless of where they are.

MCO Collaboration

The collaborative relationship between MQD and the MCOs has been important in fostering improvement interventions. Monthly meetings occur with MQD and the QUEST Integration MCOs. There are also regular medical director meetings that bring together the MQD medical director with the medical directors of the QUEST Integration MCOs. Sharing of common problems, monitoring activities, and performance measures occur in these meetings, and these collaborations result in the sharing of best practices.

Performance Measure Validation

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

The EQRO will validate all HEDIS measures in 2015. The EQRO requires corrective action for lack of improvement. In addition, MQD uses performance measures for the following quality activities:

- QUEST Integration consumer guide;
- Financial incentives for improved MCO performance; and
- Quality factors for portion of auto-assign.

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

Performance Improvement Projects

A PIP is intended to improve the care, services, or member outcomes in a focus area of study. MQD selects certain PIP topics to be collaboratively performed by the MCOs. The current mandatory PIP topics for the QUEST Integration MCOs are Plan All Cause Readmission and Diabetes Self-Management.

The EQRO's new rapid-cycle PIP approach represents a modified version of the

Institute for Healthcare Improvement's (IHI's) Quality Improvement (QI) Model for Improvement. Key concepts include the formation of a team, setting aims, establishing measures, selecting interventions, testing interventions, implementing interventions, and spreading changes. The IHI model focuses on accelerating improvement without replacing change models that different organizations may already be using. The core component of the model includes testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation that informs the project theory during the course of the improvement project.

The EQRO selected this framework as it allows broad flexibility for different health plans, builds upon proven quality concepts, and provides a systematic way to approach an improvement activity. This new framework for PIPs includes five Modules:

Module 1: PIP Initiation
Module 2: SMART Aim and Baseline Data Collection Module
3: Intervention Determination
Module 4: Intervention Testing
Module 5: PIP Conclusions

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

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

Public Reporting

The MQD has a public reporting mechanism, which includes a variety of performance measures, displayed by MCO, in a simple and understandable 'consumer guide'. This guide allows a comparison of the MCOs across a variety of measures and can be distributed to beneficiaries, providers, and stakeholders. In addition, MQD provides information on a Dashboard that identifies providers, claims paid, grievance, appeals, utilization, and other factors.

MCO Sanctions

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

PROGRESS TOWARDS OBJECTIVES

Efforts are ongoing to promote transparency and sharing of best practices among the QUEST Integration MCO administrators and clinical leadership. Active EQRO and MQD technical assistance are given to promote quality improvement processes related to these measures. Increasing collaboration has been established with DOH Chronic Disease Branches, and there are renewed efforts by DOH to work with MCOs directly. Public reporting and financial incentives are included in the QUEST Integration MCOs contract and it is expected that future results for these measures will improve. MQD posts information submitted to CMS on quality on its website at http://www.medquest.us/ManagedCare/CmsReport.html.

Goal 1: Improve preventive care for women and children

For the measures under Goal 1, there is baseline data for the QUEST MCOs who have been submitting HEDIS data to MQD. The figure below shows data from HEDIS 2014.

Table 7: QUEST MCO Baseline for Goal 1 Objectives

HEDIS Measures	HEDIS 2014/other	Comment
Childhood Immunizations—Combo 2	76.08	
*Frequency of Ongoing Prenatal Care (<21% of Visits)**	9.44	
Frequency of Ongoing Prenatal Care (81–100% of Visits)	52.89	
Timeliness of Prenatal Care	75.83	
Breast Cancer Screening	84.99	
Cervical Cancer Screening	69.67	No National Medicaid benchmark
EPSDT- Participant Ratio	0.78	No National Medicaid benchmark

Legend:

	National Medicaid HEDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

Goal 2: Improve care for chronic illness

For the measures under Goal 2, there is baseline data for the QUEST MCOs who have been submitting HEDIS data to MQD. The figure below shows data from HEDIS 2014.

Table 8: QUEST MCO Baseline for Goal 2 Objectives

HEDIS Measures	HEDIS 2014/other	Comment
Comprehensive Diabetes Care		
HgbA1c Testing	84.99	
HgbA1c Control (>9)	49.57	
HgbA1c Control (<8)	40.34	
Blood Pressure Control (<140/90)	58.28	
Retinal Screening	59.02	
Other Measures		
Controlling High Blood Pressure (<140/90)	55.86	
Appropriate Medication for Asthma- Total	79.63	
Asthma related ED visits- CY2013	7.2	No National Medicaid benchmark

Legend:

	National Medicaid H EDIS 2014 Percentile					
	<10	10-24	25-49	50-74	75-89	90-100
Color Code for Percentiles						

3: Improve beneficiary satisfaction with health plan services

The measures for beneficiary satisfaction come from the CAHPS survey, administered for adults and children in alternate years. Below is the baseline for 2014 CAHPS.

Table 9: QUEST MCO 2014 Baseline for Goal 3 Satisfaction Measures

Getting Needed Care	75.8	

Rating of Health Plan	56.2	
How Well Doctors Communicate	90.3	Above NCQA National Medicaid Average

Goal 4: Improve cost-efficiency of health plan services

For the measures under Goal 4, MQD will establish baseline data with HEDIS 2015.

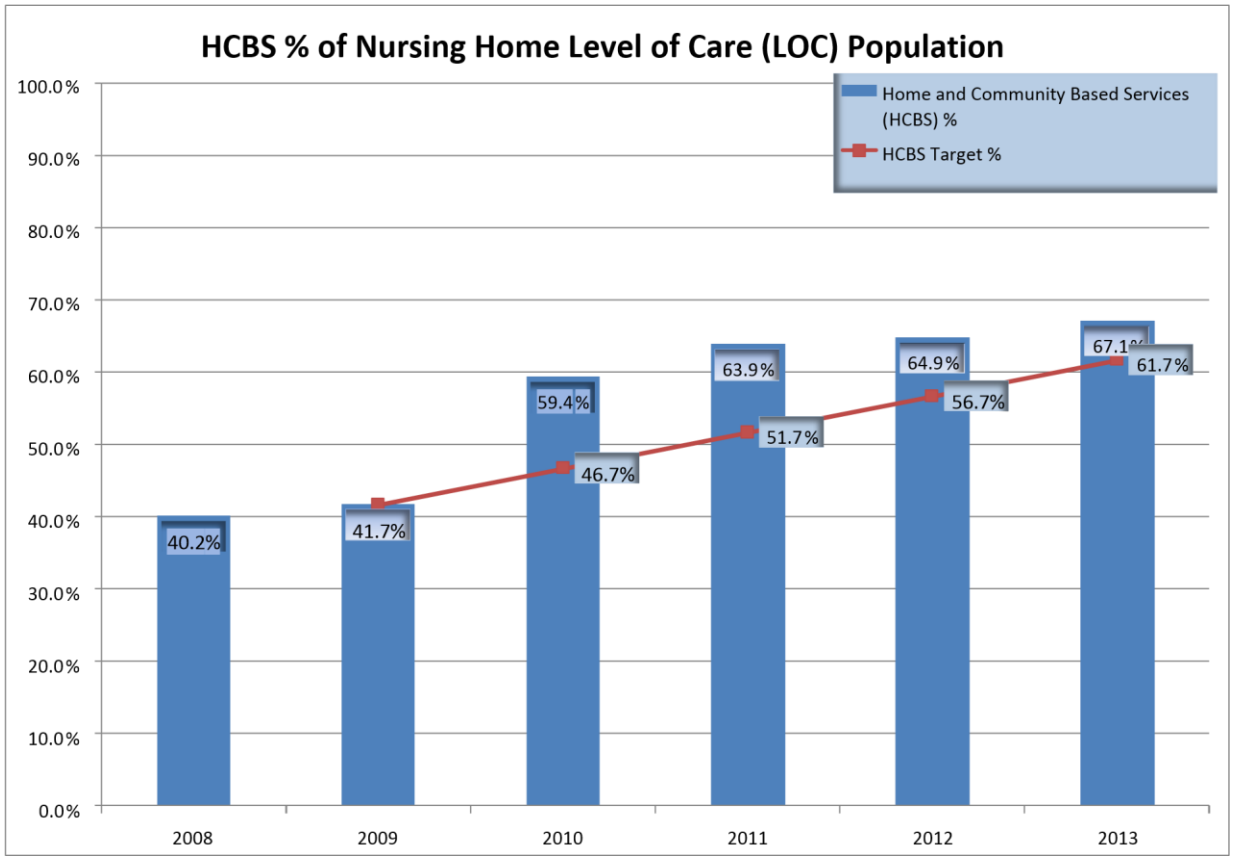
Goal 5: Expand access to HCBS and assure that individuals have a choice of instructional or HCBS

Below is a chart that identifies baseline data when MQD moved its ABD population into managed care. In addition, we have provided a graph that show growth of HCBS from 2008 to 2013. MQD intends to continue to expand this growth (though not as aggressively as it has done previously).

Table 10: MCO Baseline on Nursing Facility and HCBS Beneficiaries

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

Figure 2: Growth of HCBS for LOC Population



Goal 6: Improve access to community living and the opportunity to receive services in the most integrated setting appropriate for individuals receiving HCBS.

For the measures under Goal 6, MQD will establish baseline data with surveys conducted in April to June 2015. Annually, MQD will perform surveys to measure progress on meeting this goal.

IV. QUALITY STRATEGY REVIEW AND EFFECTIVENESS

PROCESS AND TIMELINE OF QUALITY STRATEGY REVIEW

The Quality Strategy will be reviewed at least annually by the QSLT and revised based on analyses results. However, the QSCs may suggest changes to the QSLT throughout the year that will be reviewed to identify whether a suggested change necessitates a review and revision of the quality strategy sooner than the appointed time. At each review and revision of the strategy, the QSLT will determine whether the changes made to the Quality Strategy are significant enough to require additional stakeholder input and a public comment period. Significant changes are changes that significantly impact quality activities and/or threaten the potential effectiveness of the Quality Strategy. Examples of a significant change include but are not limited to placing limits

on benefits, adding new categories of benefits not previously offered, or major changes to regulations that the quality strategy is based on. At least once every 5 years, unless significant changes dictate a sooner timeframe, a 30-day public comment period will be made available.

In subsequent years, a yearly Work Plan will be written to supplement the Quality Strategy during the annual review and revision process. The development of the Work Plan begins with an assessment of accomplishments and challenges from the previous year's Work Plan, the EQR technical report, and summary reports/input from the QSCs. The Work Plan development also incorporates input from other sources such as MCOs, beneficiaries, providers, partner government agencies, and stakeholders. The Work Plan will clearly document the effectiveness of the Quality Strategy by summarizing successes and challenges as well as interim performance results for each strategy objective. The Work Plan also outlines areas of focus for quality activities, such as quality improvement measures, improvement projects, and performance indicators.

REPORTING REQUIREMENTS

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

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

V. ACHIEVEMENTS AND OPPORTUNITIES

ACHIEVEMENTS

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

team to which all quality activities are funneled will be an important step to ensuring the implementation of quality activities.

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

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

MQD will continue to report publically and use quality data for financial incentives.

CHALLENGES AND FUTURE PLANS

It is important to continuously assess and revise the quality process to ensure the successful implementation of the Quality Strategy. In addition, performance measures and targets will also need to be continuously evaluated to ensure that the measures meet appropriate populations and domains of care. Plans for the future include the establishment of performance measures and improvement activities for Inpatient Hospitals and Long-term Care.

MQD has improved through the use of its past quality strategy to organize quality, compile data, and use it to make improvement in its programs. MQD intends to continue with these processes going forward.

This quality strategy incorporates MQD's current quality objectives. However, the MQD will submit a revised quality strategy to Centers for Medicare & Medicaid Services (CMS) to incorporate any changes required by revised managed care final rules. In addition, MQD will continue to adapt its quality program as Hawaii undergoes healthcare transformation.

Attachment D

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

OCT 2 6 2015

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

Dear Ms. Mohr Peterson:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to Hawaii's section 1115 demonstration, entitled, "QUEST Integration" (Project Number 11-W-00001/9). The technical corrections ensure that the Special Terms and Conditions (STCs) accurately reflect CMS's approval of the demonstration.

To reflect upon the agreed terms between the state and CMS, CMS has incorporated the technical changes that the state requested into the latest version of the STCs. A copy of the updated STCs and the expenditure authorities is enclosed. The waivers for this demonstration are unchanged by this amendment, and remain in force; a copy of the waiver list is also enclosed.

Your CMS project officer, Ms. Heather Ross, is available to address any questions you may have related to this correspondence. Ms. Ross can be reached at 410-786-3666 or heather.ross@cms.hhs.gov.

Official communications regarding official matters should be sent simultaneously to Ms. Ross and Ms. Henrietta Sam-Louie, Acting Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Sam-Louie can be reached at (415) 744-3552, or at Henrietta.Sam-Louie@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of Systems Reforms Demonstrations

Enclosure

cc: Henrietta Sam-Louie, Acting Associate Regional Administrator,
Region IX, San Francisco Regional Office

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 (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These amended STCs are effective from October 1, 2013 through December 31, 2018. 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. Managed Care Plan Selection Processes
VIII. Cost Sharing
IX. Delivery System: Managed Care
X. Uncompensated Care
XI. General Reporting Requirements
XII. General Financial Reporting Requirements for Defined Authorized Expenditures
XIII. Monitoring Budget Neutrality for the Demonstration
XIV. Evaluation of 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 shall control.

II. PROGRAM DESCRIPTION, OBJECTIVES, AND HISTORICAL CONTEXT

QUEST Integration is a continuation and expansion 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 paragraph 18. During the period between approval and implementation of the QUEST Integration managed care contract the state will continue operations under its QUEST and QExA programs. Further details regarding implementation and transition activities are found in STC 31 of this document.

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 includes the following program changes:

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

This renewal integrates the demonstration's eligibility groups and benefits within the context of the Affordable Care Act (ACA). From a benefit perspective, Hawaii will provide 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.

Beneficiaries enrolled in the states' Home and Community-Based Services for People with Developmental Disabilities Section 1915(c) waiver will receive capitated primary and acute care services through the authority of QUEST Integration. All other services for this group will continue to be provided under section 1915(c) authority.

The state's goals in this extension of the demonstration are to:

- Improve the health care status of the member population;
- Minimize administrative burdens, streamline access to care for enrollees with changing health status, and improve health outcomes by integrating the demonstration's programs and benefits;
- Align the demonstration with ACA;

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

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.

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.

On April 5, 2012, CMS approved an amendment which reduced the QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL and eliminated the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. This amendment was permitted because Hawaii filed a budget deficit certification, in accordance with CMS' February 25, 2011, State Medicaid Director's Letter.

In the 2011 amendment, Hawaii also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the demonstration; eliminate the QUEST enrollment limit for childless adults;; terminate the Hawaii Premium Plus program; and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

In June 2012, the state requested to extend the QUEST demonstration under section 1115(e) of the Social Security Act. Revisions were made to the waiver and expenditure authorities to update the authorization period of the demonstration, along with a technical correction clarifying that the freedom of choice waiver is necessary to permit the state to mandate managed care, and updates to the budget neutrality trend rates. A one year renewal was approved in December 2012. In December 2012, the state requested to amend the demonstration to provide full Medicaid benefits to former foster children under age 26 with income up to 300 percent FPL with no asset limit.

III. GENERAL PROGRAM REQUIREMENTS

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

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

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

   In addition, CMS reserves the right to amend and make necessary technical changes to the STCs without requiring the state to submit an amendment to the demonstration under STC 6. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs. These changes shall be effective upon written acceptance by the state.

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

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as

necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.

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

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

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

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. 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 failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state, consistent with the requirements of paragraph 14, to reach a decision regarding the requested amendment;

   b. A data analysis workbook which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

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

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming Title XIX and/or Title XXI state plan amendment, if necessary and

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

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

a. Compliance with Transparency Requirements at 42 CFR §431.412: As part of the demonstration extension request, the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and public notice requirements outlined in paragraph 14 as well as include the following supporting documentation:

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

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

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

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

v. Compliance with the Budget Neutrality Cap: The state must provide a financial data workbook (as set forth in the current STCs) demonstrating

the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current President's budget and historical trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If Title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. Draft report with Evaluation Status and Findings: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Demonstration of Public Notice 42 CFR §431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

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

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

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

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

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

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

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

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

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

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; home and community-based services;

compliance with cost sharing requirements; and reporting on financial and other demonstration components.

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

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

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal or renewal of this demonstration (42 C.F.R. §431.408(b)(3)).

    The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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

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

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

IV. ELIGIBILITY FOR THE DEMONSTRATION

18. **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, including the conversion to a modified adjusted gross income standard, 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

Medicaid Mandatory State Plan Group(s) (Categorical Eligibility)	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Infants under age 1	Subject to the Title XIX state plan.	Title XIX	State Plan Children
Children 1-18	Subject to the Title XIX state plan.	Title XIX	State Plan Children
Parents and caretaker relatives under age 21	Subject to the Title XIX state plan.	Title XIX	State Plan Children
Section 1925 Transitional Medicaid under age 21	Subject to the Title XIX state plan.	Title XIX	State Plan Children
Former Foster Care Children under age 21. Authority to include this group in the demonstration begins January 1, 2014.	Subject to Title XIX state plan.	Title XIX	State Plan Children
Pregnant women	Subject to the Title XIX state plan.	Title XIX	State Plan Adults
Parents and caretaker relatives age 21 and older	Subject to the Title XIX state plan.	Title XIX	State Plan Adults
Section 1925 Transitional Medicaid age 21 and older	Subject to the Title XIX state plan.	Title XIX	State Plan Adults
Former Foster Care Children age 21 to 25. Authority to include this group	Subject to Title XIX state plan.	Title XIX	State Plan Adults

in the demonstration begins January 1, 2014.			
SSI Aged	Subject to the Title XIX state plan.	Title XIX	Aged
SSI Blind or Disabled	Subject to the Title XIX state plan.	Title XIX	Blind or Disabled
Affordable Care Act Low-Income Adult Group eligible for Expansion State FMAP. Authority to include this group in the demonstration begins January 1, 2014.	Subject to the Title XIX state plan.	Title XIX	Expansion State Adults
Affordable Care Act Low-Income Adult Group eligible for Newly Eligible FMAP. Authority to include this group in the demonstration begins January 1, 2014.	Subject to Title XIX state plan.	Title XIX	Newly Eligible Adults
Medicaid State Plan Groups	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
Children through the CHIP Medicaid expansion	Subject to Title XIX state plan.	Title XXI	Opt. State Plan Children[1]
Optional Medicaid State Plan Groups	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance	Subject to Title XIX state plan.	Title XIX	Foster Care Children, 19-20 years old

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

agreement			
Medically Needy Non-ABD Pregnant Women	Subject to Title XIX state plan.	Title XIX	Medically Needy Adults
Medically Needy Non-ABD Children	Subject to Title XIX state plan.	Title XIX	Opt. State Plan Children
Breast and Cervical Cancer Treatment Program	Subject to Title XIX state plan.	Title XIX	Blind or Disabled
Aged Adults	Subject to Title XIX state plan.	Title XIX	Aged
Disabled Adults	Subject to Title XIX state plan.	Title XIX	Blind or Disabled
Medically Needy Non-ABD Children and Pregnant Women	Subject to Title XIX state plan.	Title XIX	Aged
Medically Needy Non-ABD Children and PW	Subject to Title XIX state plan.	Title XIX	Blind or Disabled

QUEST Integration Demonstration Expansion Population Groups

Demonstration Eligibles	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Parents or caretaker relatives of certain 18-year-olds	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.[2]	Title XIX	Demo Elig Adults

[2] For the period from October 1, 2013 to December 31, 2013, this demonstration expansion population shall not include the parents and caretakers of full time students who are 18 years of age, if these parents and caretakers are covered under the state plan during that time period.

Aged individuals in the 42 C.F.R. § 435.217 like group receiving home- and community- based services	Income up to and including 100% FPL using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.	Title XIX	Aged
Blind or disabled individuals in the 42 C.F.R. § 435.217 like group receiving home-and community-based services	Income up to and including 100% FPL using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.	Title XIX	Blind or Disabled
Aged medically needy individuals receiving home-and community-based services	Individuals who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is 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 and spousal impoverishment eligibility rules.	Title XIX	Aged
Blind or disabled	Individuals who would	Title XIX	Blind or disabled

medically needy individuals receiving home-and community-based services	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 and spousal impoverishment eligibility rules.		
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	Individuals who are not otherwise eligible under the state plan, with the same income limit that is applied for Foster Children (19-20 years old) who are receiving foster care maintenance payments or who under an adoption assistance agreement under the state plan or Kinship guardian assistance agreement.	Title XIX	Demo Elig Children
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance, age 21 to 25.	Individuals who have aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance) when placed from age 16 to age 18 years of age, would be eligible under a different eligibility group but for income, and were enrolled in the state plan or	Title XIX	Demo Elig Adults

	waiver while receiving assistance payments.		
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance, under age 21.	Individuals who have aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance) when placed from age 16 to age 18 years of age, would be eligible under a different eligibility group but for income, and were enrolled in the state plan or waiver while receiving assistance payments.	Title XIX	Demo Elig Children
Former Foster Children. Authority for this demonstration expansion group expires December 31, 2013.	Individuals who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not impose an asset limit on this population.	Title XIX	Demo Elig. Adults
Low-income childless adults. Authority for this demonstration expansion group expires December 31, 2013.	Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Medicare part A or enrolled for benefits under Medicare part B and are not a mandatory state plan population and whose income (as determined using modified adjusted gross income) does not exceed 133 percent of the FPL.	Title XIX	VIII-Like Adults

19. **Post-Eligibility Treatment of Income and Resources.** All individuals receiving nursing facility long-term care services must be subject to the post-eligibility treatment of income rules set forth in section 1924 and 42 CFR section 435.733. The application of patient income to the cost of care shall be made to the facility. Individuals receiving HCBS must be

subject to the post-eligibility treatment of income rules set forth in section 1924 and 42 CFR section 435.735 if they are medically needy, with or without spend-down, or individuals who would be eligible for Medicaid if institutionalized as set forth in 42 CFR section 435.217.

20. **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.

21. **Retroactive Eligibility.** The state will limit retroactive eligibility for all individuals eligible under the state plan or demonstration to a 10-day period prior to the date of application with the exception of individuals requesting long-term care services in which case up to three months of retroactive eligibility will be allowed.

22. **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 shall take that policy into account.

V. ENROLLMENT

23. **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 subparagraph (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 subparagraph (d).

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

24. **QUEST Integration Benefits.** Benefits provided under authority of this demonstration are delivered through mandatory managed care (except as specified in subparagraph (g)), and are as follows, for all populations under the demonstration (except as otherwise provided in this paragraph):

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. The VIII-like group will receive benefits that are identical to the benefits that will be included in the state's Medicaid State Plan.

c) **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.

i. **HCBS:** QUEST Integration health plans will 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 C 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
Skilled nursing	X	X
Specialized case management		X
Specialized medical equipment and supplies		X

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

ii. **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).
    1. Supportive Housing.
    2. Supportive Employment.
    3. Financial management services.

iii. **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.

iv. **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.

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

d) **Community Participation.** The state, either directly or through its MCO contracts, will ensure that participants' engagement and community participation is supported and facilitated to the fullest extent desired by each participant.

e) **HCBS Standards.** The state will 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.

f) **Managed Care Plan Change.** Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

g) **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 DD/MR population with the HCBS that are provided on a fee-for-service basis from the Department of Health's (DOH) Developmental Disabilities Division.

h) **Behavioral Health Benefits.** All QUEST Integration plans will provide a full array of standard behavioral health benefits (including substance abuse treatment) to members who may need such services. The state will also provide specialized behavioral health services to beneficiaries with SMI, SPMI, or requiring SEBD. The Behavioral Health Protocol addresses the following: :

(i) Services provided by the DOH Child and Adolescent Mental Health Division (CAMHD) to children with serious emotional behavioral disorders (SEBD).
(ii) Services provided to adults with SMI or SPMI by the DOH Adult Mental Health Division (AMHD), the Med-QUEST division's Community Care Services (CCS) behavioral health program, or the contracted plans.
(iii) Reimbursement
(iv) A memorandum of agreement (MOA) that reflects the current interagency agreement for behavioral health services provided by the DOH to demonstration eligibles.
(v) The process and protocol used for referral between MCOs and the DOH or CCS, as well as the DOH or CCS and MCOs.

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

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

j) **Access to Long-Term Care Services.** A key objective of the QUEST Integration demonstration is that beneficiaries meeting an institutional level of care shall have a choice of institutional services or HCBS. The HCBS provided must be person-centered and sufficient to meet the needs identified in the functional assessment, taking into account family and other supports available to the beneficiary. In order to move toward the objective of providing beneficiaries with a choice of services, the state must require the following from the contracted health plans:

   i. If the individual has previously received services under a Section 1915(c) waiver and continues to meet an institutional level of care, the individual must continue to receive HCBS appropriate to his or her needs. The services need not be identical to the ones previously received under the Section 1915(c) waiver, but any change must be based upon the functional assessment and person-centered plan.
   ii. For all other beneficiaries, if the estimated costs of providing necessary HCBS to the beneficiary are less than the estimated costs of providing necessary care in an institution (hospital or nursing facility), the plan must provide the HCBS to an individual who so chooses, subject to the limitations described in paragraph (c). Health plans will be required to document good-faith efforts to establish a cost-effective, person-centered plan of care in the community using industry best practices and guidelines. If the estimated costs of providing necessary HCBS to the beneficiary exceed the estimated costs of providing necessary care in an institution (hospital or nursing facility), a plan may refuse to offer HCBS if the state or its independent oversight contractor so approves. In reviewing such a request, the state must take into account the plan's aggregate HCBS costs as compared to the aggregate costs that it would have paid for institutional care.
   iii. A plan is not required to provide HCBS if the individual chooses institutional services, if he or she cannot be safely served in the community, if there are not adequate or appropriate providers for the services, or if there is an exceptional increase in the demand for HCBS. An exceptional increase in demand is defined as an increase beyond annual thresholds to be established by the state. In the case of an exceptional increase, the state shall be responsible for monitoring any wait for services as set forth below and reporting its findings

to CMS. Plans will offer a sub-set of HCBS services (described in subparagraph (b)(i)) to "At Risk" individuals in order to prevent a decline in health status and maintain individuals safely in their homes and communities. Based on individual assessed needs, "At Risk" individuals may be subjected to an hourly or budget limitation on HCBS services that must be sufficient to meet the individual's assessed needs. This limit would be adjusted with changes in assessed need.

iv. Individuals certified as institutional LOC may be limited to a maximum of 90 days per benefit period for HCBS services furnished on a 24-hour basis.

v. The plans may have a waiting list for HCBS services for both the institutional level of care and the "At Risk" population. Waiting list policies shall be based on objective criteria and applied consistently in all geographic areas served, and are subject to the approval by the state.

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

1. The names of the members on the waiting list;
2. The date the member's name was placed on the waiting list;
3. The specific service(s) needed by the member; and
4. Progress notes on the status of providing needed care to the member.

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

viii. The state shall adopt policies that ensure authorized LTSS continue to be provided in the same amount, duration and scope while a modification, reduction or termination is on appeal. The state shall know and monitor MCO service authorization processes and intervene if those processes regularly result in participant appeals of service authorization reductions or expirations.

VII. MANAGED CARE PLAN SELECTION PROCESSES

25. **QUEST Integration.** Eligible individuals will be enrolled in a managed care plan upon initial eligibility. Eligible individuals will choose among participating health plans offered to provide the full range of primary, acute, and home and community based services. 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 and will have 15 days from the date of auto assignment to select a different health plan from the list provided. The state shall 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 health plans operating on an island do not have an enrollment limit.

26. **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 auto-assigned to the MCO. If the enrollee was not auto-assigned to the MCO, the state must maintain a process by which the enrollee may change MCOs only if both MCOs agree to the change. The state must track and report to CMS these requests on an annual basis; along with MCO choice rates and MCO change rates that occur during the annual open enrollment period.

    b) **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 shall accommodate and grant all reasonable plan change requests from aged, blind and disabled beneficiaries that occur days 61-90. The state shall 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 63.

    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.

27. **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.

28. **Service Coordination Model.** After a beneficiary selects a health plan and completes the function described in paragraph 27, 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 paragraph 27. 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 paragraph 27;
        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 subparagraph (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 MCOs will develop and implement a person-centered written care plan that analyzes and describes the medical, social, HCBS, and/or long-term care institutional services that the member will receive. In developing the care plan, the MCO will consider appropriate options for the beneficiary related to his/her medical, behavioral health, psychosocial, case-specific needs at a specific point in time, as well as for longer term strategic planning and will be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. Service plans will be updated annually or more frequently in conjunction with the health and functional assessment.

c) **Ombudsman Program.** An Ombudsman Program will be available to all 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) will seek a qualified independent organization to assist and represent members in the resolution of problems and conflicts between the health plan and its members regarding QUEST Integration services to act as the Ombudsman prior to the initial date for delivery of services.

i. **Delivery of Ombudsman Services.** The Ombudsman will 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 will 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 will not replace the grievance and appeals process that all health plans that contract with the state must have in place, nor replace the right of a recipient to an administrative hearing. The Ombudsman may assist and represent members up to the point of an Administrative Hearing under state law. They may also assist a member during the hearing process but must not represent the member in an Administrative Hearing. The 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.

VIII. COST SHARING

29. **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.

30. **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.

IX. DELIVERY SYSTEM: MANAGED CARE

31. **Implementation Activities for QUEST Integration.** At the beginning of the QUEST Integration demonstration renewal period, implementation will be contractually through the QUEST and QUEST Expanded Access (QExA) programs with identical requirements to include, but not limited to, primary and acute care benefits, grievances and appeals, and enrollment and disenrollment procedures. Beneficiaries who require access to certain benefits, including long-term services and supports, will be disenrolled from their QUEST health plan and enrolled in a QExA health plan.

    Through its next procurement, Hawaii intends to contractually combine the scope for both the QUEST and QExA programs into a single contract to serve the full continuum of Medicaid beneficiaries. The following deliverables shall be submitted by the state for CMS review and/or approval in preparation for the execution and implementation of the single, comprehensive managed care contract to govern the QUEST Integration program, which is anticipated no earlier than January 1, 2015.

    (1) Transition Plan. The state must conduct an assessment of the plan transition needs when moving from the QUEST and QExA programs to the QUEST

Integration program. The Transition Plan submitted to CMS for review will explain the States policies to promote beneficiary continuity and continuation of care, particularly for beneficiaries who will no longer have access to his or her physician or provider for long term services and supports. In addition, the Plan will describe the communication plan for beneficiaries and providers regarding potential changes for service delivery under QUEST Integration, including policies around continuity of care. This Transition Plan shall be submitted to CMS for review no later than 90 days prior to implementation of QUEST Integration.

(2) Readiness Review. The state must assess plan readiness in accordance with the requirements of 42 C.F.R. 438. Readiness reviews will include, but are not limited to, documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The state will also notify CMS of its intent to conduct a readiness review 30 days in advance of the review and provide CMS the opportunity to observe the readiness review. The state will provide CMS a copy of their readiness review feedback/corrective action plan letter and approval letters for each readiness review.

(3) Certification of Network Adequacy under QUEST Integration Contracts. The state shall submit documentation of network adequacy as described in STC 37 to the Regional Office for review and certification. The state may not begin activities related to enrollment before receiving such certification.

32. **Contracts.** All contracts and contract modifications of existing contracts between the state and MCOs must be prior approved by CMS in accordance with 42 C.F.R. 438.6. The state will provide CMS with a minimum of 45 days to review changes for consideration of approval.

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

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

35. **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.

36. **Network Requirements.** The state must ensure the delivery of all covered benefits. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services for all of its members. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO contracts:

    a. Special Health Care Needs. Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR. §438.208(c)(4).
    b. Out of Network Requirements. Each MCO must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.

37. **Demonstrating Network Adequacy**. Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, behavioral health, specialty, and HCBS services for the anticipated number of enrollees in the service area.

    a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
        i. The number and types of providers available to provide covered services to the demonstration population;
        ii. The number of network providers accepting the new demonstration population; and
        iii. The geographic location of providers and demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

    b. The state must submit the documentation required in subparagraphs i – iii above to CMS at an agreed upon time prior to program implementation, as well as with each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO's operation, including service area reduction and/or population expansion.

38. **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).

39. **Required Components of a Comprehensive State Quality Strategy**. The Quality Strategy shall meet all the requirements of 42 CFR §438 Subpart D. The state shall adopt and implement a comprehensive and holistic, continuous Quality Improvement Strategy that focuses on all aspects of quality improvement in QUEST Integration including acute, primary, behavioral and long term services and supports. The Quality Strategy must address the following: administrative authority, level of care determinations, service plans, health and welfare, and qualified providers. The Quality Strategy must include State Medicaid Agency and MCO responsibilities, with the State Medicaid Agency retaining ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. Additionally, it must also include information on how the State will monitor and evaluate

each MCO's compliance with the contract requirements specific to the QUEST Integration demonstration as outlined in these STCs, including level of care evaluations, service plans, qualified providers as well as how the health and welfare of enrollees will be assessed and monitored. Pursuant to STC 64, the state must also provide CMS with annual reports on the implementation and effectiveness of their comprehensive Quality Strategy as it impacts the demonstration.

40. **Revisions to the State Quality Strategy.** The state must update its Quality Strategy to reflect the new QI program and submit to CMS for approval. The State must obtain the input of beneficiaries and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. Any revised performance measures should focus on outcomes, quality of life, effective processes, as well as community integration for those individuals receiving HCBS. The comprehensive Quality Strategy must be submitted to CMS for final approval within 120 days from the approval date of the demonstration. In the interim time period, the state will maintain its existing quality strategies. The state must revise the strategy whenever significant changes are made, including changes through this demonstration and consistent with STC 6.

41. **Required Monitoring Activities by State and/or External Quality Review Organization (EQRO).** The state's EQRO process shall 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 SMA, shall 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.

X. UNCOMPENSATED CARE

42. **Overview.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a FY 2007 disproportionate share hospital (DSH) allotment for Hawaii. The DSH program established in Hawaii under section 1923(f)(6)(B) of the Act must be a State Plan program and DSH payments made by the state must be made on the basis of a State Plan amendment approved by CMS. However, changes to the amount of the statutory DSH allotments will require reconsideration of the budget neutrality agreement. Federal financial participation for hospital uncompensated care (UCC) payments described in this section are separate from the

State Plan DSH program, will be provided as set forth below and must be reported under budget neutrality as a demonstration expenditure. The state must make DSH and UCC payments directly to the providers of the services as specified at section 1923(i) of the Act.

When determining hospital specific DSH limits and DSH payments, the state must take into account all Medicaid State Plan payments and demonstration projects including UCC amounts paid to hospitals under this section, as well as any payments by or on behalf of individuals with no source of third-party coverage.

43. **Available FFP for UCC.** Annually, FFP is authorized to pay for hospital and nursing facility UCC until June 30, 2016. Payments made by the state are limited to no more than the total of actual UCC incurred in any given year as defined in STCs 42 through 55 and 91, and attachment D. Expenditures may be made to the list of providers found in attachment A for hospital UCC costs in governmentally operated hospitals and private hospitals and for long term care UCC costs in governmentally-operated hospital-based and governmentally operated freestanding nursing facilities, provided the requirements of paragraph 44 are met.

    CMS may only consider a request to amend this STC if the state has submitted an amendment request in conformity with STCs 6 and 7, and the state has submitted the evaluation required in STC 44. The, evaluation should provide information on the need for uncompensated care. This evaluation must include evidence based proposals with strategies regarding hospital and nursing facility payment rate reform to reduce or eliminate Medicaid shortfall for hospitals and nursing facilities in the state that will address the shortfall amounts in the future. This evaluative analysis and report is required to precede, in accordance with STC 44, any amendment request regarding possible continuation of the UCC Pool.

44. **Evaluation of Uncompensated Care Pool:** The state shall conduct an evaluation of the use of the uncompensated care pool beginning January 1, 2014. The hypothesis test for the evaluation must focus on the effect of the Affordable Care Act coverage expansion on the existing UCC payments and how this affects future needs for both the uninsured and Medicaid shortfall scenarios. This evaluation must include changes in pool payments following the implementation of QUEST Integration and the Marketplace in Hawaii. Baseline data shall be established using the 2013 calendar year UCC pool payments.

    The evaluation must be submitted to CMS no later than January 1, 2016 and must contain the following:

    a. A detailed analysis of UCC pool payments for all pre- and post-periods of the following:
        i. Comparison of UCC pool payments that are expended on each of the following provider types:
            a. Governmentally operated hospitals;
            b. Governmentally operated nursing facilities; and
            c. Privately operated hospitals.
        ii. For each such provider type, comparison of UCC pool payments that are attributable to each of the following :
        iii. Uninsured individuals; and
        iv. Medicaid beneficiaries.

b. For the amount attributable to Medicaid beneficiaries, for each provider type, comparison of the funds that are attributable, in aggregate and by age-band to the following:
    i. QUEST Integration (managed care) shortfall; and
    ii. Fee-for-service shortfall.
c. A detailed analysis of how the allocation of the payments described changes over the evaluation period by provider type, type of individual, and type of shortfall.
d. The total amount of uncompensated care that is provided by each provider type to each of the following: unqualified aliens, qualified aliens subject to a 5-year ban, and those from countries which have entered into a compact of Free Association with the United States and a comparison of this amount to the one percent adjustment for unallowable costs of services applied in the UCC protocol in attachment D. This analysis must include use of age-banding as determined appropriate.
e. An analysis of factors that contribute to the necessity of UCC payments for uninsured individuals, including the following:
    i. The number of uninsured individuals in the state ; and
    ii. Factors that impact access to coverage, at a minimum these must include geographic location, state of residency or homelessness rates.
f. An analysis of the findings and conclusions drawn from the factors that contribute to the necessity of UCC payments overall as well as specifically for Medicaid shortfall, including the causal and solution role of fee-for-service payment rates and managed care contracting requirements.

45. **Availability of UCC Funds.** To the extent that in any demonstration year the state has a DSH allotment under section 1923 of the Act, any expenditures of that allotment must be made pursuant to an approved state plan amendment and the UCC payments authorized under this demonstration must be in addition to any such expenditures. Combined payments may not exceed a hospital's uncompensated care costs.

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

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

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

(FFS) beneficiaries, reduced by any applicable Medicaid outpatient revenues for the provision of said services to this population (FFS Outpatient shortfall).

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

    i. Inpatient Medicaid FFS shortfall, as governmental hospitals already receive inpatient payments only up to cost;
    ii. The costs of providing non-emergency care to individuals who are unqualified non-citizens, qualified non-citizens subject to a 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S., except that UCC may include the costs of providing care to individuals who are lawfully residing in the U.S. and who are enrolled under the Medicaid state plan or CHIP state plan; and
    iii. The costs of providing drugs to individuals eligible for Medicare Part D.

49. **For Governmentally-Operated Hospitals.** DSH and UCC payments to governmentally operated hospitals will be funded with certified public expenditures (CPE). The state must follow the CPE protocol in Attachment D. The UCC payments described in this section must follow the cost determination in the protocol.

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

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

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

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

    ii. UCCs *must not include*:

        1. Medicaid FFS shortfall, as governmentally-operated nursing facilities hospitals already receive payments only up to cost under the state plan;
        2. The costs of providing routine long term care services to the uninsured;

3. The costs of providing non-emergency care to individuals who are unqualified non-citizens, qualified non-citizens subject to a 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S., except that UCC may include the costs of providing care to individuals who are lawfully residing in the U.S. and who are enrolled under the Medicaid state plan or CHIP state plan; and
4. The costs of providing drugs to individuals eligible for Medicare Part D.

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

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

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

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

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

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

    i. The costs of providing non-emergency care to individuals who are unqualified non-citizens, qualified non-citizens subject to a 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S., except that UCC may include the costs of providing care to individuals who are lawfully residing in the U.S. and who are enrolled under the Medicaid state plan or CHIP state plan; and
    ii. The costs of providing drugs to individuals eligible for Medicare Part D.

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

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

55. **Aggregate Annual Limit of UCC and DSH Payments** - In any given year, the aggregate of federal share of the waiver UCC payments made under this section, combined with the federal share of aggregate DSH payments made pursuant to Hawaii's DSH allotment and under its state plan DSH methodology, should not exceed the amount equal to the federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project (paragraph 94). Furthermore, in any given DSH state plan year, each hospital's DSH payments cannot exceed its hospital-specific uncompensated care cost limit pursuant to Section 1923(g) of the Social Security Act. Each hospital's uncompensated care cost is net of the waiver UCC payments received under this section. Any excess waiver UCC payments made to an individual private hospital above its uncompensated care costs will be recouped and redistributed to other private hospitals, using the same methodology as the original private hospital UCC payments, which are distributed proportionately based on the hospitals' uncompensated care costs. The redistribution will only be made to the extent that such redistribution does not result in any hospital receiving UCC payments in excess of its uncompensated care costs. Any excess waiver payments will be redistributed to other qualifying hospitals.

XI. GENERAL REPORTING REQUIREMENTS

56. **General Financial Requirements.** The state must comply with all general financial requirements under Title XIX and Title XXI set forth in section XIII entitled, Monitoring Budget Neutrality in the demonstration.

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

58. **Corrected Budget Neutrality Information.** The state must submit corrected budget neutrality data upon request.

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

60. **Managed Care Data Requirements**. All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

    a. Encounter Data (Health Plan Responsibilities) – The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.

    b. Encounter Data (State Responsibilities) - The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

    c. Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new managed care organizations, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of demonstration enrollees.

    d. Submission of Encounter Data to CMS - The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with federal law. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

61. **Monitoring Calls.** CMS will schedule periodic conference calls with the state. The purpose of these calls is to discuss any significant, actual or anticipated, developments affecting the demonstration as well as to plan for future changes or renewals. Areas to be addressed include, but are not limited to MCO operations (such as contract amendments and rate certifications), quarterly reports, health care delivery, enrollment, including, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS must update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the Project Officer and the Regional Office) must jointly develop the agenda for the calls.

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

63. **Quarterly Progress Reports.** The state must submit quarterly progress reports in the format specified by CMS in Attachment B, no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:
    a. An updated budget neutrality monitoring spreadsheet;
    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
    c. Adverse incidents including abuse, neglect, exploitation, mortality reviews and critical incidents that result in death as known as reported;
    d. State efforts related to the collection and verification of encounter data, and utilization data;
    e. Action plans for addressing any policy, administrative, or budget issues identified;
    f. Monthly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;
    g. Number of participants who chose an MCO and the number of participants who change plans after being auto-assigned (including the number of plan change requests described in paragraph 26); and
    h. Complaints, grievances and appeals filed during the quarter by type including access to urgent, routine, and specialty care
    i. Evaluation activities and interim findings. The state shall 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 shall 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.
    j. Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, pursuant to STC 54, the state must also report on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

64. **Annual Report.** The state must submit a draft annual report containing, at a minimum, the requirements below. The state must submit the draft annual report to CMS no later than March 31 each year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted to CMS.

    a. All items included in the quarterly report pursuant to STC 53 must be summarized to reflect the operation/activities throughout the DY;

b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement;

d. Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure monitoring, summary of plan financial performance; and

e. Expenditures for uncompensated care costs.

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

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

66. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XII. GENERAL FINANCIAL REPORTING REQUIREMENTS FOR DEFINED AUTHORIZED EXPENDITURES

67. **Quarterly Reports.** The state must provide quarterly expenditure reports using the form

CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section XIII entitled, Monitoring Budget Neutrality in the demonstration.

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

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

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

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

    d. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides an increased federal medical assistance of 100 percent for the amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may exclude from the budget neutrality test for this demonstration the portion of the increase for which the federal government pays 100 percent. These amounts should be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

    e. For each demonstration year, 19 separate waiver forms, using Forms CMS-64.9 Waiver and/or 64.9P Waiver, must be completed, using the waiver names in

parentheses below, to report expenditures for individuals enrolled in the demonstration and for hospital and long-term care facility uncompensated care payments as follows:

Expenditure and Eligibility Group Reporting	Required CMS 64.9 Waiver and CMS 64.9P Waiver forms	Description of Waiver form
State Plan Children	State Plan Children	Mandatory Title XIX Children
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrants/COFAs	Mandatory Title XIX Adults, excluding-pregnant immigrants/COFAs, newly eligible adults, and expansion state adults; Mandatory Title XIX Pregnant Immigrants/COFAs
Aged	Aged w/ Mcare Aged w/o Mcare	Aged with Medicare Aged without Medicare
Blind or Disabled	B/D w/ Mcare B/D w/o Mcare BCCTP	Blind or Disabled with Medicare Blind/Disabled without Medicare Breast and Cervical Cancer Treatment Program
Expansion State Adults	Expansion State Adults	Expansion State Adults
Newly Eligible Adults	Newly Eligible Adults	Newly Eligible Adults
Optional State Plan Children	Optional State Plan Children	Optional Title XIX Children, including medically needy children and Title XXI children if Title XXI allotment is exhausted
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old
Medically Needy Adults	Medically Needy Adults	Medically Needy Adults
Demonstration Eligible Adults	Demonstration Eligible Adults	Demonstration Eligible Adults
Demonstration Eligible Children	Demonstration Eligible Children	Demonstration Eligible Children
VIII-Like Group	VIII-Like Group	VIII-Like Demonstration Eligible Adults
UCC-Governmental	UCC-Governmental	Hospital payments to governmentally-operated hospitals
UCC-Governmental LTC	UCC-Governmental LTC	Long term care payments to governmentally-operated nursing facilities
UCC-Private	UCC-Private	Hospital payments to private hospitals

69. **Expenditures Subject to the Budget Neutrality Ceiling.** For purposes of this section, the term "expenditures subject to the budget neutrality ceiling" must include all Medicaid expenditures on behalf of individuals who are enrolled in this demonstration and for hospital

uncompensated care payments as described in section XI, entitled General Reporting Requirements of these STCs. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

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

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

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

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

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

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

    c. For the purposes of this demonstration, the term "demonstration eligibles" refers to the eligibility groups described in section XIII, entitled Monitoring Budget

Neutrality in the demonstration. The term "demonstration eligibles" specifically excludes unqualified aliens, including aliens from the Compact of Free Association countries.

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

75. **Extent of Federal Financial Participation.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS must provide FFP at the applicable federal matching rates for the following, subject to the limits described in section XIII, entitled Monitoring Budget Neutrality in the demonstration.

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

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

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

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

General Financial Requirements under Title XXI

Beginning January 1, 2008, the state will not receive FFP under Title XXI for expenditures for QUEST children who are not authorized in the CHIP State Plan.

79. **Expenditures Subject to the Allotment Neutrality Limit.** Eligible Title XXI demonstration expenditures subject to the allotment neutrality agreement are expenditures for services provided through this demonstration to Title XXI children with FPL levels within the approved CHIP State Plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the state's available Title XXI funding.

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

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

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

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

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

83. **Administrative Costs.** All administrative costs are subject to the Title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

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

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

86. **Exhaustion of Title XXI Funds.** After the state has exhausted Title XXI funds, expenditures for optional targeted low-income children within the CHIP State Plan approved income levels, may be claimed as Title XIX expenditures, as approved in the Medicaid state plan. The state shall report expenditures for these children, identified as "Optional State Plan Children," as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with the instructions that can be found in STC 68 (entitled Reporting Expenditures Under the Demonstration).

87. **Exhaustion of Title XXI Funds Notification**. The state must notify CMS in writing of any anticipated Title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures. The state must follow Hawaii Medicaid state plan criteria for the beneficiaries

unless specific waiver and expenditure authorities are granted through this demonstration.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

88. **Limit on Title XIX Funding.** The state must be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a combined per capita cost method and aggregate DSH method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

89. **Risk.** Hawaii must be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles in the EGs 1 through 6 as described below under this budget neutrality agreement, but not for the number of Medicaid eligibles in each of the groups. By providing FFP for all eligibles in the specified EGs, Hawaii must not be at risk for changing economic conditions that impact enrollment levels. However, by placing Hawaii at risk for the per capita costs for Medicaid eligibles in each of the EGs under this agreement, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

90. **Eligibility Groups (EG) Subject to the Budget Neutrality (BN) Agreement.** The 6 EGs subject to this budget neutrality agreement are:

EG subject to BN	Expenditure and eligibility reporting groups
EG 1 - Children	• State Plan Children • Opt. State Plan Children • Foster Care Children, 19-20 Years Old
EG 2 – Adults	• State Plan Adults
EG 3– Aged*	• Aged
EG 4 – Blind/Disabled*	• Blind or Disabled • Medically needy adults
EG 5 – VIII-Like Adults	• VIII-Like Adults
EG 6 – VIII Group Combined	• Newly Eligible Adults • Expansion State Adults

* The demonstration expansion populations that are included in EG 3 and 4 (i.e. the 217-like group and certain medically needy individuals) are "pass-through" or "hypothetical" populations. Therefore, the State may not derive savings from these populations.

91. **Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality ceiling:

    a. For each year of the budget neutrality agreement an annual limit is calculated for the EGs described above, on a total computable basis. The annual limit for the

demonstration is the sum of the projected annual limits for EGs 1 through 4, plus a DSH adjustment for that year described in STC 94, plus the EGs included in the supplemental budget neutrality tests below.

b. The budget neutrality ceiling is the sum of the annual PMPM limits for the demonstration period plus the sum of the DSH adjustment, plus the amount of unused budget authority carried over from prior demonstration years. The federal share of the budget neutrality ceiling represents the maximum amount of FFP that the state may receive for expenditures on behalf of eligibles described in STC 90 during the demonstration period. The Federal share of this ceiling will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in STC 97 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (State Plan Children, Opt. State Plan Children, Foster Care Children, 19-20 Years Old, State Plan Adults, Aged, Blind or Disabled, Medically Needy adults, Demonstration Eligible Adults, Demonstration Eligible Children, UCC-Governmental, UCC-Governmental LTC, and UCC-Private), plus any excess spending from the Supplemental Tests described in STCs 95 and 96.

92. **Capita Budget Neutrality Limit.**

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

b. The PMPM costs in subparagraph (c) were determined by applying the growth rate for each EG.

c. The following are the ceiling PMPM costs for the calculation of the budget neutrality expenditure ceiling for EG 1 through 4. The PMPM costs below must be the net of premiums paid by QUEST Integration eligibles.

Eligibility Group	Growth Rate	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM	DY 24 PMPM	DY 25 PMPM
EG 1 - Children	1.01	$421.09	$424.24	$428.49	$432.77	$437.10	$441.47
EG 2 - Adults	1.037	$749.94	$755.56	$783.51	$812.50	$842.56	$873.74
EG 3 - Aged	1.034	$1,596.99	$1,608.95	$1,663.66	$1,720.22	$1,778.71	$1,839.19
EG 4 – Blind/Disabled	1.045	$2,057.78	$2,073.20	$2,166.49	$2,263.98	$2,365.86	$2,472.33

93. **DSH Adjustment.** The DSH adjustment is based upon Hawaii's DSH allotment for 1993 and calculated in accordance with current law. The total computable DSH for each subsequent year must be the previous demonstration year's adjustment trended by the policy contained in current law. In this manner, Hawaii will have available funding for DSH adjustments similar to other states. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation that impacts the calculation of DSH allotments.

94. **DSH Adjustment Limits.** The following are the aggregate DSH adjustment limits for demonstration years 20, 21, 22, and 23 of the demonstration.

	Growth Rate	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM *
DSH adjustment	1.024	$48,848,589	$99,450,504	$101,837,316	$51,832,471

* The amount for DY 23 is only for the period from January 1, 2016 through June 2016.

95. **Supplemental Budget Neutrality Test 1: VIII-like group.** The budget neutrality test for this demonstration includes an allowance for the VIII-like group. The expected costs of the VIII-like group is reflected in the "without-waiver" budget neutrality expenditure limit. The state must not accrue budget neutrality "savings" from this population. To accomplish these goals, a separate expenditure cap is established for the VIII-like group, to be known as Supplemental Budget Neutrality Test 1.

a. The MEGs listed in the table below are for the Supplemental Budget Neutrality Test 1.

Eligibility Group	Growth Rate	DY 20 PMPM
EG 5 – VIII-Like group	N/A	$663.42

b. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for the group in the above table for the DY, times the number of eligible member months for that group and DY. The federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 2.

c. Supplemental Budget Neutrality Test 1 is a comparison between the Federal share of Supplemental Cap 1 and total FFP reported by the State for the VIII-like group.

d. If total FFP for the VIII-like group should exceed the Federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in paragraph 91.

96. **Supplemental Budget Neutrality Test 2: VIII Group.** Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality. The state will not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for this group, to be known as Supplemental Budget Neutrality Test 1.

a. The MEGs listed in the table below are for the Supplemental Budget Neutrality Test 2.

Eligibility Group	Growth Rate	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM	DY 24 PMPM	DY 25 PMPM
EG 6 – VIII group combined	1.051	N/A	$684.37	$719.27	$755.95	$794.51	$835.03

b. If the state's experience of the take up rate for the VIII group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the VIII group, the state may submit an adjustment to paragraph (a) for CMS review without submitting an amendment pursuant to paragraph 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

c. The Supplemental Cap 2 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap 2 is obtained by multiplying total computable Supplemental Cap 2 by the Composite Federal Share 3.

d. Supplemental Budget Neutrality Test 2 is a comparison between the federal share of the Supplemental Cap 2 and total FFP reported by the State for VIII Group.

e. If total FFP for VIII Group should exceed the federal share of Supplemental Cap 2 after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in STC 91.

97. **Composite Federal Share:** The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures for EG 1 through 4 and the DSH adjustment under STC 92 and 94; Composite Federal Share 2, based on the expenditures for the VIII-like group under STC 95(a); and Composite Federal Share 3, based on the expenditures for the VIII-group under STC 96(a). Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. 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 upon method.

98. **Reporting Actual Member Months.** For the purpose of monitoring budget neutrality,

within 60 days after the end of each quarter, the state must provide a report to CMS in the format provided by CMS in Attachment B, identifying the state's actual member months for each EG and corresponding actual expenditures for each EG, less the amount of premiums paid by QUEST Integration eligibles.

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

DY	Cumulative Target Definition	Percentage
Year 21	Cumulative budget neutrality limit plus:	1,0 percent
Years 22 through 23	Cumulative budget neutrality limit plus:	0.5 percent
Year 24 and 25	Cumulative budget neutrality limit plus:	0 percent

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

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

XIV. EVALUATION OF THE DEMONSTRATION

101. **State Must Evaluate the Demonstration.** The evaluation report as approved by CMS for the prior extension is due no later than the date that is 120 days after the date of approval of the extension of this demonstration. In addition, the state must submit to CMS for approval a draft evaluation design with appropriate revisions to accommodate programmatic changes no later than that date.

a. **Goals, objectives, and hypothesis**: The draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration.
b. **Outcome measures:** The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population.
c. **Data Sources:** The evaluation design must also discuss the data sources, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys, and sampling methodology for assessing these outcomes.
d. **Detailed Analysis plan:** The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state.
e. **Level of Analysis:** The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and

include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

f. **Identification of evaluator:** The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

The state must also submit the evaluation required under STC 44 not later than January 1, 2016.

102. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft design within 60 days of receipt, and the state must submit a final design within 60 days of receipt of CMS comments. The state must implement the evaluation design and submit its progress in the quarterly reports. The state must submit to CMS a draft of the evaluation report 120 days prior to the expiration of the demonstration. CMS must provide comments within 60 days of receipt of the report. The state must submit the final report prior to the expiration date of the demonstration. The Final Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the demonstration; the evaluation questions and hypotheses tested; and key findings and policy implications.

b. Demonstration Description. This includes a description of the demonstration programmatic goals and strategies, particularly how they relate to the Triple Aim and interventions implemented.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses, type of study design, impacted populations; data sources; and data collection and analysis techniques.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful demonstration strategies to be replicated in other State Medicaid programs.

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

104. **Public Access.** The state shall post the final approved Evaluation Plan, Quarterly and Annual Progress Reports, Interim Evaluation Report, if applicable, and Final Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

In addition, CMS must be notified prior to the public release or presentation of these reports and related journal articles, by the contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

105. **Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

106. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the state must fully cooperate with federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION PERIOD

Due Date	Deliverable
30 days from approval letter date	State Acceptance of Demonstration Extension, STCs, Waivers, and Expenditure Authorities.
120 days from approval letter date	Quality Strategy (STC 39)
120 days from approval letter date	Ensure that all prior MSIS reports are timely and accurate (STC 68)
120 days from approval letter date	Evaluation Report for Demonstration through September 30, 2013
120 days from approval letter date	Submit Draft Evaluation Design
60 days after receipt of CMS comments	Submit Final Evaluation Design
March 31, 2014, and each subsequent year	Post Award Forum Transparency deliverable
March 31, 2014, and each subsequent year	Submit Draft Annual Report (STC 54)
January 1, 2014 and each subsequent year	CARTS report for previous fiscal year (STC 64)
90 days prior to implementation of QUEST Integration single contract	Transition plan (STC 31)
30 days before conducting a readiness review	Notice of readiness review (STC 31)
45 days before a new contract or contract change	Contract for CMS review (STC 32)
Before beginning enrollment in QUEST integration single contract	Documentation of network adequacy (STC 31)
January 1, 2016	UCC evaluation (STC 44)
120 prior to expiration of demonstration	Submit draft evaluation report (STC 102)

Quarterly	Deliverable
	Quarterly Reports meeting requirements of Attachment B (STC 63)
	Title XXI Enrollment Reporting (SEDS) (STC 65)
	Expenditure Reports Title XXI (STC 80)
Monthly	**Deliverable**
	Participate in monthly monitoring calls (STC 61)
	Submit monthly enrollment data (STC 62)

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

Governmental Hospitals

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

Private Hospitals

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

Nursing Facilities

Hilo Medical Center
Kona Community Hospital
Leahi Hospital
Maluhia

Approval Period: October 1, 2013 through December 31, 2018

Attachment B
Quarterly Report Format

Under Section XI, paragraph 53, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT:

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

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

Introduction

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

Enrollment Information

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

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

Expenditure and Eligibility Group Reporting	CMS 64.9 Waiver and CMS 64.9P Waiver forms	Current Enrollees (to date)
State Plan Children	State Plan Children	
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrants/COFAs	
Aged	Aged w/ Mcare Aged w/o Mcare	
Blind or Disabled	B/D w/ Mcare B/D w/oMcare	

	BCCTP	
Expansion State Adults	Expansion State Adults	
Newly Eligible Adults	Newly Eligible Adults	
Optional State Plan Children	Optional State Plan Children	
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	
Medically Needy Adults	Medically Needy Adults	
Demonstration Eligible Adults	Demonstration Eligible Adults	
Demonstration Eligible Children	Demonstration Eligible Children	
VIII-Like Group	VIII-Like Group	
UCC-Governmental	UCC-Governmental	
UCC-Governmental LTC	UCC-Governmental LTC	
UCC-Private	UCC-Private	

And

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	
Title XXI funded State Plan	
Title XIX funded Expansion	
Enrollment Current as of	Mm/dd/yyyy

Outreach/Innovative Activities

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

Operational/Policy Developments/Issues

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

Expenditure Containment Initiatives

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

Financial/Budget Neutrality Development/Issues

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

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
EG 1 - Children				
EG 2 – Adults				
EG 3– Aged				
EG 4 – Blind/Disabled				
EG 5 – VIII-Like Adults				
EG 6 – VIII Group Combined				

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
State Plan Children				
State Plan Adults				
Aged				
Blind or Disabled				
Expansion State Adults				
Newly Eligible Adults				
Optional State Plan Children				
Foster Care Children, 19-20 years old				
Medically Needy Adults				
Demonstration Eligible Adults				
Demonstration Eligible Children				
VIII-Like Group				
UCC-Governmental				
UCC-Governmental LTC				
UCC-Private				

QUEST Integration Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Corrective actions and the number of outstanding issues that remain unresolved must be included. Also, discuss feedback received from consumer groups.

Enrollment of individuals eligible for Long term services and supports

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

Behavioral Health Programs Administered by the DOH

A summary of the programmatic activity for the quarter for demonstration eligibles. This shall include a count of the point in time demonstration eligible individuals receiving MQD FFS services through the DOH CAMHD and AMHD Programs.

QUEST Integration transition

A summary and detail of state and MCO activities performed during the quarter, or long-term planning items in progress that are performed with the goal of transitioning to a single QUEST Integration contract.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

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

State Contact(s)

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

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	Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants in accordance with HAR§17-1417. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services. Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency. Adult Day Care Centers are licensed by the Department of Human Services and maintained and operated by an individual, organization, or agency. Included in the sub-set of services for the "At Risk" population.
Adult Day Health Center	Adult Day Health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96 and HAR §11-94-5. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community. Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse. In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, meals which do not constitute a full nutritional program, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services. Adult Day Health Centers are licensed by the Department of Health. Included in the sub-set of services for the "At Risk" population.
Assisted Living Facility	Assisted living services include personal care and supportive care services (homemaker, chore, attendant services, and meal preparation) that are furnished to members who reside in an assisted living facility. Assisted living facilities are home-like, non-institutional settings. Payment for room and board is prohibited. Section 30.200 describes Assisted Living Facilities as a facility, as defined in HRS 321-15.1, that is licensed by the Department of Health. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.
Community Care Management Agency (CCMA)	CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. A health plan may, at its option, demonstrate the ability to provide CCMA services by contracting with an entity licensed under HAR subchapters 1 and 2. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to

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

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	conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.
Expanded Adult Residential Care Home (E-ARCH) or Residential Care Services	Residential care services are personal care services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principal care provider who lives in the home. Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH), allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the DHS to live in a Type I home with no more than two (2) of whom may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. An E-ARCH's is a facility, as defined in HAR §11-100.1.2 and licensed by the Department of Health, that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of expanded care ARCHs in accordance with HRS § 321-1562 as described above.
Home Delivered Meals	Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization. Included in the sub-set of services for the "At Risk" population
Home Maintenance	Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.
Moving Assistance	Moving assistance is provided in rare instances when it is determined through an assessment by the care coordinator that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.
Non-Medical Transportation	Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH

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	are not eligible for this service.
Personal Assistance Services (Level I)	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 • 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. Included in the sub-set of services for the "At Risk" population
Personal Assistance Services (Level II)	Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform activities of daily living (ADLs) and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. The following activities may be included as a part of personal assistance services Level II: • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing; • Assistance with bowel and bladder care; • Assistance with ambulation and mobility; • Assistance with transfers; • Assistance with medications, which are ordinarily self-administered when ordered by member's physician; • Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician; • Assistance with feeding, nutrition, meal preparation and other dietary activities; • 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

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

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	Included in the sub-set of services for the "At Risk" population
Private Duty Nursing	Private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses (as defined in HAR § 16-89) within the scope of state law. Included in the sub-set of services for the "At Risk" population
Respite Care	Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; foster home/expanded-care adult residential care home; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the state. Respite care services are authorized by the member's PCP as part of the member's care plan. Respite services may be self-directed.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation and may include: • Specialized infant car seats; • Modification of parent-owned motor vehicle to accommodate the child (i.e., wheelchair lifts); • Intercoms for monitoring the child's room; • Shower seat; • Portable humidifiers; • Electric bills specific to electrical life support devices (ventilator, oxygen concentrator); • Medical supplies; • Heavy duty items including, but not limited to, patient lifts or beds that exceed $1,000 per month; • Rental of equipment that exceeds $1,000 per month such as ventilators; and • Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month. Items reimbursed shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies shall be recommended by the member's PCP.

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

Introduction

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

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

Summary of Medicare Cost Report Worksheets

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

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

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

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

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

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

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

1. Inpatient Cost to Charge Ratio

Routine Charges: Worksheet C, Part I, Column 6, lines 30 to 43 (Routine Acute Charges, excluding any LTC unit cost centers)
Routine Cost: Worksheet C, Part I, Column 1 lines 30 to 43 (Routine Acute Costs, excluding any LTC unit cost centers) – Line 201 (Observation Beds Cost)
Ancillary Inpatient Charges: Worksheet C, Part I, Column 6, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable
Ancillary Total Charges: Worksheet C, Part I, Column 8, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Inpatient Costs: (Ancillary Inpatient Charges/Ancillary Total Charges) x (Worksheet C Part 1, Column 1, line 200 (Total Cost) – Lines 30 to 45 (Routine Costs including LTC) – Any non-hospital component cost center if applicable (e.g., HHA))

Inpatient Cost to charge Ratio = [Routine Cost + Ancillary Inpatient Costs]/[Routine Charge + Ancillary Inpatient Charges]

2. Outpatient Cost to Charge Ratio

Ancillary Total Charges: Worksheet C, Part I, Column 8, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Outpatient Charge: Worksheet C, Part I, Column 7, line 200 – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Outpatient Cost: (Ancillary Outpatient Charges/Ancillary Total Charges) x (Worksheet C, Part 1, Column 1 line 200 (Total Cost) – Lines 30 to 45 (Routine Costs line LTC) – Any non-hospital component cost center if applicable (e.g., HHA))

Outpatient Cost to charge Ratio = [Ancillary Outpatient Costs]/[Ancillary Outpatient Charges]

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

NOTES:

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

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

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

The "Uncompensated care costs (UCC)" includes covered inpatient and outpatient hospital services costs from the Medicaid Fee for Services (Medicaid FFS), Medicaid QUEST Integration, and Uninsured population, less payments received from Medicaid FFS, QUEST Integration, and from uninsured patients, and excluding costs attributable to services to unqualified aliens. However, UCC are subject to the limitations as set forth in STC section X. Specifically, paragraph 44b, for government-operated hospitals, excludes inpatient Medicaid FFS shortfall, non-emergency care to unqualified aliens, and costs of drugs for individuals eligible for Part D.

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

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

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

Interim Quarterly Expenditure Payment

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

The process of determining the CPEs to cover UCC eligible for FFP begins with the use of each hospital's most recently filed Medicare cost report for purposes of obtaining cost to charge ratios for inpatient and outpatient services using the methodology described in this document. The inpatient cost to charge ratio is applied to the inpatient program charges for the current quarter to determine inpatient costs. The outpatient cost to charge ratio is applied to the outpatient program charges for the current quarter to determine outpatient costs. The service period for inpatient is determined by the discharge date and for outpatient it is the service date. UCC is the cost of providing inpatient and outpatient services as computed above, reduced by an appropriate

adjustment for the cost of undocumented aliens and any applicable revenue collected for the provision of services. Only inpatient and outpatient program charges related to medical services that are eligible under the UCCs will be used to compute inpatient and outpatient program costs for this CPE process. Payments that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments. Direct UCC waiver payments, computed in this protocol, to hospitals by the state will not be included in the total program payments. Non-Medicaid payments, fundings, and subsidies made by a state or unit of local government shall not be offset.

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

Annual Reconciliation Payment

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

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

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

For outpatient UCC cost computation, each ancillary hospital cost center cost-to-charge ratio is

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

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

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

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

Final Reconciliation Payment

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

The inpatient and outpatient cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then

reconciled to the interim quarterly UCC payments and any interim annual reconciliation payments made.

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

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

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

Introduction

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

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

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

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

(1) *Interim Payment*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3) *Final Reconciliation to Finalized Cost Report*

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

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

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

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 or under the Developmental Disabilities or Intellectual Disabilities (DD/ID) 1915(c) waiver.

All beneficiaries have access to standard behavioral health services through the contracted managed care health plans. The standard behavioral health services include inpatient psychiatric hospitalization, medications, medication management, psychiatric and psychological evaluation and management, and alcohol and drug dependency treatment services.

Beneficiaries with SMI, SPMI, or SEBD may be in need of specialized behavioral health services. For children (individuals <21), the SEBD services are provided through the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD); for adults (individuals ≥21) the SMI/SPMI services are provided through the DOH Adult Mental Health Division (AMHD), the MQD's behavioral health program Community Care Services (CCS), or the managed care health plans. Regardless of how adults with SMI/SPMI access specialized behavioral health services, all have access to the same services, and MQD ensures no duplication. The available specialized services include:

- For children: multidimensional treatment foster care, family therapy, functional family therapy, parent skills training, intensive home and community based intervention, community-based residential programs, and hospital-based residential programs, and
- For adults: crisis management, crisis and specialized residential treatment, intensive care coordination/case management, psychosocial rehabilitation (including clubhouse), , peer specialist, financial management services, supportive employment, supportive housing partial or intensive outpatient hospitalization, and therapeutic living supports.

See Addendum A for an overview of the behavioral health services delivery systems for individuals with SMI, SPMI, or SEBD; and see Addendum B for a detailed description of the

services provided by CAMHD, AMHD, CCS, and the managed care health plans.

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. The CAMHD is responsible for providing SEBD services to all individuals age three through twenty (3-20) years who meet eligibility criteria. CAMHD provides services to approximately 900 children. CAMHD had previously functioned as a Pre-paid Inpatient Health Plan (PIHP) but changed to billing these services to MQD through a fee-for-service (FFS) process effective October 1, 2008.

The health plan can make a referral to CAMHD through use the SEBD Referral Form developed by CAMHD. The health plan will continue to provide behavioral health services even after CAMHD admits the individual into their program. In these cases, the health plan will not provide services offered by CAMHD, and CAMHD will not provide services offered by the health plan. The MQD informs the health plans, via the 834-transaction file, when an individual is receiving services through the CAMHD program. When a child is no longer eligible for services through CAMHD, CAMHD will coordinate transition of care with the child's health plan. The health plan will be notified that the individual is no longer receiving services via CAMHD via the 834-transaction file.

Referrals to CAMHD can also occur through the school, parent, child, or the health plan. CAMHD considers all referrals through an assessment process. Even if a child qualifies for SEBD services, parents can choose to have their children's behavioral health services provided through the child's health plan. However, the health plans are only able to provide the 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 ≥21 YEARS)

A. Clinical Criteria

For the beneficiaries >/=21 years old with a SMI or SPMI are eligible for specialized behavioral health services if they meet the following criteria:

- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The beneficiary meets at least one of the criteria below demonstrating instability and/or functional impairment:
  - Global Assessment of Functioning (GAF) < 50;
  - Clinical records demonstrate that the beneficiary is currently unstable under current treatment or plan of care. (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

The current organization for the delivery of specialized behavioral health services is largely historical. Around the time that the QUEST program was implemented in the mid-1990's, for which specialized behavioral health services were carved out, the CCS program was created due to the lack of behavioral health services for Medicaid beneficiaries with a SMI/SPMI. (AMHD had a limited service package at that time.) In the early 2000 timeframe, AMHD expanded its services significantly, largely modeling the CCS services, due to a mandated court decree that was withdrawn in 2006. However, MQD continued to offer its CCS program despite the expansion of services within AMHD.

CCS predominately served non-Aged, Blind and Disabled (ABD) individuals, and AMHD largely served ABDs. When QExA was implemented as managed care for the ABD population, specialized behavioral health services remained carved out. Over the years as individuals were offered choice, an increasing number of non-ABDs began to receive their services through AMHD, and an increasing number of ABDs began to receive their services through CCS.

In an effort to improve integration between medical and behavioral health care, effective July 1, 2010, the MQD transitioned all behavioral health services provided to QUEST adult beneficiaries by AMHD and the CCS program into the QUEST health plans. MQD observed that neither behavioral health outcomes nor medical outcomes were improved for this population, and the fragmentation among multiple health plans created confusion for patients and providers alike.

Effective March 1, 2013, CCS will be converted from primarily a third party administrator contract to a Pre-paid Inpatient Health Plan (PIHP), and MQD intends to transition all adults to receive their specialized behavioral health services through CCS. The state anticipates completing this transition by January 1, 2015. The following describes the current alternative service delivery options for adults until all adults can be transitioned to the CCS program to receive their specialized behavioral health services as described in this protocol.

1. AMHD

   MQD had a MOU with AMHD to provide services to Medicaid beneficiaries. Currently, AMHD provides specialized behavioral health services to approximately 1,200 Medicaid ABD adults, until this population can be transitioned to the CCS program. AMHD bills specialized behavioral health services to the MQD through a FFS process.

   Referrals to AMHD occur through either the beneficiary (self-referral) by calling the AMHD access line, or by beneficiary choice after a health plan referral and determination of eligibility. AMHD considers all referrals through an assessment process and uses the same criteria as listed in section A above. If the individual meets criteria, AMHD will notify MQD, develop an individual service plan, and begin providing services.

   Currently, the QExA health plans make referrals for adult members identified with a SMI/SPMI. All referrals are reviewed by a MQD physician for eligibility. Eligible beneficiaries can choose to receive their specialized behavioral health services through AMHD or CCS, until the transition at which time they will only be able to receive the specialized behavioral health services through CCS.

   The specialized behavioral health services provided by AMHD include both intensive case management and targeted case management. These services are distinct from the services provided through the managed care health plans.

2. CCS
   The CCS program provides specialized behavioral health services to approximately 900 Medicaid ABD adults. MQD awards the CCS program to a contractor through a Request for Proposals (RFP) to provide specialized behavioral health services to eligible adults as a PIHP. Certain new services may be reimbursed on a fee-for-service basis until able to be incorporated into the capitation rates.

   Currently, the QExA health plans make referrals for adult members identified with a SMI/SPMI. All referrals are reviewed by a MQD physician for eligibility. Eligible beneficiaries can choose to receive their specialized behavioral health services through AMHD or CCS, until the transition at which time they will only be able to receive the specialized behavioral health services through CCS. Once enrolled in CCS, CCS performs an assessment and develops an individual service plan.

3. Managed Care Health Plans
   All managed care health plans provide all their beneficiaries with standard behavioral health services. Currently, the QUEST health plans also provide approximately 2,000 adults with specialized behavioral health services, until this population is transitioned to receive specialized behavioral health services through CCS. Payment to the health plans is incorporated into their capitation rates. The health plans identify adult members with a SMI/SPMI and perform an assessment to develop an individual service plan. Certain specialized services are provided by CCS instead of the health plan.

Regardless of the specialized behavioral health service delivery option an adult utilizes, the individual will have access to the same specialized behavioral health services. This will be clear, and the delivery system will be more integrated, once MQD successfully transitions all adults with SMI/SPMI to receive their specialized behavioral health services through the CCS program.

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 futher 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.

Attachment E
Behavioral Health Services Protocol

A. State Plan Standard Behavioral Health Services (including substance abuse treatment)

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

B. State Plan Specialized Behavioral Health Services

1. Assertive Community Treatment (intensive case management and community-based residential programs)
2. Biopsychosocial Rehabilitation
3. Crisis Management
4. Crisis Residential Services
5. Hospital-based Residential Programs
6. Intensive Family Intervention
7. Intensive Outpatient Hospital Services
8. Therapeutic Living Supports and Therapeutic Foster Care Supports (Addendum D includes the State plan pages for these Community Mental Health Rehabilitative Services)
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. Supportive Employment

a. Supported employment includes activities needed to obtain and sustain paid work within the general workforce by beneficiaries and includes assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the beneficiary, transitioning the beneficiary from volunteer work to paid employment, and assisting the beneficiary in maintaining an individual job in the general workforce at or above the state's minimum wage.

b. Supported employment support is conducted in a variety of settings to include self-employment. With regard to self-employment, individual employment support services may include:
   i. Aiding the beneficiary to identify potential business opportunities;
   ii. Assisting in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business;
   iii. Identifying the supports that are necessary in order for the beneficiary to operate the business; and
   iv. Providing ongoing assistance, counseling and guidance once the business has been launched.

3. Supportive Housing
   a. This is housing-based care management focused on identifying and securing affordable housing resources to include assistance with finding and retaining housing such as Section 8, Section 811, other Housing and Urban Development (HUD) programs, public housing and advocating for increased housing resources through state and local consolidated planning processes.
   b. Transitioning beneficiaries into housing and supporting them by providing housing stabilization and retention services to include but not limited to training in being a good tenant, establishing procedures and contacts to maintain/upkeep housing accommodations (lease compliance), obtaining reasonable accommodations and modifications

Exhibit 1 to Attachment E

Overview of Behavioral Health Services Delivery

	Adults without SMI/SPMI	Non-ABD Adults with SMI/SPMI	ABD Adults with SMI/SPMI Enrolled in AMHD	Adults with SMI/SPMI Enrolled in CCS	Children with SEBD Enrolled in CAMHD
Standard Behavioral Health Services					
Acute Psychiatric Hospitalization	HP	HP	HP	CCS	HP
Diagnostic/laboratory Services	HP	HP	HP	CCS	HP
Electroconvulsive Therapy	HP	HP	HP	CCS	HP
Evaluation and Management	HP	HP	HP	CCS	CAMHD/ HP
Methadone Treatment	HP	HP	HP	CCS	HP
Prescription Medications	HP	HP	HP	CCS	HP
Substance Abuse Treatment	HP	HP	HP	CCS	HP
Transportation	HP	HP	HP	CCS	HP
Specialized State Plan Behavioral Health Services					
Biopsychosocial Rehabilitation	n/a	HP	AMHD	CCS	n/a
Community Based Residential Programs	n/a	n/a	n/a	n/a	CAMHD
Crisis Management	n/a	HP	AMHD	CCS	CAMHD
Crisis Residential Services	n/a	HP	AMHD	CCS	CAMHD
Hospital-based Residential Services	n/a	n/a	n/a	n/a	CAMHD
Intensive Case Management	n/a	HP	AMHD	CCS	CAMHD
Intensive Family Intervention	n/a	n/a	n/a	n/a	CAMHD
Intensive Outpatient Hospital Services	n/a	HP	AMHD	CCS	CAMHD
Therapeutic Living Supports and Therapeutic Foster Care Supports	n/a	HP	AMHD	CCS	CAMHD

Specialized 1115 Behavioral Health Services					
Financial management services	n/a	CCS	AMHD	CCS	n/a
Supportive Employment	n/a	CCS	AMHD	CCS	n/a
Supportive Housing	n/a	CCS	AMHD	CCS	n/a

Legend:

ABD	Aged, Blind, or Disabled
AMHD	Adult Mental Health Division in the Department of Health
HP	Health Plan
CAMHD	Child and Adolescent Mental Health Division in the Department of Health
CCS	Community Care Services program
SEBD	Support for Emotional and Behavioral Development
SMI	Severe Mental Illness
SPMI	Serious and Persistent Mental Illness

Exhibit 2 to Attachment E

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[3] licensed to provide psychiatric services	Twenty-four (24) hour care for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services as needed	Provided by health plan	Twenty-four hour acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services, as needed o Other medically	Provided by health plan

[3] Excludes Institutions of Mental Disease (IMDs) as defined at 42 CFR 435.1010

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		o Other medically necessary services o Pharmaceuticals o Rehabilitation services, as needed		necessary services o Pharmaceuticals o Rehabilitation services, as needed	
Diagnostic/ laboratory services	Laboratories	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol problems Other medically necessary diagnostic services	Provided by health plan	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol Other medically necessary diagnostic services	Provided by health plan
Electroconvulsive Therapy (ECT)	Acute Psychiatric Hospital Outpatient facility	ECT o Medically necessary, may do more than one/day Inclusive of anesthesia	Provided by health plan	ECT o 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	Psychiatric or psychological evaluation Individual and group counseling and	Psychiatric or psychological evaluation for SMI/SPMI Individual and group	Psychiatric, psychological or neuropsychological evaluation for SMI/SPMI	Psychiatric, psychological or neuropsychological evaluation for SEBD Individual and group

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	monitoring	counseling and monitoring for SMI/SPMI HP provides individual and group counseling and monitoring for non-SMI/SPMI	Individual and group counseling and monitoring for SMI/SPMI HP provides individual and group counseling and monitoring for non-SMI/SPMI	counseling and monitoring for children requiring SEBD HP provides individual and group counseling and monitoring for all other children
Methadone treatment	Methadone clinics	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan
Prescription Medications	Providers licensed to prescribe (e.g. Psychiatrist and APRN Rx). Medications are dispensed by licensed pharmacies.	Prescribed drugs including medication management and patient counseling	Provided by health plan	Prescribed drugs including medication management and patient counseling	Provided by health plan
Substance Abuse	Licensed providers and certified	Substance Abuse-Residential	Provided by health plan	Substance Abuse-Residential	Provided by health plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	substance abuse counselors* Specialized residential treatment facilities Facilities licensed to perform substance abuse treatment	o Medically necessary services based on American Society of Addiction Medicine (ASAM) Substance Abuse – Out-patient o Screening o Treatment and treatment planning o Therapy/counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary o Screening for drugs and alcohol.		o Medically necessary services based on American Society of Addiction Medicine (ASAM) Substance Abuse – Out-patient o Screening o Treatment and treatment planning o Therapy/counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary o Screening for drugs and alcohol.	
Transportation	Approved	Transportation	Provided by health	Transportation	Provided by health

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	transportation providers to include medical vans, taxi cabs, bus services, and handicap bus services.	o Air o Ground for medically necessary services	plan	o Air o Ground for medically necessary services	plan
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[4]	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.+

[4] Meet inpatient psych under 21 requirements under 42 CFR 440.160

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Crisis Management	Qualified Mental Health Provider**	Crisis Management a. 24-hour crisis telephone consultation b. Mobile outreach services Crisis intervention/ stabilization services	Crisis Management c. 24-hour crisis telephone consultation d. Mobile outreach services e. Crisis intervention/ stabilization services	Crisis Management a. 24/7 Crisis hotline (through 800#) b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization	Crisis Management a. 24/7 Crisis hotline (through 800#) b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization d.
Crisis Residential Services	Qualified Mental Health Provider**	Not provided	Crisis Residential Services	Crisis Residential Services	Crisis Residential Services
Hospital based residential treatment[5]	Acute psychiatric hospital	Not provided	Not provided	Not provided	Hospital based residential treatment
Intensive Case Management	Qualified Mental Health Provider**	Care Coordination/Case Management	Intensive Case Management/ community-based care management Targeted Case Management	Care Coordination/Case Management o Case assessment o Case planning (service planning, care planning) o Outreach o Ongoing monitoring and service coordination	Intensive Case Management/ community-based care management Targeted Case Management

[5] Excludes services in IMD as defined at 42 CFR 435.1010.

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Intensive family intervention	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	Not provided	Not provided	Not provided	Intensive family intervention
Intensive Outpatient Hospital Services	Acute psychiatric Hospitals Qualified Mental Health Provider**	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and	Intensive Outpatient Hospital Services: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and	Intensive Outpatient Hospital Services: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		aftercare o Other medically necessary services	aftercare o Other medically necessary services	aftercare o Other medically necessary services	aftercare o Other medically necessary services
Peer Specialist	Certified peer specialist	Structured activities within a peer support center that promote socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promote socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promote socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Not provided
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
Supportive Employment	Qualified Mental Health Provider**	Not provided	Activities to obtain and sustain paid work by beneficiaries.	Activities to obtain and sustain paid work by beneficiaries.	Not provided
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 Attachment E

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:

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)
- Delusional Disorders (297.1)
- Mood Disorders - Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders - Depressive Disorders (296.24, 296.33, 296.34)
- Post-traumatic stress disorder
- Substance induced psychosis

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September 28, 2004

MEMORANDUM OF AGREEMENT

BETWEEN
DEPARTMENT OF HUMAN SERVICES
AND
DEPARTMENT OF HEALTH

This MEMORANDUM OF AGREEMENT (MOA) between the Med-QUEST Division (MQD) of the Department of Human Services (DHS) and the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health (DOH) is to provide behavioral services for QUEST and Medicaid Fee-For-Service (FFS) children and adolescents age 3 through age 20 who are eligible and determined to be Seriously Emotionally and Behaviorally Disturbed (SEBD) and in need of intensive mental health services. This MOA covers the period from July 1, 2004 to June 30, 2005. The above-mentioned state agencies agree to the following provisions specified herein.

I. THE CAMHD OF THE DEPARTMENT OF HEALTH SHALL:

A. Provide the following services to youth covered under this MOA as specified in Attachment I.

B. Determine level and medical appropriateness of behavioral health managed care services as documented in the client's individualized behavioral health treatment plan in accordance with state quality assurance and utilization review standards.

C. Have an internal Grievance and Appeals process in place. All grievances and appeals should be resolved within thirty (30) days from the receipt of the written or verbal expression of dissatisfaction, unless a fourteen (14) day Extension or Expedited appeal is initiated. The policies and procedures for resolution of grievances and appeals shall be included as part of the CAMHD Quality Assurance Program and be in compliance with the grievance and appeal requirements of the MQD. CAMHD shall provide MQD with a quarterly grievance and appeals report in a format determined by the MQD.

D. Comply with any DHS Administrative Appeals Office (AAO) decision relating to the provision of behavioral health services covered by the MOA. A recipient shall utilize the CAMHD Grievance System before appealing to the DHS AAO. CAMHD shall notify the recipient/family of the right to appeal to DHS. Appeals shall be limited to Medicaid covered services. Any appeal to DHS shall not waive the recipient's right to judicial appeal.

E. Provide a continuation of benefits during an appeal or state fair hearing.

F. Implement in full the Quality Assurance Program (QAP) approved by the MQD. CAMHD shall implement changes to operations, policies and procedures, and provider contracts to remain in compliance with the approved QAP.

G. Maintain staffing level and proficiency and an adequate provider network to provide the quality and extent of services and activities required under the state and federal regulations applicable to a Prepaid Inpatient Health Plan. CAMHD clinical staff and providers shall be qualified and trained in the principles and techniques of mental health treatment and services. Providers shall meet state licensing requirements for professions where licensing is required to provide mental health services.

H. Establish monitoring schedules and criteria, and monitor CAMHD providers of services and staff on a regular basis to ensure compliance with the QUEST program.

I. Maintain documentation that CAMHD providers are maintaining records of services provided by providers' staff and contractors in compliance with the QAP requirements. Maintain confidentiality of such records as required by state and federal laws.

J. Comply with requests from the state and federal government and/or their representatives to review all medical and financial records of CAMHD, and its subcontractors and providers, and CAMHD staff to ensure compliance with the terms and condition of this Agreement and the state and federal rules and regulations.

K. Process electronic transmission of daily and monthly rosters for eligibility for QUEST and Medicaid FFS youth covered under this MOA and support the electronic transmission of daily and monthly rosters for eligibility.

L. Submit a monthly invoice to support billing for QUEST and Medicaid FFS youth covered under this Agreement.

M. Provide a monthly (if network changes take place) or a quarterly submission of CAMHD's provider network in accordance with instructions and filing requirements established by the MQD.

N. Provide a monthly submission of encounter data in accordance with instructions and filing requirements established by the MQD.

O. Provide a signed Letter of Certification at the time of the encounter and provider data submission. The letter of certification shall be signed by the Chief Executive Officer, Chief Financial Officer or an individual who has been delegated authority to sign for and who reports directly to one of the above organizational officers. The letter must certify that the data is accurate, complete and truthful.

P. Pay for behavioral health services for eligible children and adolescents that CAMHD determines to be necessary but are not covered under this agreement.

Q. Inform MQD of recipients who are accepted into or disenrolled from CAMHD services within thirty (30) days. CAMHD shall be responsible to verify the enrollment and disenrollment date of recipients from the daily and/or daily and monthly rosters provided by MQD.

R. Minimize the disruption of behavioral health services during the transition of care for recipients covered under this Agreement when transitioning from the QUEST plans to CAMHD. Assure the continued provision of comparable services and preserve existing therapeutic relationships between the child and provider as medically necessary for the child/adolescent.

S. CAMHD shall inform the QUEST plan when a transition or termination of a recipient's services is to occur due to a change in their status and pay for all behavioral health services provided by a QUEST plan prior to the transition or termination. CAMHD will be responsible for notifying MQD of referrals between CAMHD and the QUEST plan.

T. If a recipient is enrolled in the CAMHD plan under this MOA and is in need of urgent care and/or crisis intervention and a CAMHD provider is not available to provide the services, CAMHD agrees that the QUEST plan shall provide the service if possible and if it is determined to be medically necessary by the QUEST plan. The CAMHD shall be responsible to reimburse the QUEST plan through MQD for the service(s) provided plus a 10 % administrative fee.

U. Provide written information to recipients and their families informing them of their benefits, rights, and responsibilities within the acceptable timeframe established by the MQD.

V. Meet the terms of the medical Request for Proposal (RFP) rules and requirements as they apply to CAMHD as a Prepaid Inpatient Health Plan.

W. Comply with all federal and state rules and regulations to include the Balanced Budget Act of 2002, implemented August 13, 2004.

II. THE MQD OF THE DEPARTMENT OF HUMAN SERVICES SHALL:

A. Pay the CAMHD a monthly reimbursement rate of $ 542.87 per member per month for each youth/adolescent covered under this MOA that are not classified under Section 504 as needing mental health services. Payment shall be made no later than thirty (30) calendar days subsequent to receiving the submission of encounter data and shall be reconciled annually to actual costs based on utilization reported as encounters and priced at Medicaid rates. Any adjustment for the year will be applied retroactively.

- The monthly reimbursement rate payment shall be paid on a prorated basis for the number of days during the month in which the child was enrolled with CAMHD.

- The date of disenrollment from CAMHD shall be effective at the end of the month in which DHS is notified through use of the Enrollment/Disenrollment

B. Pay for services on a Fee-For-Service basis for behavioral health services provided by CAMHD to Medicaid eligibles that are classified as blind or disabled and are not enrolled in a QUEST health plan. FFS claims for behavioral health services covered under the Hawaii State Medicaid program shall be submitted to the MQD's fiscal agent. Claims billing and processing shall be conducted in accordance with established billing and payment procedures.

C. Review the operations and policies of the CAMHD on a continuing basis to determine if Hawaii QUEST quality assurance (QA) standards for a written QAP are met. The MQD reserves the right to delay re-implementation of this MOA until all quality assurance standards are met.

D. Monitor CAMHD to ensure that it has implemented its written QAP. MQD reserves the right to withhold and/or deny payments if CAMHD cannot implement its QAP.

E. Ensure that clients meet eligibility and enrollment criteria for Medicaid.

F. Ensure that enrollments and disenrollments of youth covered under this MOA are done accurately and in an efficient and timely manner and in accordance with agreed upon procedures.

G. Provide the directives to CAMHD during the transition period of youth covered under this MOA into CAMHD to assure the continued provision of comparable services and to preserve existing therapeutic relationships if it is medically necessary for the child/adolescent.

H. Inform other QUEST plans regarding their responsibility to transition indicated youth to the CAMHD behavioral health plan.

Reimbursement for Services:

a) The CAMHD shall submit a monthly invoice and be reimbursed by DHS for behavioral health services provided to recipients who are covered by this MOA at the Monthly Reimbursement rate of $ 542.87 per member per month subject to annual reconciliation to actual costs. DHS shall pay CAMHD based on the monthly eligibility roster. The above rate includes federal and state funding.

b) The monthly reimbursement rate is calculated based on the estimated per member per month based on historical encounters and enrollments, and will be reconciled to actual costs incurred by CAMHD on an annual basis. Within ninety (90) days of the end of the fiscal year, or by September 30th of each year, CAMHD shall supply MQD with encounters, in the format specified in the Health Plan Manual, for all services provided to children covered under this agreement during the fiscal year for purposes of reconciliation. The costs indicated by the encounter data shall be the sole source of reporting costs incurred by CAMHD to the MQD.

MQD shall then reconcile monthly payments against the federally funded portion of the actual costs incurred. If the total payments exceed the federally funded portion of actual costs, CAMHD shall refund the difference to MQD. If the total payments are less than the federally funded portion of actual costs, MQD shall pay the difference to CAMHD. At the end of each reconciliation, the reimbursement rate will be re-determined for the next Fiscal Year based on the previous years federally funded actual costs for similar services.

c) Federal funds are not available for children classified as needing mental health treatment services under Section 504; therefore CAMHD shall not receive reimbursement from DHS for these children. CAMHD will be responsible for determining whether individuals who require 504 accommodations include mental health services.

d) The DHS shall pay the DOH for the federal share at the Hawaii Federal Medical Assistance Percentage (FMAP) in place for the month for which reimbursement is made. The DOH is responsible for the state's share of the expenditures.

e) The total amount of this AGREEMENT shall not exceed $7.5 million in federal funds per state fiscal year.

f) The CAMHD shall reimburse MQD any amount disallowed by CMS for services provided under this MOA.

g) For services covered by this MOA, MQD agrees to coordinate reimbursement from CAMHD for intensive behavioral health services provided by QUEST plans plus a 10% administrative fee for services provided to CAMHD recipients covered under this MOA during their assessment and transition. The reimbursement shall be a net against the capitation payment.

h) For services not covered by this MOA, if CAMHD provides and pays for services for which the QUEST medical plans are financially responsible, MQD agrees to coordinate reimbursement from the QUEST medical plans plus a 10% administrative fee to CAMHD for services provided to QUEST recipients.

i) The MOA period shall be for a period of one year. For purposes of continuity of care the DHS shall have the option to renew and/or extend the contract with CAMHD for the next fiscal year. Any renewal or extension of the contract will be subject to available funding.

This Agreement is for the sole benefit of the parties hereto, and is not for the benefit of any third party beneficiaries, including any members of the Hawaii QUEST Program. The MEMORANDUM OF AGREEMENT may also be terminated by either party for any reason with thirty (30) calendar days written notice to the other party. Amendments, as mutually agreed upon, may be made, as appropriate, in writing.

DEPARTMENT OF HUMAN SERVICES	DEPARTMENT OF HEALTH
_____/s/_____	_____/s/_____
Lillian B. Koller, Esq.	Chiyome Fukino, M.D.
Director	Director
Date: _____	Date: _____

FY04-FY05

Scope of Services

To be included but not limited to:

1. CRISIS MANAGEMENT
    a. 24-hour crisis telephone consultation
    b. Mobile outreach/stabilization services
    c. Crisis intervention/stabilization services
2. OUTPATIENT BEHAVIORAL HEALTH SERVICES
    a. Psychosexual assessments/evaluations
3. INTENSIVE FAMILY INTERVENTION SERVICES
    a. Intensive Family Intervention
    b. Multi-systemic Therapy (MST)
4. CRISIS RESIDENTIAL SERVICES
5. INTENSIVE OUTPATIENT HOSPITAL SERVICES
6. THERAPEUTIC LIVING SUPPORTS AND THERAPEUTIC FOSTER CARE SUPPORTS
    a. Foster Homes with Therapeutic Services
    b. Mental Health Respite Homes
    c. Community-Based Residential Programs
    d. Therapeutic Group Homes
7. RESIDENTIAL TREATMENT IN A HOSPITAL SETTING

Exhibit 5 to Attachment E

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

November 5, 2010

MEMORANDUM OF AGREEMENT

BETWEEN

DEPARTMENT OF HUMAN SERVICES AND DEPARTMENT OF HEALTH

This MEMORANDUM OF AGREEMENT (MOA) between the Med-QUEST Division (MQD) of the Department of Human Services (DHS) and the Adult Mental Health Division (AMHD) of the Department of Health (DOH) is to provide mental health services for all Medicaid recipients over 18 years old with serious mental illness. This MOA covers the period from **July 1, 2009 through June 30, 2012**. At the end of the MOA, MQD shall have the option to renew the MOA for another defined term. The above-mentioned state agencies agree to the following provisions specified herein.

I. THE AMHD OF THE DEPARTMENT OF HEALTH SHALL:

A. Implement processes for certifying Provider Agencies or State Operated Facilities to determine eligibility for participation in the Community Mental Health Program. Any revisions to the current process shall be approved by MQD. Specifically, the AMHD agrees to:

1. Determine Provider Agencies' or State Operated Facilities' eligibility for participation in the Community Mental Health Program subject to Hawaii Administrative Rules (HAR) chapter 11-172 .

2. Gather and review all applications from Provider Agencies or State Operated Facilities seeking eligibility for participation in the Community Mental Health Program. AMHD will provide MQD information on Provider Agencies or State Operated Facilities who have been approved to participate in the Community Mental Health Program. AMHD will be responsible for communicating decisions regarding eligibility to the Provider Agencies or State Operated Facilities submitting an application.

3. Notify MQD immediately regarding changes in the Provider Agencies' or State Operated Facilities' eligibility.

4. Recertify Provider Agencies or State Operated Facilities every three years. Annually, AMHD will perform on-site reviews of each eligible Provider Agency or State Operated Facility to ensure they comply with programmatic, operational and fiscal requirements established in HAR chapters 11-172 and 17-1736. AMHD will establish monitoring schedules and criteria, and provide information on these reviews to MQD on an annual basis.

5. AMHD may submit claims to the MQD for qualified mental health providers (QMHP) to include psychiatrists, licensed psychologists, licensed clinical social workers, licensed mental health counselors, and licensed marriage family therapists as long as the QMHP is a Medicaid provider.

B. Implement a utilization management process to evaluate the appropriateness of services, lengths of stay and quality of services. AMHD will utilize established utilization management policies and procedures for conducting these reviews. All utilization management decisions will be provided to Provider Agencies or State Operated Facilities in accordance with the AMHD utilization management policies. Appeals by Provider Agencies or State Operated Facilities regarding these decisions will be reviewed in accordance with AMHD due process procedures set forth in AMHD Policy 60.908.

C. Coordinate within the Department of Health, in general, to develop methodology and receive approval from the Department of Health and Human Services, Division of Cost Allocation for claiming the federal reimbursement for administrative services.

D. Receive and pay all claims for MQD covered mental health services from Provider Agencies or State Operated Facilities eligible for participation in the Community Mental Health Program based on the fee schedule in Attachment II. Covered mental health services are provided in Attachment I.

E. Submit a list of all Medicaid clients receiving services through the AMHD to the MQD on a monthly basis. The format shall be 834 or similar format mutually

agreed upon by MQD and AMHD. MQD shall use this information to assure that claims are processed in accordance with established Medicaid standards.

F. Provide a paid, adjusted, and voided claims file to the MQD or its fiscal agent on a bi-monthly basis or as otherwise agreed to by the parties, in accordance with instructions and filing requirements established by MQD. The format shall be *837/835* or similar format mutually agreed upon by MQD and AMHD. As required by 42 CFR §433.51 (a), (b), and (c), the AMHD will certify that the public funds expended as the state's share represent expenditures eligible for federal financial participation (FFP) for each filing. This certification also requires the claims data supporting the payment and proof of the AMHD payments made to the providers. Targeted Case Management services provided by the AMHD Community Mental Health Centers (CMHC) will be submitted to the MQD on a regular basis using a valid HIPAA format.

G. Maintain a current provider manual for the Community Mental Health Program, as approved by MQD. AMHD will distribute the manual to eligible Provider Agencies and State Operated Facilities.

H. Ensure the provision of services to consumers between the age of eighteen (18) and twenty-one (21) are in accordance with federal Early, Periodic, Screening, Detection, and Treatment (EPSDT) requirements.

I. Provide sufficient professional staff to coordinate, supervise and implement their responsibilities under this MOA.

J. Agree to pay the state share for Community Mental Health Program services, which are determined to be eligible for federal financial participation and furnished to Medicaid recipients.

K. Agree to return any federal share that is disallowed by the federal government, or determined to be inappropriate for reimbursement by the MQD. Cooperate with the activities of the MQD Fraud Unit and assist in recovering any overpayments or inappropriate payments from certified AMHD providers and State Operated Facilities. AMHD shall monitor AMHD providers for fraud and report suspected fraudulent activity in writing to MQD and the Department of the Attorney General, Medicaid Investigations Division within thirty (30) days of discovery.

II. <u>THE MQD OF THE DEPARTMENT OF HUMAN SERVICES SHALL</u>:

A. Pay the AMHD on a monthly basis the federal reimbursement for eligible paid claims based on the paid claims file and the Targeted Case Management file submitted by AMHD. Reimbursement shall be allowed on clean claims determined payable after review by the edits in the MQD claims processing system. Clean claims reimbursement shall be paid within thirty (30) days of

submittal by AMHD. Claims denied by MQD's claims processing system will be returned to AMHD for resolution.

B. Establish and/or terminate Provider Agencies or State Operated Facilities within thirty (30) days of receipt of information from AMHD.

C. Provide eligibility information to AMHD on a regular basis, but no less than monthly, using a batch process agreed upon by MQD and AMHD.

D. Pay AMHD the federal reimbursement based upon the methodology approved by the Department of Health and Human Services, Division of Cost Allocation for the Medicaid Administration activities performed by AMHD staff, including skilled medical professional staff, to coordinate, supervise, and implement its responsibilities under this MOA.

E. Review, during the term of this MOA, the operations and policies of AMHD as necessary to determine if the terms of this MOA are met.

F. Conduct desk reviews and audits of Provider Agencies' and State Operated Facilities' claims and inform AMHD of the results of such reviews and audits within thirty (30) days of their completion.

Either party for any reason may terminate this MEMORANDUM OF AGREEMENT upon ninety (90) calendar day's written notice to the other party. Amendments, as mutually agreed upon, may be made, as appropriate, in writing.

DEPARTMENT OF HUMAN SERVICES	DEPARTMENT OF HEALTH
/s/	_____/s/_____
Lillian B. Koller, Esq.	Chioyme Leinaala Fukino, M.D.
Director of Human Services	Director of Health
_____	_____
Date	Date

ATTACHMENT I

1. Crisis Management

    a. 24-hour crisis telephone consultation
    b. Mobile outreach services
    c. Crisis intervention/stabilization services

2. Crisis Residential Services

3. Intensive Outpatient Hospital Services

4. Therapeutic Living Supports

    a. Community-Based Specialized Residential

5. Biopsychosocial Rehabilitative Programs

6. Assertive Community Treatment

7. Intensive Case Management/Community Based Case Management

8. Targeted Case Management

    Targeted case management shall be provided in accordance with Hawaii Administrative Rules 17-1738 http://hawaii.gov/dhs/main/har/har_current/AdminRules/document_view. In the event any of the terms of this agreement conflict with or are not required by HAR §17-1738, the HAR shall control.

ATTACHMENT II

DOH—AMHD
With MQD rates and HCPCS Codes

SPA	AMHD Service	HCPCS Code	Unit	MQD Rate	Comments
Crisis Management	Crisis Mobile Outreach (CMO)	H2011	15 minutes	$ 27.50	
	Crisis Support Management (CSM)	H2015	15 minutes	$ 20.25	Must bill as Intensive Case Management/ Community Based Case Management
Crisis Residential	Licensed Crisis Residential Services (LCRS)	H0018	Daily	$211.80	Must be licensed, only treatment covered
Biopsychosocial Rehabilitation	Psychosocial Rehabilitation	H201 7	15 minutes	$ 3.30	Clubhouse not included
Intensive outpatient hospital services	Intensive Outpatient Hospital Services	H0035	Daily	$250.00	
Therapeutic Living Supports	Community Based Specialized Residential	H0019	Daily	$236.14	Must be licensed, only treatment covered
Assertive Community Treatment	Assertive Community Treatment, face-to-face contact	H0039	15 minutes	$ 27.00	75% of Assertive Community Treatment claims must be face-to-face
	Assertive Community Treatment, case assessment	H0039U1	15 minutes	$ 27.00	
	Assertive Community Treatment, treatment planning	H0039U2	15 minutes	$ 27.00	
	Assertive Community Treatment, collateral contact with no consumer contact	H0039U3	15 minutes	$ 27.00	
	Assertive Community Treatment, telephonic treatment planning with **11311,** Kahi Mohala	H0039HT	15 minutes	$ 27.00	
	Assertive Community Treatment, telephonic consultation with consumer	H0039U5	15 minutes	$ 27.00	

DOH—AMHD
With MQD rates and HCPCS Codes

SPA	AMHD Service	HPCPS Code	Unit	MQD Rate	Comments
Intensive Case Management/ Community Based Case Management	Intensive Case Management/Community Based Case Management, face-to-face contact	H2015	15 minutes	$20.25	75% of Intensive Case - Management/Community Based Case Management claims must be face-to-face.
	Intensive Case Management/Community Based Case Management, case assessment	H2015U1	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, treatment planning	H2015U2	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, collateral contact with no consumer contact	H2015U3	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, telephone treatment planning with HSH, Kahi Mohala	H2OI5HT	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, telephone consultation with consumer	H2015U5	15 minutes	$20.25	
	Targeted Case Management	T1017U5	15 minutes	$9.75	
	Targeted Case Management	T1017U6	15 minutes	$9.75	

Exhibit 6 to Attachment E

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

Name _____ ☐ MALE ☐ FEMALE
Last First MI

Home Address _____ Phone No. _____

Case No. _____

Mailing Address _____ Client ID No. _____

Social Security No. _____

Date of Birth _____ Age _____ ☐ HAWAII ☐ MAUI ☐ KAUAI COUNTY ☐ OAHU

Health Plan: ☐ Ohana ☐ UnitedHealthcare ☐ OTHER: _____

Primary Diagnosis _____ DSMIV Code _____

Secondary Diagnosis _____ DSMIV Code _____

Current Medical Conditions (Indicate, if none) _____

Date of Referral: _____ Name of PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	**CURRENTLY AT:** ☐ **Castle** ☐ **Queen's** ☐ **Other:** _____ (list) **Admitted on** ____/____/____			
Past Hospitalizations- Facility	Location	Date Admitted	Date Discharged	Diagnosis

MEDICATIONS	Strength	Dosage	Start Date	End Date

OUTPATIENT THERAPISTS	Diagnosis	Start Date	End Date

Section below to be completed by MQD/CSO Evaluation Panel

Date of Evaluation _____ Date of Enrollment/Disenrollment of CCS Services _____

Approved for CCS Referral: ☐ Yes ☐ No ☐ Additional Information Needed
Re-Evaluation Required: ☐ Yes ☐ No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments _____

Signature: _____

Client Name: _____ **Client I.D. No.:** _____

I. **MENTAL STATES**

A. *GENERAL*

1. Appearance: Within normal limits [ ] Other [ ] _____
2. Dress: Appropriate [ ] Bizarre [ ] Clean [ ] Dirty [ ]
3. Grooming: Neat [ ] Disheveled [ ] Needs improvement [ ]

B. *BEHAVIOR*

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]
2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] _
3. Body Mvemts: None [ ] Involuntary [ ] Akathisia [ ] Other [ ] ____

C. *SPEECH:* Clear [ ] Mumbled [ ] Rapid [ ] Whispers [ ] Monotone [ ]
Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]
Other [ ] _____

D. *MOOD*: Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]
Aggressive [ ] Hostile [ ] Depressed [ ]
Other [ ] _____

E. *AFFECT:* Full range [ ] Flat [ ] Constricted [ ] Inappropriate [ ]
Other [ ] _____

F. *THOUGHT*

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas [ ]
Neologism [ ] Perseveration [ ] Blocking [ ]
2. Content: Delusions [ ] Thought broadcasting [ ] Thought insertion [ ]
Thought withdrawal [ ] Other [ ] _____

G. *PERCEPTION – HALLUCINATIONS:*

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

H. *REALITY ORIENTATION:*

1. Mark all areas which the recipient can name:
Time: Day [ ] Month [ ] Year [ ]
Place: (can describe location) Yes [ ] No [ ]
Person: Self [ ] Family or friend [ ]
2. Memory: Recent intact? Yes [ ] No [ ] Remote intact: Yes [ ] No [ ]

I. *INSIGHT:* Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. *JUDGMENT:* Good [ ] Fair [ ] Poor [ ]

Client Name: _____ **Client I.D. No.:** _____

II. FUNCTIONAL SCALES: ***(check and specify any problem(s) in the following areas)***

[ ] Medical/Physical _____

_____

[ ] Family/Living _____

_____

[ ] Interpersonal Relations _____

_____

[ ] Role Performance _____

_____

[ ] Socio-Legal _____

_____

[ ] Self-Care/Basic Needs _____

_____

III. **ADDITIONAL COMMENTS:** Please supply any additional information which would be of assistance in reaching a decision with regard to this patient's evaluation.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name)*: _____

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

Medical Director or Attending Physician for in-patients *(Print Name)*: _____

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 be regarded as expenditures under the state's title XIX plan but are further limited by the Special Terms and Conditions (STCs) for the QUEST 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 for capitation payments provided to managed care organizations (MCOs) in which the state restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.

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

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.[1]

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.

f. Demonstration Population 6. Individuals who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not impose an asset limit on this population. Authority for this demonstration population expires December 31, 2013.

g. Demonstration Population 7. Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Medicare part A or enrolled for benefits under Medicare part B and are not a mandatory state plan population and whose income (as determined using modified adjusted gross income) does not exceed 133 percent of the FPL, determined using modified

[1] For the period from October 1, 2013 to December 31, 2013, this demonstration expansion population shall not include the parents and caretakers of full time students who are 18 years of age, if these parents and caretakers are covered under the state plan during that time period.

adjusted gross income. Authority for this demonstration population expires December 31, 2013.

4. **Hospital Uncompensated Care Costs.** Expenditures for actual uncompensated care costs incurred by certain hospital providers and nursing facility providers for inpatient and outpatient hospital services and long-term care services provided to the uninsured as well as Medicaid managed care and fee-for-service shortfalls, subject to the restrictions placed on hospital and nursing facility uncompensated care costs, as defined in the STCs and the CMS approved Certified Public Expenditures/Government-Owned Hospital Uncompensated Care Cost Protocol. This expenditure authority is effective through June 30, 2016.

5. **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.

    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.

6. **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 Housing.
        ii. Supportive Employment.
        iii. 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.

7. **Medicaid Eligibility Quality Control.** **Section 1903(u)**

Expenditures that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

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.

Attachment E

2017 Post Award Forum for the 1115 Demonstration Project
SUMMARY

STATE:	Hawaii
AGENCY:	Department of Human Services/Med-QUEST Department
DATE:	June 19, 2017
TIME:	8:30 am to 11:30 am
LOCATIONS:	Hawaii: Hilo State Office Building Kauai: Lihue State Office Building Maui: Wailuku State Office Building Oahu (West Side): Kakuhihewa Building Oahu (East Side): Kalanimoku Building

1. Summarize how the public forum and comments from the public related to the progress of the 1115 demonstration project announced and solicited.

   The announcement of the public forum and the opportunity to provide comments were published in the Honolulu Star Advertiser, Hawaii Tribune Herald, West Hawaii Today, The Maui News, and The Garden Island on May 8, 2017 as well as posted to the State's website.

   The public forum was conducted on June 19, 2017 at 8:30 am on the island of Oahu with video conferencing capability to hold meetings on the islands of Hawaii, Kauai, and Maui.

2. Summarize the types of attendees present at the public forum.

   Individuals in attendance were as follows:
   - 1st health plan had one (1) representative;
   - 2nd health plan had two (2) representatives;
   - One healthcare association had three (3) representatives; and
   - Eleven (11) Med-QUEST staff members.

3. Summarize the agenda. Summarize the written and oral comments received from the public regarding the progress of the 1115 demonstration project.

   The agenda for the post award forum was to provide a general update on the QUEST Integration program and to solicit feedback. Med-QUEST staff conducted a public meeting on the State's supportive housing amendment prior to the meeting. There were no oral and written comments received from the public for the post award forum.

4. Summarize the department's or agency's responses to the comments received in item 3.

   Not applicable.

5. How many persons attended the public forum (excluding Med-QUEST staff)? 6

6. How many persons orally testified at the public forum related to the 1115 Demonstration Project? 0

7.	How many persons submitted written comments in response to the progress of the 1115 demonstration project?	0

Attachment F

DAVID Y. IGE
GOVERNOR

RACHAEL WONG, DrPH
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Administration
P. O. Box 700190
Kapolei, Hawaii 96709-0190

February 29, 2016

Mr. Eliot Fishman, Ph.D.
Director
State Demonstrations Group
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Dear Director Fishman:

RE: EVALUATION AND ANALYSIS OF THE UNCOMPENSATED CARE POOL

Enclosed is the Hawaii Department of Human Services (DHS) submittal of the section 1115(a) Medicaid demonstration entitled, "Hawaii QUEST Integration" (Project Number 11-W-00001/9), Special Terms and Conditions (STCs) deliverable for item #44, "The Evaluation and Analysis of the Uncompensated Care Pool" report.

The uncompensated care pool evaluation and detailed analysis was performed by Myers & Stauffer LC, a certified public accounting firm and an independent entity qualified to assess the impact and use of the uncompensated care pool payments based on the criteria outlined in the STC item #44 deliverable.

We appreciate your partnership and continued support with the State to provide guidance and technical assistance for the completion of this reporting requirement.

Please contact Ms. Shanti Venkatesan, Finance Officer, at 808-692-7956 or by e-mail at svenkatesan@dhs.hawaii.gov should there be any questions regarding the "Evaluation and Analysis of the Uncompensated Care Pool" report.

Sincerely,

[redacted]

Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

Enclosure

c: Ms. Kristin Dillon, Acting Associate Regional Administrator, Region IX
Ms. Christy Bonstelle, Acting Technical Director
Ms. Andrea Casart, Action Director for the Division of Medicaid Expansion Demonstrations
Ms. Heather Ross, CMS Project Officer

QUEST Integration

Section 1115(a) Medicaid Demonstration

Special Terms and Conditions #44

Evaluation of the Uncompensated Care Pool

Introduction

Hawaii's section 1115(a) Medicaid demonstration, Project Number 11-W-00001/0 includes a provision for direct payments to providers through uncompensated care (UCC) pool payments. The State may make payments to governmentally operated hospitals, governmentally operated freestanding and hospital-based nursing facilities, and private hospitals to cover uncompensated care costs (UCC) for hospital and long term care services.

For governmentally operated hospitals, the UCCs include cost of providing hospital inpatient and outpatient services to the uninsured, Medicaid FFS, and Medicaid managed care enrollees reduced by any payments received. UCC does not include any inpatient shortfall for critical access hospitals for which the provider has already received payment up to cost.

For governmentally operated hospital-based and governmentally operated freestanding nursing facilities, the UCCs include cost of providing routine long term care services to Medicaid managed care enrollees reduced by any payments received. UCC does not include cost of providing long term care services to the uninsured. UCC does not include any routine long term care shortfall for critical access hospitals for which the provider has already received payment up to cost.

For private hospitals, UCCs include cost of providing inpatient and outpatient services to uninsured, Medicaid Fee for Service (FFS), and Medicaid managed care (MCO) enrollees reduced by any payments received.

The UCC payments to governmentally operated hospitals will be funded with certified public expenditures. For private hospitals, direct UCC payments may cover UCCs up to the amount of funds made available by the State.

Federal Financial Participation is authorized to pay for hospital and nursing facility uncompensated care cost until June 30, 2016. At this time, Hawaii will not be requesting renewal of the UCC pool payments after June 30, 2016. Instead Hawaii is pursuing enhancement of the capitated rates paid to Medicaid managed care health plans. The rate enhancement shall be used for increasing reimbursement to hospitals to support the availability of services and to ensure access to care to Medicaid managed care health plan enrollees.

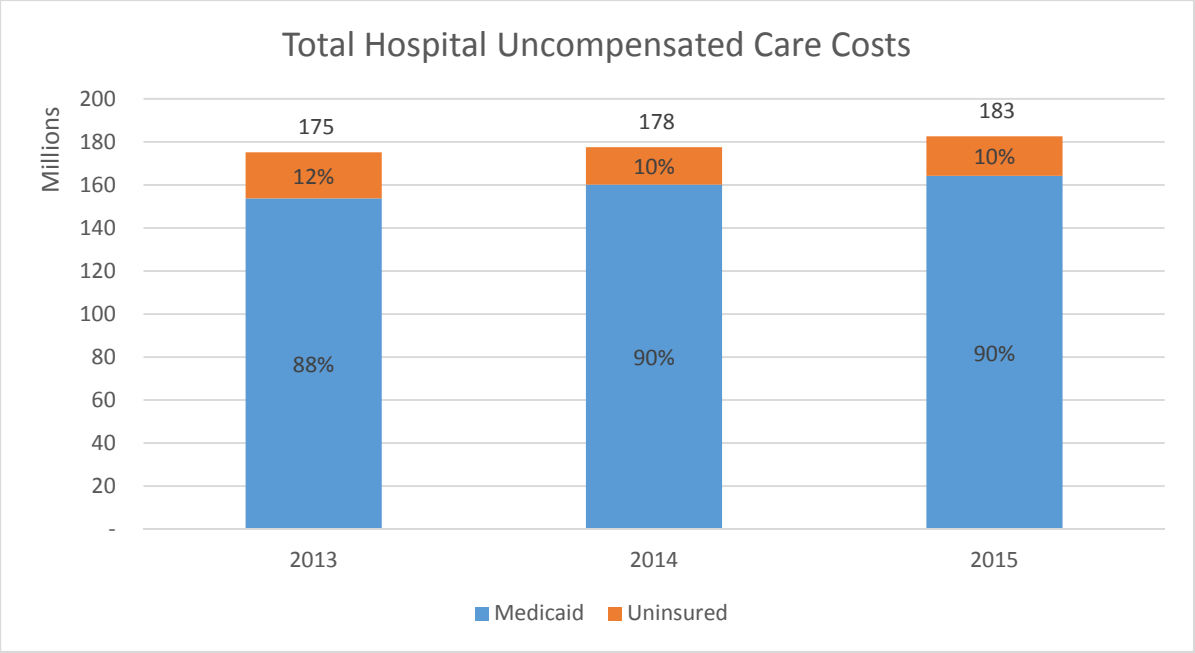
Overview of Uncompensated Care Cost and UCC Pool Payments for Hospitals

Hospital Medicaid and Uninsured Uncompensated Care Cost

	2013	2014	2015
Uncompensated Care Cost*			
Uninsured	21,380,450	17,379,237	18,386,261
Medicaid (MCO and FFS)	153,771,485	160,146,021	164,247,835
Total	$ 175,151,935	$ 177,525,258	$ 182,634,096
UCC Pool Payments			
Uninsured	(18,384,581)	(15,583,307)	(15,668,272)
Medicaid (MCO and FFS)	(72,138,800)	(79,306,177)	(79,310,183)
Total	$ (90,523,381)	$ (94,889,484)	$ (94,978,455)
Net Uncompensated Care Cost			
Uninsured	2,995,869	1,795,930	2,717,989
Medicaid (MCO and FFS)	81,632,685	80,839,844	84,937,652
Total	$ 84,628,554	$ 82,635,774	$ 87,655,641

* Includes estimated data for the period 7/1/2015 - 12/31/2015

Hospital uncompensated care costs continues to rise in Hawaii. Since 2013 there has been a 4% increase in uncompensated care cost for hospitals. Total UCC cost has increased to 183 million in 2015 from 175 million in 2013. Correspondingly there has been a 5% increase in UCC pool payments. Total UCC pool payments have increased to 95 million in 2015 from 91 million in 2013. The majority of the shortfall is attributable to Medicaid underpayments resulting from rates set below the costs of providing care. The graph below shows that in 2015, 90% of the uncompensated care cost is attributable to the Medicaid shortfall. Hawaii has improved coverage to assure beneficiary access to health care and as a result only 10% of uncompensated care costs are attributable to uninsured losses.



In governmentally operated hospitals 87% of UCC pool payments were made to cover cost of providing care to the uninsured. 13% was paid to cover Medicaid shortfalls. For private hospitals, 8% of UCC pool payments covered uninsured losses and 91% covered the Medicaid shortfall. However, both provider types still incurred uncompensated care losses even after UCC pool payments.

UCC Pool Payments Governmentally Operated Hospitals			
Year	Medicaid	Uninsured	Total
2013	921,199	10,213,296	11,134,495
2014	2,753,596	9,137,378	11,890,974
2015	509,793	8,952,922	9,462,715

UCC Pool Payments Privately Operated Hospitals			
Year	Medicaid	Uninsured	Total
2013	71,217,601	8,171,285	79,388,886
2014	76,552,581	6,445,929	82,998,510
2015	78,800,390	6,715,350	85,515,740

Overview of Uncompensated Care Cost and UCC Pool Payments for Nursing Facilities

For the period January 1, 2013 through December 31. 2015, no UCC pool payments were made for uncompensated care losses to governmentally operated nursing facilities.

Comparison of UCC Pool Payments beginning January 1, 2013 through December 31, 2015

Attachment A: UCC Pool Payments by Provider Type

- Governmentally Operated Hospitals
- Governmentally Operated Nursing Facilities
- Privately Operated Hospitals

Attachment B: UCC Pool Payments Attributable to Uninsured and Medicaid

Attachment C: UCC Pool Payments Attributable to FFS and Managed Care by Age Band

Necessity of UCC Payments for the Uninsured

At 5.3%, Hawaii currently has the third lowest rate of uninsured individuals in the nation. According to the U.S. Census Bureau, the estimated number of uninsured individuals in the state of Hawaii is 72,000 in 2014. This is a decrease from the 2013 estimate of 91,000 uninsured individuals.[1]

Most people in Hawaii have health care coverage through their employment or through Medicare or Medicaid. The state of Hawaii implemented the Affordable Care Act and expanded Medicaid eligibility to more individuals. Hawaii expanded coverage in October 2013 by determining eligibility for Medicaid individuals using new Modified Adjusted Gross Income (MAGI) criteria. Due to Medicaid expansion, Hawaii has seen a decrease in the number of uninsured individuals. As a result, UCC pool payments for uninsured have also decreased.

Hospital Uninsured Uncompensated Care Cost

	2013	2014	2015
Uninsured Uncompensated Care Cost*			
Governmentally Operated	10,213,296	9,137,378	9,153,632
Privately Operated	11,167,154	8,241,859	9,232,629
Total	$ 21,380,450	$ 17,379,237	$ 18,386,261
Uninsured UCC Pool Payments			
Governmentally Operated	(10,213,296)	(9,137,378)	(8,952,922)
Privately Operated	(8,171,285)	(6,445,929)	(6,715,350)
Total	$ (18,384,581)	$ (15,583,307)	$ (15,668,272)
Net Uncompensated Care Cost			
Governmentally Operated	-	-	200,710
Privately Operated	2,995,869	1,795,930	2,517,279
Total	$ 2,995,869	$ 1,795,930	$ 2,717,989

* Includes estimated data for the period 7/1/2015 - 12/31/2015

[1] Smith, Jessica C., and Carla Medalia. "Health Insurance Coverage in the United States: 2014." *Census.gov*. United States Census Bureau, 16 Sept. 2015. Web. 26 Feb. 2016.

Uncompensated Care Provided to Compact of Free Association (COFA)

The UCC protocol in Attachment D of the Special Terms and Conditions specifies that government owned hospital uncompensated care cost is adjusted by 1% to remove the cost of providing inpatient and outpatient services to undocumented aliens.

Based on review of current COFA Medicaid Enrollees for 2015, the 1% adjustment is adequate to remove the cost of care provided to COFA.

Estimate of Uncompensated Care Provided to Compact of Free Association (COFA)

COFA Medicaid Enrollees

COFA Residents served	3,567
Total Medicaid Enrollees	339,302
Estimated Percent of COFA Medicaid Enrollees for 2015	1%

Estimated Uncompensated Care Cost Attributable to COFA

Governmentally Operated Hospital	549,409
Privately Operated Hospital	998,078
Total Hospital Uncompensated Care Cost for 2015	$ 1,547,487

Conclusion

In Hawaii, hospital uncompensated care costs are mostly attributable to Medicaid underpayments. Hawaii's Quest Integration demonstration arranges for health care through capitated managed care plans. To improve payments to hospitals, Hawaii will pursue enhancement of the capitated rates paid to Medicaid managed care health plans. The rate enhancement shall be used for increasing reimbursement to hospitals to support the availability of services and to ensure access to care to Medicaid managed care health plan enrollees.

Contact:
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Rae Ann Okunami
Senior Manager
Myers and Stauffer, LC
733 Bishop Street Suite 1220
Honolulu, Hawaii 96813
rokunami@mslc.com

Attachment A
Uncompensated Care Costs and Pool Payments by Provider Type

	2013	2014	2015
Total Uncompensated Care Costs *			
Governmentally Operated Hospitals	66,656,405	71,402,149	65,062,404
Governmentally Operated Nursing Facilities	19,683,388	20,683,709	21,860,494
Privately Operated Hospitals	108,495,530	106,123,108	117,571,691
Total	$ 194,835,323	$ 198,208,966	$ 204,494,589
Total Uncompensated Care Pool Payments			
Governmentally Operated Hospitals	(11,134,495)	(11,890,974)	(9,462,715)
Governmentally Operated Nursing Facilities	-	-	-
Privately Operated Hospitals	(79,388,886)	(82,998,510)	(85,515,740)
Total	$ (90,523,381)	$ (94,889,484)	$ (94,978,455)
Net Uncompensated Care Costs			
Governmentally Operated Hospitals	55,521,910	59,511,175	55,599,689
Governmentally Operated Nursing Facilities	19,683,388	20,683,709	21,860,494
Privately Operated Hospitals	29,106,644	23,124,598	32,055,951
Total	$ 104,311,942	$ 103,319,482	$ 109,516,134

* Includes estimated data for the period 7/1/2015 - 12/31/2015

Attachment B
Uncompensated Care Cost and Pool Payments Attributable to Uninsured and Medicaid

Governmentally Operated Hospitals

	2013	2014	2015
Uncompensated Care Cost *			
Uninsured Uncompensated Care Cost	10,213,296	9,137,378	9,153,632
Medicaid Uncompensated Care Cost	56,443,109	62,264,771	55,908,772
Total	$ 66,656,405	$ 71,402,149	$ 65,062,404
UCC Pool Payments			
Uninsured Pool Payments	(10,213,296)	(9,137,378)	(8,952,922)
Medicaid Pool Payments	(921,199)	(2,753,596)	(509,793)
Total	$ (11,134,495)	$ (11,890,974)	$ (9,462,715)
Net Uncompensated Care Cost			
Net Uninsured Uncompensated Care Cost	-	-	200,710
Net Medicaid Uncompensated Care Cost	55,521,910	59,511,175	55,398,979
Total	$ 55,521,910	$ 59,511,175	$ 55,599,689

Attachment B
Uncompensated Care Cost and Pool Payments Attributable to Uninsured and Medicaid

Governmentally Operated Nursing Facilities

	2013	2014	2015
Uncompensated Care Cost *			
Uninsured Uncompensated Care Cost	793,356	1,024,793	1,369,724
Medicaid Uncompensated Care Cost	18,890,032	19,658,916	20,490,770
Total	$ 19,683,388	$ 20,683,709	$ 21,860,494
UCC Pool Payments			
Uninsured Pool Payments	-	-	-
Medicaid Pool Payments	-	-	-
Total	-	-	-
Net Uncompensated Care Cost			
Net Uninsured Uncompensated Care Cost	793,356	1,024,793	1,369,724
Net Medicaid Uncompensated Care Cost	18,890,032	19,658,916	20,490,770
Total	$ 19,683,388	$ 20,683,709	$ 21,860,494

Attachment B
Uncompensated Care Cost and Pool Payments Attributable to Uninsured and Medicaid

Privately Operated Hospitals

	2013	2014	2015
Uncompensated Care Cost *			
Uninsured Uncompensated Care Cost	11,167,154	8,241,859	9,232,629
Medicaid Uncompensated Care Cost	97,328,376	97,881,250	108,339,063
Total	$ 108,495,530	$ 106,123,109	$ 117,571,692
UCC Pool Payments			
Uninsured Pool Payments	(8,171,285)	(6,445,929)	(6,715,350)
Medicaid Pool Payments	(71,217,601)	(76,552,581)	(78,800,390)
Total	$ (79,388,886)	$ (82,998,510)	$ (85,515,740)
Net Uncompensated Care Cost			
Net Uninsured Uncompensated Care Cost	2,995,869	1,795,930	2,517,279
Net Medicaid Uncompensated Care Cost	26,110,775	21,328,669	29,538,673
Total	$ 29,106,644	$ 23,124,599	$ 32,055,952

* Includes estimated data for the period 7/1/2015 - 12/31/2015

Attachment C
Medicaid Hospital
Uncompensated Care Pool Payments by Age-Band

Medicaid Governmentally Operated Hospital Payments by Age-Band

	2013	2014	2015
<1 Age Band			
Managed Care	16,317	64,557	-
Fee-for-Service	-	49	-
1-18 Age Band			
Managed Care	38,543	188,359	-
Fee-for-Service	11,287	11,824	-
19-64 Age Band			
Managed Care	342,816	1,862,936	-
Fee-for-Service	377,818	483,880	463,235
65+ Age Band			
Managed Care	9,964	70,614	-
Fee-for-Service	124,453	71,377	46,558
Total	921,199	2,753,596	509,793

Medicaid Privately Operated Hospital Payments by Age-Band

	2013	2014	2015
<1 Age Band			
Managed Care	-	-	-
Fee-for-Service	860,422	757,141	520,427
1-18 Age Band			
Managed Care	7,600,467	5,467,253	7,824,047
Fee-for-Service	85,093	327,561	290,797
19-64 Age Band			
Managed Care	55,178,689	62,389,665	61,140,247
Fee-for-Service	4,102,770	3,182,340	4,962,027
65+ Age Band			
Managed Care	2,875,821	3,932,925	3,898,190
Fee-for-Service	514,339	495,696	164,655
Total	71,217,601	76,552,581	78,800,390

ELIGIBILITY GROUP	DY 20-24	DY 25	DY 26	DY 27	DY 28	DY 29	DY 30	TOTAL WOW
Children								
Total Expenditure		$ 815,844,764	$ 844,603,291	$ 874,375,557	$ 905,197,296	$ 937,105,501	$ 970,138,469	$ 5,347,264,878
Adults								
Total Expenditure		$ 427,788,236	$ 454,706,811	$ 483,319,237	$ 513,732,100	$ 546,058,692	$ 580,419,436	$ 3,006,024,512
Aged								
Total Expenditure		$ 600,099,302	$ 626,707,705	$ 654,495,925	$ 683,516,274	$ 713,823,386	$ 745,474,315	$ 4,024,116,907
Blind/ Disabled								
Total Expenditure		$ 773,845,379	$ 816,755,105	$ 862,044,176	$ 909,844,525	$ 960,295,404	$ 1,013,543,784	$ 5,336,328,373
DSH payments								
Total Allotment		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total		$ 2,617,577,681	$ 2,742,772,913	$ 2,874,234,895	$ 3,012,290,195	$ 3,157,282,983	$ 3,309,576,004	$ 17,713,734,670

With Waiver

ELIGIBILITY GROUP	DY 20-24	DY 25	DY 26	DY 27	DY 28	DY 29	DY 30	TOTAL WW
Children								
Total Expenditure		$ 443,275,372	$ 458,900,829	$ 475,077,083	$ 491,823,551	$ 509,160,331	$ 527,108,232	$ 2,905,345,399
Adults								
Total Expenditure		$ 195,082,200	$ 207,357,748	$ 220,405,734	$ 234,274,765	$ 249,016,505	$ 264,685,868	$ 1,370,822,820
Aged								
Total Expenditure		$ 421,679,503	$ 440,376,772	$ 459,903,079	$ 480,295,181	$ 501,591,469	$ 523,832,035	$ 2,827,678,040
Blind/ Disabled								
Total Expenditure		$ 535,655,884	$ 565,358,003	$ 596,707,104	$ 629,794,513	$ 664,716,619	$ 701,575,156	$ 3,693,807,280
UCC Payments								
Total Allotment		$ -	$ -	$ -	$ -	$ -	$ -	$ -
Cost Share								
Total		$ (39,000,000)	$ (39,000,000)	$ (39,000,000)	$ (39,000,000)	$ (39,000,000)	$ (39,000,000)	$ (234,000,000)
Total		$ 1,556,692,960	$ 1,632,993,353	$ 1,713,093,001	$ 1,797,188,010	$ 1,885,484,924	$ 1,978,201,291	$ 10,563,653,539

DY BN Savings (TC)		$ 1,060,884,720	$ 1,109,779,560	$ 1,161,141,894	$ 1,215,102,185	$ 1,271,798,059	$ 1,331,374,713	$ 7,150,081,131
Less 75% (phase down of savings)			$ (832,334,670)	$ (870,856,421)	$ (911,326,639)	$ (953,848,544)	$ (998,531,034)	
Cumulative Savings (TC)	$3,742,881,640	$ 4,803,766,361	$ 5,081,211,251	$ 5,371,496,724	$ 5,675,272,271	$ 5,993,221,785	$ 6,326,065,463	

Hawaii 1115 QUEST Waiver				1/2018-12/2018	1/2019-12/2019	1/2020-12/2020	1/2021-12/2021	1/2022-12/2022	1/2023-12/2023	
TOTAL COMPUTABLE			**DY 20-25**	**DY25**	**DY26**	**DY27**	**DY28**	**DY29**	**DY30**	**Total**
	MEGS	***MEG Description and Comments/Crosswalk***	***Trend Rates***				***1115A Renewal***			
	Without waiver									
	PMPMS									
	Children	**Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children**	**1.010**	$441.47	$445.88	$450.34	$454.85	$459.39	$463.99	
	Adults	**Pregnant to 185%, 1931, 1925, TANF above cash**	**1.037**	$873.74	$906.07	$939.59	$974.36	$1,010.41	$1,047.79	
	Aged	**Aged over 65 with and without Medicare**	**1.034**	$1,839.19	$1,901.72	$1,966.38	$2,033.24	$2,102.37	$2,173.85	
	Blind/Disabled	**Blind or Disabled with or without Medicare**	**1.045**	$2,472.33	$2,583.58	$2,699.84	$2,821.33	$2,948.29	$3,080.97	
	VIII Group Combined	**VIII Group Adults**	**1.051**	$835.03	$877.61	$922.37	$969.41	$1,018.85	$1,070.82	
Member Months	**Member Months**									
	Children	**Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children**	**1.0250**	1,848,021	1,894,222	1,941,577	1,990,116	2,039,869	2,090,866	
	Adults	**Pregnant to 185%, 1931, 1925, TANF above cash**	**1.0250**	489,607	501,847	514,393	527,253	540,435	553,945	
	Aged	**Aged over 65 with and without Medicare**	**1.010**	326,285	329,548	332,843	336,172	339,533	342,929	
	Blind/Disabled	**Blind or Disabled with or without Medicare**	**1.010**	313,003	316,133	319,294	322,487	325,712	328,969	
	VIII Group Combined	**VIII Group Adults**	**1.0250**	1,487,933	1,525,131	1,563,260	1,602,341	1,642,400	1,683,460	
		Total Without Waiver Member Months		**4,464,849**	**4,566,881**	**4,671,368**	**4,778,370**	**4,887,949**	**5,000,169**	
	Total Expenditures - WOW									
	Children	**Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children**		$815,844,764	$844,603,291	$874,375,557	$905,197,296	$937,105,501	$970,138,469	**$5,347,264,878**
	Adults	**Pregnant to 185%, 1931, 1925, TANF above cash**		$427,788,236	$454,706,811	$483,319,237	$513,732,100	$546,058,692	$580,419,436	**$3,006,024,512**
	Aged	**Aged over 65 with and without Medicare**		$600,099,302	$626,707,705	$654,495,925	$683,516,274	$713,823,386	$745,474,315	**$4,024,116,907**
	Blind/Disabled	**Blind or Disabled with or without Medicare**		$773,845,379	$816,755,105	$862,044,176	$909,844,525	$960,295,404	$1,013,543,784	**$5,336,328,373**
	VIII Group Combined	**VIII Group Adults**		$1,242,465,955	$1,338,477,512	$1,441,908,362	$1,553,331,830	$1,673,365,547	$1,802,674,870	**$9,052,224,076**
		Total Without Waiver Expenditures		**$3,860,043,636**	**$4,081,250,424**	**$4,316,143,256**	**$4,565,622,025**	**$4,830,648,530**	**$5,112,250,874**	**$26,765,958,746**
		VIII Group Adults		$1,242,465,955	$1,338,477,512	$1,441,908,362	$1,553,331,830	$1,673,365,547	$1,802,674,870	$9,052,224,076
		Total Without Waiver Expenditures w/o VIII Group		**2,617,577,681**	**2,742,772,913**	**2,874,234,895**	**3,012,290,195**	**3,157,282,983**	**3,309,576,004**	**17,713,734,670**
	DSH adjustment - WOW									
DSH		Budget neutrality DSH ceiling	1.024							
	With Waiver									
	PMPMS									
	Children	**Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children**	**1.010**	$239.86	$242.26	$244.69	$247.13	$249.60	$252.10	
	Adults	**Pregnant to 185%, 1931, 1925, TANF above cash**	**1.037**	$398.45	$413.19	$428.48	$444.33	$460.77	$477.82	
	Aged	**Aged over 65 with and without Medicare**	**1.034**	$1,292.37	$1,336.31	$1,381.74	$1,428.72	$1,477.30	$1,527.52	
	Blind/Disabled	**Blind or Disabled with or without Medicare**	**1.045**	$1,711.34	$1,788.35	$1,868.83	$1,952.93	$2,040.81	$2,132.65	
	VIII Group Combined	**VIII Group Adults**	**1.051**	$488.91	$513.85	$540.06	$567.60	$596.55	$626.97	
Member Months	**Member Months**									
	Children	**Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children**	**1.0250**	1,848,021	1,894,222	1,941,577	1,990,116	2,039,869	2,090,866	

	Adults	**Pregnant to 185%, 1931, 1925, TANF above cash**	**1.0250**	489,607	501,847	514,393	527,253	540,435	553,945	
	Aged	**Aged over 65 with and without Medicare**	**1.010**	326,285	329,548	332,843	336,172	339,533	342,929	
	Blind/Disabled	**Blind or Disabled with or without Medicare**	**1.010**	313,003	316,133	319,294	322,487	325,712	328,969	
	VIII Group Combined	**VIII Group Adults**	**1.0250**	1,487,933	1,525,131	1,563,260	1,602,341	1,642,400	1,683,460	
		Total With Waiver Member Months		**4,464,849**	**4,566,881**	**4,671,368**	**4,778,370**	**4,887,949**	**5,000,169**	
	Total Expenditures - With waiver									
	Children	**Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children**		$443,275,372	$458,900,829	$475,077,083	$491,823,551	$509,160,331	$527,108,232	**$2,905,345,399**
	Adults	**Pregnant to 185%, 1931, 1925, TANF above cash**		$195,082,200	$207,357,748	$220,405,734	$234,274,765	$249,016,505	$264,685,868	**$1,370,822,820**
	Aged	**Aged over 65 with and without Medicare**		$421,679,503	$440,376,772	$459,903,079	$480,295,181	$501,591,469	$523,832,035	**$2,827,678,040**
	Blind/Disabled	**Blind or Disabled with or without Medicare**		$535,655,884	$565,358,003	$596,707,104	$629,794,513	$664,716,619	$701,575,156	**$3,693,807,280**
	VIII Group Combined	**VIII Group Adults**		$727,472,301	$783,687,724	$844,247,192	$909,486,394	$979,766,955	$1,055,478,447	**$5,300,139,013**
	UC pool									
	UCC-Governmental									
	UCC-GOVT LTC									
	UCC-Private									
		Total with waiver expenditures		**$2,323,165,262**	**$2,455,681,076**	**$2,596,340,193**	**$2,745,674,404**	**$2,904,251,879**	**$3,072,679,738**	**$16,097,792,552**
		VIII Group Adults		**$727,472,301**	**$783,687,724**	**$844,247,192**	**$909,486,394**	**$979,766,955**	**$1,055,478,447**	**$5,300,139,013**
				$1,595,692,960	**$1,671,993,353**	**$1,752,093,001**	**$1,836,188,010**	**$1,924,484,924**	**$2,017,201,291**	**$10,797,653,539**
		Cost Share (Not reported on 64 Waiver)		-$39,000,000	-$39,000,000	-$39,000,000	-$39,000,000	-$39,000,000	-$39,000,000	**-$234,000,000**
		Total with waiver Expenditures w/o VIII Group or Cost Share		**$1,556,692,960**	**$1,632,993,353**	**$1,713,093,001**	**$1,797,188,010**	**$1,885,484,924**	**$1,978,201,291**	**$10,563,653,539**
	Summary									
	DY BN Savings (TC)			**$1,060,884,720**	**$1,109,779,560**	**$1,161,141,894**	**$1,215,102,185**	**$1,271,798,059**	**$1,331,374,713**	
	Cumulative Savings (TC)			**$4,803,766,361**	**$5,913,545,921**	**$7,074,687,815**	**$8,289,790,000**	**$9,561,588,059**	**$10,892,962,772**	
	Countable Savings				**$5,081,211,251**	**$5,371,496,724**	**$5,675,272,271**	**$5,993,221,785**	**$6,326,065,463**	

		DY 24 Expenditures	DY 23 Expenditures	DY 22 Expenditures	DY 21 Expenditures			
Children	Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children	428,180,387.00	372,945,769	352,660,926	306,228,446			
Adults	Pregnant to 185%, 1931, 1925, TANF above cash	183,634,509.00	170,307,963	174,312,844	203,104,049			
Aged	Aged over 65 with and without Medicare	403,821,257.00	376,753,705	358,199,868	402,914,189			
Blind/Disabled	Blind or Disabled with or without Medicare	507,733,534.00	468,233,174	448,752,853	389,643,958			
Group VIII		675,999,161.00	599,773,480	503,390,300	408,975,902			
		MM DY 24	MM DY 23	MM DY 22	MM DY 21			
Children	Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children	1,802,947	1,817,163	1,766,292	1,745,051	0.0122	0.0288	(0.0078)
Adults	Pregnant to 185%, 1931, 1925, TANF above cash	477,665	471,973	496,098	622,907	(0.2036)	(0.0486)	0.0121
Aged	Aged over 65 with and without Medicare	323,054	309,628	300,577	279,074	0.0771	0.0301	0.0434
Blind/Disabled	Blind or Disabled with or without Medicare	309,904	311,434	299,313	305,647	(0.0207)	0.0405	(0.0049)
Group VIII		1,451,642	1,389,900	1,212,864	925,308	0.3108	0.1460	0.0444
		PMPM	PMPM	PMPM	PMPM			
Children	Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children	237.49	205.24	199.66	175.48	0.1378	0.0279	0.1571
Adults	Pregnant to 185%, 1931, 1925, TANF above cash	384.44	360.84	351.37	326.06	0.0776	0.0270	0.0654
Aged	Aged over 65 with and without Medicare	1,250.01	1,216.79	1,191.71	1,443.75	(0.1746)	0.0210	0.0273
Blind/Disabled	Blind or Disabled with or without Medicare	1,638.36	1,503.47	1,499.28	1,274.82	0.1761	0.0028	0.0897
Group VIII		465.68	431.52	415.04	441.99	(0.0610)	0.0397	0.0792

MM Trend	PMPM Trend			DY 24 Expenditures	DY 24 MM	$ PMPM	DY 25	DY 26	DY 27	DY 28	DY 29	DY 30
1.025	1.01	Children	Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children	428,180,387.00	1,802,947	237.49	239.86	242.26	244.69	247.13	249.60	252.10
1.025	1.037	Adults	Pregnant to 185%, 1931, 1925, TANF above cash	183,634,509.00	477,665	384.23	398.45	413.19	428.48	444.33	460.77	477.82
1.01	1.034	Aged	Aged over 65 with and without Medicare	403,821,257.00	323,054	1,249.87	1,292.37	1,336.31	1,381.74	1,428.72	1,477.30	1,527.52
1.01	1.045	Blind/Disabled	Blind or Disabled with or without Medicare	507,733,534.00	309,904	1,637.65	1,711.34	1,788.35	1,868.83	1,952.93	2,040.81	2,132.65
1.025	1.051	Group VIII		675,999,161.00	1,451,642	465.19	488.91	513.85	540.06	567.60	596.55	626.97
					4,365,212							

DY 25 trended MM
1,848,021.00
489,607.00
326,285.00
313,003.00
1,487,933.00
4,464,849.00
363,767.67

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 1/2018

State: Hawaii

Summary of Expenditures by Waiver Year
Waiver: 11W00000

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Aged without Medica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(23,433)	0	(23,433)	(23,433)
Blind/Disabled witho	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(23,433)**	**0**	**(23,433)**	**(23,433)**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
Aged without Medica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(12,872)	0	(12,872)	(12,872)
Blind/Disabled witho	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(12,872)**	**0**	**(12,872)**	**(12,872)**

Summary of Expenditures by Waiver Year
Waiver: 11W00001

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
1,115	0	70,981,761	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70,981,761	70,981,761
1902 R 2	0	173,206,589	0	0	0	0	(28,108)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	173,178,481	173,178,481
1902 R 2X	0	(8,243,749)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(8,243,749)	(8,243,749)
1902R2	0	121,392	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	121,392	121,392
AFDC	0	148,069,654	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	148,069,654	148,069,654
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(295)	121,279,464	314,952,648	350,714,627	326,518,117	349,156,948	184,750,729	364,919,391	308,022,477	320,576,114	332,179,081	0	2,973,069,301	2,973,069,301
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,424,989	17,555,107	24,914,002	19,728,957	24,483,589	14,925,306	37,994,798	50,665,247	56,279,590	73,129,761	0	322,101,346	322,101,346
Aged with Medicare -	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(473,188)	(505,165)	(191,620)	0	(1,169,973)	(1,169,973)
Aged without Medica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(14,668)	(44,822)	(11,167)	0	(70,657)	(70,657)
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(13,736)	31,794,652	74,847,768	81,263,856	77,845,498	88,201,319	49,105,426	98,847,383	163,399,031	158,407,088	156,597,104	0	980,295,389	980,295,389
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(28,991)	81,514,842	211,789,936	248,939,865	257,518,261	282,677,730	148,444,906	290,210,999	285,462,054	308,333,681	366,751,242	0	2,481,614,525	2,481,614,525
Blind/Disable without	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(324,738)	(333,645)	(161,566)	0	(819,949)	(819,949)
Blind/Disabled with M	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(61,110)	(74,223)	(82,351)	0	(217,684)	(217,684)
Breast Cervical Cance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2)	4,053	545,332	904,018	750,145	365,104	585,576	277,616	222,052	105,130	0	3,759,024	3,759,024
CURRENT	0	493,934,086	0	0	0	0	1,661,326	159,616,917	75,521,154	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	730,733,483	730,733,483
CURRENT POP	0	272,778,438	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	272,778,438	272,778,438
Current-Hawaii Quest	0	0	0	0	0	0	0	0	40,064,795	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	40,064,795	40,064,795
Demo Elig Adults	0	0	0	0	0	0	0	0	134,638	1,995	51,709	318,560	127,982,800	129,456,848	154,209,257	177,392,619	201,628,981	238,945,778	244,752,500	227,394,213	43,951,050	10,309	(5,724)	735	0	0	1,546,226,268	1,546,226,268
Expansion State Adul	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	191,925,290	340,012,385	478,919,874	560,786,779	0	1,571,644,328	1,571,644,328
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	91,499	83,366	94,158	137,403	73,022	176,510	174,133	703,614	618,530	886,222	1,232,867	0	4,271,324	4,271,324
HawaiiQuest-1902(R)I	0	700,529	107,270	2,484,576	1,636,854	860,335	1,594,466	0	0	284	34,836	438,582	0	0	33,061	26,332	8,001	0	0	0	0	0	0	0	0	0	7,925,126	7,925,126
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	135,520	683,159	0	0	0	0	0	0	0	0	0	0	818,679	818,679
HealthQuest-Current	0	3,884,748	350,430	12,121,771	10,002,019	7,377,643	10,651,130	9,373,702	64,428,704	230,593,470	268,955,153	392,471,288	(2,325,152)	0	0	0	0	0	0	0	0	0	0	0	0	0	1,007,884,906	1,007,884,906
HealthQuest-Others	0	1,783,163	215,685	5,322,833	3,698,445	2,678,918	3,915,013	3,306,673	21,010,550	63,645,959	99,234,046	93,729,117	(621,643)	0	0	0	0	0	0	0	0	0	0	0	0	0	297,918,759	297,918,759
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	56,504	120,767	115,693	58,345	117,005	109,837	8,305	0	0	0	0	0	0	0	586,456	586,456
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,715	3,960	0	0	0	0	0	0	0	0	0	11,675	11,675
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	122,839	581,513	0	0	0	0	0	0	0	0	0	0	704,352	704,352
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,331	217,050,612	163,377,915	118,552,565	133,699,746	0	632,682,169	632,682,169
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,100,418	16,199,737	0	0	0	0	0	0	0	0	0	0	21,300,155	21,300,155
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	76,678	103,084	80,075	257,166	253,182	31	0	0	0	0	0	0	0	0	770,216	770,216
OTHERS	0	288,512,308	0	0	0	0	786,332	56,430,712	30,507,680	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	376,237,032	376,237,032
Others-Hawaii Quest	0	0	0	0	0	0	0	0	13,142,103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,142,103	13,142,103
OthersX	0	(15,309,727)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(15,309,727)	(15,309,727)
QUEST ACE	0	0	0	0	0	0	0	0	0	0	0	0	(2,751)	798,681	5,696,094	14,348,747	23,867,636	30,465,656	27,968,205	76,432,838	26,173,447	(425)	0	0	0	0	205,748,128	205,748,128
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,862,479	17,432,949	0	0	0	0	0	0	0	0	0	0	25,295,428	25,295,428
St Pl Adults-Preg Imr	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,990	2,628,840	2,628,927	2,873,646	987,921	1,531,033	1,448,764	2,048,646	2,218,467	0	16,391,234	16,391,234
State Plan Adults	0	0	0	0	0	0	0	0	(10)	218	99	39,158	111,982,730	118,021,622	109,034,691	128,225,118	132,190,152	124,250,307	114,068,576	130,112,910	80,835,624	201,563,132	172,869,804	167,789,334	185,217,514	0	1,776,200,979	1,776,200,979
State Plan Children	0	0	0	0	0	0	0	(41)	(9,403)	2,008	878	2,541,467	181,803,051	179,672,723	155,392,585	168,853,209	203,883,851	215,817,886	191,487,038	215,993,093	106,616,220	247,372,600	306,115,308	314,004,792	356,464,436	0	2,846,011,701	2,846,011,701
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	7,500,002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,500,002	7,500,002
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	17,822,210	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,822,210	17,822,210
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	15,688,221	22,546,108	18,919,184	16,356,580	24,507,605	34,064,491	48,859,842	12,164,879	5,856,911	11,998,091	8,952,922	3,982,487	0	0	223,897,321	223,897,321
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	609,561	0	0	0	0	0	0	0	609,561	609,561
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	10,056,500	3,403,710	7,500,000	7,500,000	7,500,000	7,500,000	0	38,818,619	39,694,442	82,153,936	85,515,739	66,000,000	0	0	355,642,946	355,642,946
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	71,468,225	(8,863)	0	0	0	0	71,459,362	71,459,362
Total	**0**	**1,430,419,192**	**673,385**	**19,929,180**	**15,337,318**	**10,916,896**	**18,580,159**	**228,727,963**	**244,800,211**	**294,243,934**	**368,276,721**	**514,860,384**	**444,696,938**	**454,123,543**	**464,250,373**	**785,020,500**	**1,213,229,033**	**1,360,297,911**	**1,312,970,827**	**1,449,236,439**	**773,350,775**	**1,746,857,476**	**1,885,858,364**	**1,995,045,325**	**2,167,935,423**	**0**	**19,199,638,270**	**19,199,638,270**
																				10,630,590,907								

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
1,115	0	35,490,882	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35,490,882	35,490,882
1902 R 2	0	86,769,823	0	0	0	0	(14,054)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	86,755,769	86,755,769
1902 R 2X	0	(4,205,136)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(4,205,136)	(4,205,136)
1902R2	0	60,696	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	60,696	60,696
AFDC	0	74,034,827	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	74,034,827	74,034,827
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(199)	81,134,508	211,362,743	229,319,379	165,433,841	179,767,116	95,671,244	189,594,054	162,264,809	173,796,076	182,336,839	0	1,670,680,410	1,670,680,410
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,622,988	11,822,762	16,022,396	9,984,628	12,621,590	7,728,650	19,714,962	26,666,740	30,484,955	40,131,579	0	176,801,250	176,801,250
Aged with Medicare -	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(249,679)	(273,613)	(105,257)	0	(628,549)	(628,549)
Aged without Medica	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(7,720)	(24,377)	(6,134)	0	(38,231)	(38,231)
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(9,251)	21,277,328	49,916,398	52,637,624	39,301,119	45,400,574	25,392,193	51,341,281	86,055,226	85,848,919	85,953,479	0	543,114,890	543,114,890
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(19,525)	54,511,233	141,883,522	161,404,345	130,455,011	145,626,614	76,875,219	150,341,457	149,713,072	166,560,783	201,208,942	0	1,378,560,673	1,378,560,673
Blind/Disable without	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(171,495)	(180,813)	(88,748)	0	(441,056)	(441,056)
Blind/Disabled with M	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(32,236)	(40,358)	(45,235)	0	(117,829)	(117,829)
Breast Cervical Cance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(1)	2,754	361,286	592,247	495,478	241,945	376,266	201,477	152,122	78,616	0	2,502,190	2,502,190
CURRENT	0	247,684,665	0	0	0	0	904,176	83,526,544	40,668,142	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	372,783,527	372,783,527
CURRENT POP	0	136,389,220	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	136,389,220	136,389,220
Current-Hawaii Quest	0	0	0	0	0	0	0	0	22,572,505	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22,572,505	22,572,505
Demo Elig Adults	0	0	0	0	0	0	0	0	79,127	1,144	30,236	186,922	75,196,276	74,766,107	87,642,204	114,378,784	135,452,513	154,819,222	123,131,091	116,746,756	22,522,331	5,362	(3,183)	397	0	0	904,955,289	904,955,289
Expansion State Adul	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	157,575,707	313,187,813	459,471,604	520,230,143	0	1,450,465,267	1,450,465,267

FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	51,916	53,413	63,415	89,013	36,291	90,900	89,970	365,633	326,182	480,970	676,665	0	2,324,368	2,324,368
HawaiiQuest-1902(R)	0	353,988	53,702	1,242,907	818,930	430,573	808,769	0	0	166	20,369	256,468	0	0	18,679	19,755	5,389	0	0	0	0	0	0	0	0	0	4,029,695	4,029,695
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	76,578	438,797	0	0	0	0	0	0	0	0	0	0	515,375	515,375
HealthQuest-Current	0	1,963,002	175,736	6,063,866	5,004,058	3,692,366	5,386,340	4,903,637	36,087,606	132,768,282	165,985,082	231,578,381	(1,365,848)	0	0	0	0	0	0	0	0	0	0	0	0	0	592,242,508	592,242,508
HealthQuest-Others	0	901,053	107,974	2,662,739	1,849,641	1,340,727	1,981,352	1,733,011	11,768,154	36,642,802	60,584,431	55,313,761	(363,962)	0	0	0	0	0	0	0	0	0	0	0	0	0	174,521,683	174,521,683
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	32,497	68,553	68,082	38,985	78,049	64,590	4,238	0	0	0	0	0	0	0	354,994	354,994
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,196	2,666	0	0	0	0	0	0	0	0	0	7,862	7,862
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	69,404	368,050	0	0	0	0	0	0	0	0	0	0	437,454	437,454
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,331	217,032,614	163,377,679	118,514,349	127,011,994	0	625,937,967	625,937,967
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,881,647	10,235,011	0	0	0	0	0	0	0	0	0	0	13,116,658	13,116,658
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	44,819	59,404	45,487	166,217	170,408	21	0	0	0	0	0	0	0	0	486,356	486,356
OTHERS	0	144,525,295	0	0	0	0	426,612	29,580,209	16,428,385	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	190,960,501	190,960,501
Others-Hawaii Quest	0	0	0	0	0	0	0	0	7,404,260	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,404,260	7,404,260
OthersX	0	(7,809,492)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(7,809,492)	(7,809,492)
QUEST ACE	0	0	0	0	0	0	0	0	0	0	0	0	(1,583)	454,606	3,232,556	9,373,768	16,050,472	19,640,154	13,856,685	39,331,445	13,397,540	(220)	0	0	0	0	115,335,423	115,335,423
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,442,944	10,922,768	0	0	0	0	0	0	0	0	0	0	15,365,712	15,365,712
St Pl Adults-Preg Imm	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,829	1,707,938	1,317,977	1,473,988	508,843	794,853	764,288	1,111,786	1,217,763	0	8,914,265	8,914,265
State Plan Adults	0	0	0	0	0	0	0	0	(6)	125	52	22,986	65,812,117	68,288,552	61,892,816	82,540,889	88,872,198	81,069,310	57,010,745	66,741,115	41,648,154	104,427,273	90,859,778	90,549,259	101,635,907	0	1,001,371,270	1,001,371,270
State Plan Children	0	0	0	0	0	0	0	(23)	(5,530)	1,173	507	1,494,521	106,725,591	103,797,242	88,086,005	108,850,847	137,161,875	139,098,190	94,500,830	110,489,567	54,523,860	128,315,946	161,359,527	170,135,173	195,645,054	0	1,600,180,355	1,600,180,355
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	4,385,251	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,385,251	4,385,251
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	10,614,749	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10,614,749	10,614,749
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	9,212,484	13,041,165	10,762,501	10,040,250	16,505,872	22,280,473	24,838,917	6,249,536	3,037,111	6,229,742	4,707,711	2,149,747	0	0	129,055,509	129,055,509
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	307,706	0	0	0	0	0	0	0	307,706	307,706
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	5,787,516	1,958,835	4,237,500	4,959,750	5,051,250	4,697,250	0	20,131,336	20,583,506	42,677,271	45,049,870	35,626,800	0	0	190,760,884	190,760,884
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37,060,184	(4,595)	0	0	0	0	37,055,589	37,055,589
Total	**0**	**716,158,823**	**337,412**	**9,969,512**	**7,672,629**	**5,463,666**	**9,493,195**	**119,743,378**	**135,002,643**	**169,413,692**	**226,620,677**	**303,853,039**	**261,079,907**	**262,434,464**	**263,479,344**	**510,938,536**	**814,419,115**	**883,211,191**	**660,771,326**	**745,166,015**	**399,282,081**	**1,068,787,606**	**1,204,069,859**	**1,334,363,779**	**1,455,881,607**	**0**	**11,567,613,496**	**11,567,613,496**

6,105,228,564

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	39,312,729	11,586,429	43,993,148	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	77,875,213	0	791,494,742	791,494,742
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	755,748	34,375,214	12,833,291	0	0	0	0	0	0	0	0	0	47,964,253	47,964,253
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7,241,969**	**42,748,419**	**40,068,477**	**45,961,643**	**56,826,439**	**59,479,815**	**54,588,745**	**85,205,753**	**62,594,608**	**82,954,286**	**118,530,760**	**105,382,868**	**77,875,213**	**0**	**839,458,995**	**839,458,995**

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	20,907,343	6,121,891	25,253,918	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	58,184,523	0	544,026,409	544,026,409
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	377,874	17,784,187	6,534,554	0	0	0	0	0	0	0	0	0	24,696,615	24,696,615
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3,679,980**	**22,272,827**	**21,285,217**	**23,906,078**	**31,788,472**	**34,488,282**	**31,963,518**	**59,588,869**	**48,414,408**	**61,342,106**	**93,307,850**	**78,500,894**	**58,184,523**	**0**	**568,723,024**	**568,723,024**

Created On: Thursday, January 25, 2018 2:15 PM

Hawaii 1115 QUEST Waiver TOTAL COMPUTABLE			DY 01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
					Initial				*BBA*			*BIPA*			*Std Renewal/Extension*											
WITHOUT WAIVER		**FMAP**	0.5	0.5	0.5	0.5	0.5	0.50505	0.5243	0.55095	0.57555	0.61785	0.599353846	0.58725	0.57865	0.56762 5	0.640275	0.6735	0.6546	0.5081	0.5152	51.85%	52.14%	53.54%	54.69%	54.82%
								50.00%	51.01%	53.85%	56.34%	61.72%	61.85%	58.47%	58.81%	57.55%	56.50%	67.35%	67.35%	51.79%	50.48%	51.86%	51.85%	52.23%	53.98%	54.93%	54.93%
	MEG							51.01%	53.85%	56.34%	58.77%	61.85%	58.90%	58.81%	57.55%	56.50%	66.13%	54.24%	64.52%	50.48%	51.86%	51.85%	52.23%	53.98%	54.93%	54.78%
		MEG Description and Comments/Crosswalk											58.47%				67.35%		62.63%							
				6.0130%	6.1112%	5.8406%	7.5859%	6.6615%	8.0290%	8.9536%	8.3368%	7.3038%	7.7898%													
	Children	**Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children**												$261.16	$281.11	$302.59	$322.62	$343.98	$366.75	$391.03	$416.92	$421.09	$424.24	$428.49	$432.77	$437.10
	Adults	**Pregnant to 185%, 1931, 1925, TANF above cash**												$458.35	$493.37	$531.07	$564.90	$600.88	$639.18	$679.87	$723.18	$749.94	$755.56	$783.51	$812.50	$842.56
	Aged	**Aged over 65 with and without Medicare**															$1,204.63	$1,281.84	$1,364.01	$1,451.44	$1,544.48	$1,596.99	$1,608.95	$1,663.66	$1,720.22	$1,778.71
	Blind/Disabled	**Blind or Disabled with or without Medicare**															$1,489.42	$1,597.11	$1,712.58	$1,836.40	$1,969.17	$2,057.78	$2,073.20	$2,166.49	$2,263.98	$2,365.86
	VIII Group Combined	**VIII Group Adults**																			$641.64	$663.42	$684.37	$719.27	$755.95	$794.51
Member Months																										
	MEG																									
	Children	**Infants <1 age to 185%, 1-5 to 133%, 6-18 to 100%, 1931 or 1925 children**												943,063	930,199	891,143	979,228	1,101,814	1,183,803	1,226,925	1,311,907	664,996	1,366,383	1,434,123	1,499,108	1,471,620
	Adults	**Pregnant to 185%, 1931, 1925, TANF above cash**												339,848	331,334	302,135	348,185	390,404	421,978	423,965	466,956	270,912	622,907	496,098	471,973	477,665
	Aged	**Aged over 65 with and without Medicare**															98,208	228,008	236,980	236,986	248,894	129,235	279,074	300,577	309,628	323,054
	Blind/Disabled	**Blind or Disabled with or without Medicare**															115,268	273,836	288,282	288,441	293,080	148,002	305,647	299,308	311,434	309,904
	VIII Group Combined	**VIII Group Adults**																				179,226	925,308	1,212,870	1,390,122	1,451,642
		Total Without Waiver Member Mon	790,894	1,290,219	1,204,628	1,229,115	1,231,311	1,209,889	1,115,995	1,051,093	1,112,663	1,146,031	1,173,044	**1,282,911**	**1,261,533**	**1,193,278**	**1,540,889**	**1,994,062**	**2,131,043**	**2,176,317**	**2,320,837**	**1,392,371**	**3,499,319**	**3,742,976**	**3,982,265**	**4,033,885**
Ceiling Without DSH		Total Without Waiver Expenditures including	$154,128,215	$259,357,574	$278,888,097	$300,555,960	$323,703,568	$339,383,311	$333,850,950	$349,876,623	$401,105,060	$443,320,352	$489,105,471	$402,056,806	$424,960,513	$443,327,661	$837,492,981	$1,343,204,149	$1,520,828,093	$1,641,669,393	$1,846,189,655	$994,132,995	$2,133,003,490	$2,151,705,266	$2,269,959,061	$2,353,515,633
DSH														$80,364,047	$81,971,327	$83,856,667	$87,546,360	$89,735,019	$91,350,249	$93,542,655	$95,974,764	$48,848,589	$99,450,504	$101,837,316	$51,832,471	
Total Ceiling			**$154,128,215**	**$259,357,574**	**$278,888,097**	**$300,555,960**	**$323,703,568**	**$339,383,311**	**$333,850,950**	**$349,876,623**	**$401,105,060**	**$443,320,352**	**$489,105,471**	**$482,420,853**	**$506,931,840**	**$527,184,328**	**$925,039,341**	**$1,432,939,168**	**$1,612,178,342**	**$1,735,212,048**	**$1,942,164,419**	**$1,042,981,584**	**$2,232,453,994**	**$2,253,542,582**	**$2,321,791,532**	**$2,353,515,633**
WITH WAIVER																										
		1115	$70,981,761	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		1902 R 2	$173,206,589	$0	$0	$0	$0	($28,108)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		1902 R 2X	($8,243,749)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		1902R2	$121,392	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		AFDC	$148,069,654	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		Aged w/Mcare	$0	$0	$0	$0	$0	$0	$0	$134,638	$1,995	$51,709	$318,560	$127,982,800	$129,458,220	$154,645,547	$177,395,777	$201,629,082	$238,976,706	$244,548,890	$227,226,840	$43,951,050	$10,309	-$5,724	$735	$0
		Aged w/o Mcare	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($295)	$121,279,583	$314,952,742	$350,714,627	$327,591,264	$349,136,645	$184,750,729	$364,919,391	$308,022,477	$320,576,114	$332,179,081
		FosterCare(19-20)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,424,989	$17,555,107	$24,914,002	$19,830,566	$24,478,496	$14,925,306	$37,994,798	$50,665,247	$56,279,590	$73,129,761
		HawaiiQuest-1902(R)(2)	$700,529	$107,270	$2,484,576	$1,636,854	$860,335	$1,594,466	$0	$0	$284	$34,836	$438,582	$0	$0	$33,061	$26,332	$8,001	$0	$0	$0	$0	$0	-$473,188	-$525,165	-$191,620
		HCCP	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$135,520	$683,159	$0	$0	$0	$0	$0	$0	$0	$0	$0
		HealthQuest-Current	$3,884,748	$350,430	$12,121,771	$10,002,019	$7,377,643	$10,651,130	$9,373,702	$64,428,704	$230,593,470	$268,955,153	$392,471,288	($2,325,152)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		HealthQuest-Others	$1,783,163	$215,685	$5,322,833	$3,698,445	$2,678,918	$3,915,013	$3,306,673	$21,010,550	$63,645,959	$99,234,046	$93,729,117	($621,643)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		Med Needy Adults	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$56,504	$120,767	$115,693	$58,345	$117,005	$109,837	$8,305	$0	$0	$0	$0	$0	$0
		Med Needy Children	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,715	$3,960	$0	$0	$0	$0	$0	$0	$0	$0
		MFCP	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$122,839	$581,513	$0	$0	$0	$0	$0	$0	$0	$0	$0
		Newly Eligible Adults	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,331	$217,050,612	$163,377,915	$118,552,565	$133,699,746
		NH w/o W	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$5,100,418	$16,199,737	$0	$0	$0	$0	$0	$0	$0	$0	$0
		Opt St Pl Children	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$76,678	$103,084	$80,075	$257,166	$253,182	$31	$0	$0	$0	$0	$0	$0	$0
		OTHERS	$288,512,308	$0	$0	$0	$0	$786,332	$56,430,712	$30,507,680	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		Others-Hawaii Quest	$0	$0	$0	$0	$0	$0	$0	$13,142,103	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		OthersX	($15,309,727)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		QUEST ACE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($2,751)	$798,681	$5,696,094	$14,348,855	$23,871,010	$30,466,706	$27,903,461	$76,349,735	$26,173,447	-$425	$0	$0	$0
		RAACP	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,862,479	$17,432,949	$0	$0	$0	$0	$0	$0	$0	$0	$0
		St Pl Adults-Preg Immig/COFAs	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$24,990	$2,628,840	$2,625,695	$2,867,476	$987,921	$1,531,033	$1,448,764	$2,048,646	$2,218,467
		State Plan Adults	$0	$0	$0	$0	$0	$0	$0	$0	($10)	$218	$99	$39,158	$111,982,730	$118,021,622	$109,034,691	$128,225,118	$132,190,152	$124,253,835	$113,880,407	$129,970,747	$80,835,624	$201,563,132	$172,869,804	$167,789,334	$185,217,514
		State Plan Children	$0	$0	$0	$0	$0	$0	($41)	($9,403)	$2,008	$878	$2,541,467	$181,803,051	$179,672,789	$155,392,914	$168,853,245	$203,885,664	$215,817,889	$190,928,381	$215,727,193	$106,616,220	$247,372,600	$306,115,308	$314,004,792	$356,464,436
		Supp. - Private	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$7,500,002	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		Supp. - State Gov.	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$17,822,210	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
		UCC-Governmental	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$15,688,221	$22,546,108	$18,919,184	$16,356,580	$24,507,605	$34,064,491	$48,859,842	$12,164,879	$5,856,911	$11,998,091	$8,952,922	$3,982,487	$0
		UCC-GOVT LTC	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$609,561	$0	$0	$0	$0	$0	$0
		UCC-Private	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$10,056,500	$3,403,710	$7,500,000	$7,500,000	$7,500,000	$7,500,000	$0	$38,818,619	$39,694,442	$82,153,936	$85,515,739	$66,000,000	$0
		VIII-Like Group	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$71,468,225	-$8,863	$0	$0	$0
	Total Expenditures Per CMS-64 Waiver		**$1,430,419,192**	**$673,385**	**$19,929,180**	**$15,337,318**	**$10,916,896**	**$18,580,159**	**$228,727,963**	**$244,800,211**	**$294,243,934**	**$368,276,721**	**$514,860,384**	**$444,696,938**	**$454,124,981**	**$464,686,992**	**$785,023,977**	**$1,213,234,602**	**$1,360,333,681**	**$1,314,844,769**	**$1,448,467,634**	$701,881,219	$1,337,890,437	$1,382,468,064	$1,400,764,482	$1,454,238,091
	Premium Share (Not reported on 64 Waiver)													-$1,459,097	-$1,189,919	-$660,309	-$4,962,002	-$38,297,536	-$43,476,661	-$38,375,159	-$38,277,091	-$19,913,325	-$39,517,066	-$39,153,120	-$39,272,774	-$38,996,013
	Total Expenditures		**$1,430,419,192**	**$673,385**	**$19,929,180**	**$15,337,318**	**$10,916,896**	**$18,580,159**	**$228,727,963**	**$244,800,211**	**$294,243,934**	**$368,276,721**	**$514,860,384**	**$443,237,841**	**$452,935,062**	**$464,026,683**	**$780,061,975**	**$1,174,937,066**	**$1,316,857,020**	**$1,276,469,610**	**$1,410,190,544**	**$681,967,894**	**$1,298,373,371**	**$1,343,314,944**	**$1,361,491,708**	**$1,415,242,078**
	DY BN Savings		**-$1,276,290,977**	**$258,684,189**	**$258,958,917**	**$285,218,642**	**$312,786,672**	**$320,803,152**	**$105,122,987**	**$105,076,412**	**$106,861,126**	**$75,043,631**	**-$25,754,913**	**$39,183,013**	**$53,996,778**	**$63,157,645**	**$144,977,366**	**$258,002,102**	**$295,321,322**	**$458,742,438**	**$531,973,876**	**$361,013,690**	**$934,080,622**	**$910,227,638**	**$960,299,824**	**$938,273,555**
	Cummulative Savings		**-$1,276,290,977**	**-$1,017,606,788**	**-$758,647,871**	**-$473,429,229**	**-$160,642,557**	**$160,160,596**	**$265,283,583**	**$370,359,995**	**$477,221,121**	**$552,264,752**	**$526,509,840**	**$565,692,852**	**$619,689,630**	**$682,847,275**	**$827,824,640**	**$1,085,826,742**	**$1,381,148,065**	**$1,839,890,503**	**$2,371,864,378**	**$2,732,878,069**	**$3,666,958,691**	**$4,577,186,330**	**$5,537,486,154**	**$6,475,759,709**
	Most recent 5 Years																					**$361,013,690**	**$934,080,622**	**$1,844,308,261**	**$2,804,608,085**	**$3,742,881,640**
												P/S, SDCS	Sept	-$334,903	-$352,488	-$217,644	-$22,587	-$15,945,497	-$15,835,580	-$10,164,390	-$9,626,446					
													Dec	-$323,973	-$263,058	-$239,466	-$19,777	-$6,517,946	-$9,185,458	-$9,300,862	-$9,349,096					
													Mar	-$347,005	-$279,056	-$147,219	-$22,317	-$9,503,023	-$9,356,037	-$9,335,080	-$9,759,910					
													Jun	-$453,216	-$295,317	-$55,980	-$4,897,321	-$6,331,070	-$9,099,586	-$9,574,826	-$9,540,739					
	Medicaid Rehab became new benefit during year 11 Children's outreach lead to more adults, including adults below the line (Adults-expansion) during year 11																									
			1430419192	673385	19929180	15337318	10916896	18580159	228727963	244800211	294243934	368276721	514860384	444695716	454123252	464684714	785025194	$1,213,239,280	1360179352	1312026514	1394854494					
			$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,222	$1,729	$2,278	-$1,217	-$4,678	$154,329	$2,818,255	$53,613,140					

	DY 21	DY 22	DY 23	DY 24
CHIP Total	378,668	332,169	318,055	331,327
CHIP Total	58,152,232	45,927,088	57,458,616	69,131,596

Attachment H

Larrimore, Aaron

From: Mauricio, Emelinia M
Sent: Tuesday, July 31, 2018 8:37 AM
Cc: Larrimore, Aaron; Befitel, Aileen; Mayeshiro, Edie
Subject: 1115 Renewal - 2nd Public Notice

The State of Hawaii, Department of Human Services (the State) is proposing to request approval from the federal Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) to extend the "QUEST Integration" Demonstration Project (Project Number 11-W-00001/9) under Section 1115(a) of the Social Security Act for an additional five years in order to further transform and improve the healthcare delivery system for low-income Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration (Waiver) beginning January 1, 2019 and continuing through December 31, 2023.

In accordance to 42 C.F.R. 431.408, the State must provide at least a 30 day public notice comment period regarding the application for a demonstration project, or extension of an existing demonstration project that the State intends to submit to CMS for review and consideration.

The State previously issued public notice on February 17, 2018 and conducted two public hearings on March 2, 2018 and March 6, 2018. However, the State is reissuing notice to provide some additional information related to the financing approach, to share the interim evaluation results of the demonstration, to provide documentation of the annual post award forum, and to confirm our process for tribal consultation. The draft application has also been updated to provide more description of the state's objectives for the 1115 Demonstration Project.

Therefore, the State invites the public to comment on the renewal application and documents relevant to the renewal application a second time. The State reopens the comment period from July 31, 2018 (Tuesday) and end on August 30, 2018 (Thursday). This public input process will provide the opportunity for the public to review and provide comment on the draft Demonstration renewal proposal and relevant documents.

For further details on the program descriptions, goals, and objective, please refer to the State's full public notice, the draft Demonstration renewal proposal, the Hawai'i 'Ohana Nui Project Expansion (HOPE) Program Vision Document, the Potential Initiatives Under HOPE document and relevant documents located in the following link: https://medquest.hawaii.gov/en/about/state-plan-1115.html.

Thank you.

Emelinia Mauricio
Secretary
DHS/MQD/PPDO
601 Kamokila Blvd., Room 518
Kapolei, HI 96707

Email: emauricio@dhs.hawaii.gov
Ph: 692-8058 Fax: 692-8173

Attachment I

Statement of Public Notice
Section 1115(a) Renewal of Section 1115 Demonstration

The State of Hawai'i, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 Demonstration Project from the Centers for Medicare & Medicaid Services (CMS). The State is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. §431.408(a)(2)(ii).

The State is proposing to request approval from the federal Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) to extend and amend the QUEST Integration Demonstration under Section 1115(a) of the Social Security Act for an additional five years, and to amend Medicaid State Plan, as appropriate, in order to incorporate specific measures that will further transform and improve the current health delivery system for eligible Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration (Waiver) to be effective January 1, 2019, and continuing through December 31, 2024.

For over two decades, Hawai'i's demonstration has efficiently and effectively delivered comprehensive benefits to a large number of beneficiaries, including expansion populations, through competitive managed care delivery systems. Under the renewal, "QUEST Integration" continues to build on this success by delivering services through managed care, while integrating the demonstration's programs and benefits to have a more patient-centered care delivery system and alignment of the demonstration with applicable requirements. All eligible beneficiaries will continue to be enrolled under "QUEST Integration", and access to services will be determined by clinical criteria and medical necessity. The renewal continues to incorporate the simplified Medicaid eligibility structure under the Affordable Care Act into Hawaii's demonstration.

Under the "QUEST Integration" renewal, the State requests approval from the federal government to continue to deliver services through managed care under existing waiver authorities in order to continue to implement and deliver coordinated care system services while slowing growth in costs, and will ask for new flexibilities to continue to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care, and to implement the following strategies:

- Invest in primary care, prevention, and health promotion.
- Improve outcomes for High-Need and High-Cost individuals.
- Promote payment reform and financial alignment.
- Support locally driven initiatives to improve population health.

In addition, the Med-QUEST (MQD) will improve the health care delivery system by supporting the following foundational building blocks:

- Health Information Technology - Use data and analytics to transform and drive clinical care.
- Workforce Strategy - Increase workforce capacity and flexibility.
- Continuous Improvement - Performance measurement and evaluation.

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			

The waiver renewal goals and strategies will continue as documented in the current waiver. Hawai'i will request flexibility to make the following, but not limited to these 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 Managed Care Organizations (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.

For further details on the program descriptions, goals, and objective, please refer to the "Medicaid Innovation Initiative" located in the following link: https://medquest.hawaii.gov/en/resources/rules-and-policy.html.

The draft renewal application and the State's full public notice, which describe the demonstration and the proposed renewal in more detail, can be found at https://medquest.hawaii.gov/en/resources/rules-and-policy.html. Hard copies are available for review at the Department of Human Services, Med-QUEST, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707.

Comments

We invite comments on this proposal. Please submit any comments or questions to Ms. Edie Mayeshiro by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at emayeshiro@dhs.hawaii.gov.

Comments will be accepted for consideration between February 17, 2018, and March 19, 2018 (30 days from the date of this notice).

Public Hearings

The State will hold two public hearings to solicit comments from interested parties on the proposed renewal:

1. March 2, 2018, from 8:00 am to 12:00 pm:

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

2. March 6, 2018, from 8:00 am to 12:00 pm:

   Oahu — Kakuhihewa Videoconference Center
   Kakuhihewa State Office Building
   601 Kamokila Boulevard, Room 167B
   Kapolei, Hawaii

   Hawaii — Hilo Videoconference Center
   Hilo State Office Building
   75 Aupuni Street, Basement
   Hilo, Hawaii

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

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

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (*e.g.*, sign or foreign language or wheelchair accessibility), please contact:

Oahu	Emelinia Mauricio (808) 692-8058
Hawaii	Calvin Unoki (808) 933-0339, extension 101
Kauai	Iris Venzon (808) 241-3575, extension 101
Maui	Agriffa Kristia Braquit (808) 243-5780, extension 101

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.
(WHT1073475 2/17/18)

AFFIDAVIT OF PUBLICATION

STATE OF HAWAII, } ss.
County of Maui. }

Rhonda M. Kurohara being duly sworn deposes and says,that she is in Advertising Sales of the Maui Publishing Co., Ltd., publishers of THE MAUI NEWS, a newspaper published in Wailuku, County of Maui, State of Hawaii; that the ordered publication as to

STATEMENT OF PUBLIC NOTICE

of which the annexed is a true and correct printed notice, was published 1 times in THE MAUI NEWS, aforesaid, commencing on the 17th day of February, 2018, and ending on the 17th day of February, 2018 (one day) inclusive), to-wit: on

February 17, 2018

and that affiant is not interested in the above entitled matter.

[redacted]

158304

24215

This 1 page ___ of PUBLIC, dated February 17, 2018, was subscribed and sworn to before me this 20th day of February, 2018 in the Second Circuit of the State of Hawaii, by Rhonda M. Kurohara

[redacted]

Notary Public, Second Judicial Circuit, State of Hawaii
BETTY E. UEHARA
My Commission expires 09-26-2019

BETTY E. UEHARA NOTARY PUBLIC No. 83-344 STATE OF HAWAII

Statement of Public Notice
Section 1115(a) Renewal of Section 1115 Demonstration

The State of Hawai'i, Department of Human Services (the State), hereby notifies the publi intends to seek a five-year renewal of its Section 1115 Demonstration Project from the Ce Medicare & Medicaid Services (CMS). The State is providing this abbreviated notice pursuant requirements in 42 C.F.R. §431.408(a)(2)(ii).

The State is proposing to request approval from the federal Department of Health and Human (DHHS), Centers for Medicare and Medicaid Services (CMS) to extend and amend the Integration Demonstration under Section 1115(a) of the Social Security Act for an additional fi and to amend Medicaid State Plan, as appropriate, in order to incorporate specific measures further transform and improve the current health delivery system for eligible Hawai'i residents. T will request approval of a five-year extension of the 1115 Demonstration (Waiver) to be January 1, 2019, and continuing through December 31, 2024.

For over two decades, Hawai'i's demonstration has efficiently and effectively delivered compr benefits to a large number of beneficiaries, including expansion populations, through con managed care delivery systems. Under the renewal, "QUEST Integration" continues to build success by delivering services through managed care, while integrating the demonstration's progr benefits to have a more patient-centered care delivery system and alignment of the demonstrat applicable requirements. All eligible beneficiaries will continue to be enrolled under " Integration", and access to services will be determined by clinical criteria and medical necess renewal continues to incorporate the simplified Medicaid eligibility structure under the Afforda Act into Hawaii's demonstration.

Under the "QUEST Integration" renewal, the State requests approval from the federal gover continue to deliver services through managed care under existing waiver authorities in order to cor implement and deliver coordinated care system services while slowing growth in costs, and will new flexibilities to continue to build on the state's history of providing the most vulnerable reside effective, efficient, evidence-based health care, and to implement the following strategies:

- Invest in primary care, prevention, and health promotion.
- Improve outcomes for High-Need and High-Cost individuals.
- Promote payment reform and financial alignment.
- Support locally driven initiatives to improve population health.

In addition, the Med-QUEST (MQD) will improve the health care delivery system by suppor following foundational building blocks:

- Health Information Technology – Use data and analytics to transform and drive clinical care.
- Workforce Strategy – Increase workforce capacity and flexibility.
- Continuous Improvement – Performance measurement and evaluation.

HOPE PROJECT SUMMARY				
Goals	Healthy Families and Healthy Communities and Achieving the Triple Aim – Better Health, Better Care, Sustainable			
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 drive initiatives to improve population h
Foundational Building Blocks	1. Use health information technology to drive transformation 2. Increase workforce capacity 3. Performance measurement and evaluation			

The waiver renewal goals and strategies will continue as documented in the current waiver. will request flexibility to make the following, but not limited to these targeted changes, in the renewal:

- Increase the proportion of health care spending on primary care in order to promote the health s orientation toward high-value care.
- Continue to promote further developments in value-based purchasing and alternative p methodologies.
- Promote best practices that address the needs of HNHC individuals (i.e. care coordination, pa 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 valu payments to Managed Care Organizations (MCOs). MQD will request to provide new perfo incentive payments to primary care providers.
- Cover additional evidence-based services that further integrate physical and behavioral health s 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 MC reduce costs through the use of these services can receive financial incentives to offset tho reductions.
- Support workforce development efforts such as Project ECHO, a teaching program for providers

For further details on the program descriptions, goals, and objective, please refer to the "M Innovation Initiative" located in the following link:
https://medquest.hawaii.gov/en/resources/rules-and-policy.html.

The draft renewal application and the State's full public notice, which describe the demonstrat the proposed renewal in more detail, can be found at https://medquest.hawaii.gov/en/resources/rul policy.html. Hard copies are available for review at the Department of Human Services, Med-C Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707.

Comments

We invite comments on this proposal. Please submit any comments or questions to Ms. Edie Ma by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at emayeshiro@dhs.hawaii.gov.

Comments will be accepted for consideration between February 17, 2018, and March 19, 2018 (30 days from the date of this notice).

Public Hearings

The State will hold two public hearings to solicit comments from interested parties on the pr renewal:

1. March 2, 2018, from 8:00 am to 12:00 pm:
   Department of Human Services
   1390 Miller Street, Conference Rooms 1 & 2
   Honolulu, Hawaii
2. March 6, 2018, from 8:00 am to 12:00 pm:
   - Oahu: Kakuhihewa Videoconference Center, Kakuhihewa State Office Building, 601 Kamokila Boulevard, Room 167B, Kapolei, Hawaii
   - Hawaii: Hilo Videoconference Center, Hilo State Office Building, 75 Aupuni Street, Basement, Hilo, Hawaii
   - Kauai: Lihue Videoconference Center, Lihue State Office Building, 3060 Eiwa Street, Basement, Lihue, Hawaii
   - Maui: Wailuku Videoconference Center, Wailuku Judiciary Building, 2145 Main Street, First Floor, Wailuku, Hawaii

AFFIDAVIT OF PUBLICATION

IN THE MATTER OF
Statement of Public Notice

STATE OF HAWAII }
} SS.
City and County of Honolulu }

Doc. Date: FEB 19 2018 # Pages: 1

Notary Name: COLLEEN E. SORANAKA First Judicial Circuit

Doc. Description: Affidavit of Publication

[redacted] FEB 19 2018

Notary Signature Date

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-263 STATE OF HAWAII

Gwyn Pang being duly sworn, deposes and says that she is a clerk, duly authorized to execute this affidavit of Oahu Publications, Inc. publisher of The Honolulu Star-Advertiser, MidWeek, The Garden Island, West Hawaii Today, and Hawaii Tribune-Herald, that said newspapers are newspapers of general circulation in the State of Hawaii, and that the attached notice is true notice as was published in the aforementioned newspapers as follows:

Honolulu Star-Advertiser 1 times on:
02/17/2018
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Hawaii Tribune-Herald 0 times on:
West Hawaii Today 0 times on:
Other Publications: 0 times on:

And that affiant is not a party to or in any way interested in the above entitled matter.

[redacted]
Gwyn Pang

Subscribed to and sworn before me this 19 day of February D. 20 18

[redacted]
Colleen E. Soranaka, Notary Public of the First Judicial Circuit, State of Hawaii
My commission expires: Jan 06 2020

Ad # 0001073202

Statement of Public Notice
Section 1115(a) Renewal of Section 1115 Demonstration

The State of Hawai'i, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 Demonstration Project from the Centers for Medicare & Medicaid Services (CMS). The State is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. §431.408(a)(2)(ii).

The State is proposing to request approval from the federal Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) to extend and amend the QUEST Integration Demonstration under Section 1115(a) of the Social Security Act for an additional five years, and to amend Medicaid State Plan, as appropriate, in order to incorporate specific measures that will further transform and improve the current health delivery system for eligible Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration (Waiver) to be effective January 1, 2019, and continuing through December 31, 2024.

For over two decades, Hawai'i's demonstration has efficiently and effectively delivered comprehensive benefits to a large number of beneficiaries, including expansion populations, through competitive managed care delivery systems. Under the renewal, "QUEST Integration" continues to build on this success by delivering services through managed care, while integrating the demonstration's programs and benefits to have a more patient-centered care delivery system and alignment of the demonstration with applicable requirements. All eligible beneficiaries will continue to be enrolled under "QUEST Integration", and access to services will be determined by clinical criteria and medical necessity. The renewal continues to incorporate the simplified Medicaid eligibility structure under the Affordable Care Act into Hawai'i's demonstration.

Under the "QUEST Integration" renewal, the State requests approval from the federal government to continue to deliver services through managed care under existing waiver authorities in order to continue to implement and deliver coordinated care system services while slowing growth in costs, and will ask for new flexibilities to continue to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care, and to implement the following strategies:

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- Health Information Technology - Use data and analytics to transform and drive clinical care.
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- Continuous Improvement - Performance measurement and evaluation.

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			

The waiver renewal goals and strategies will continue as documented in the current waiver. Hawai'i will request flexibility to make the following, but not limited to these 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.
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- Support workforce development efforts such as Project ECHO, a teaching program for providers.

For further details on the program descriptions, goals, and objective, please refer to the "Medicaid Innovation Initiative" located in the following link: https://medquest.hawaii.gov/en/resources/rules-and-policy.html.

The draft renewal application and the State's full public notice, which describe the demonstration and the proposed renewal in more detail, can be found at https://medquest.hawaii.gov/en/resources/rules-and-policy.html. Hard copies are available for review at the Department of Human Services, Med-QUEST, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707.

Comments

We invite comments on this proposal. Please submit any comments or questions to Ms. Edie Mayeshiro by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at emayeshiro@dhs.hawaii.gov.

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   Kakuhihewa State Office Building
   601 Kamokila Boulevard, Room 1678
   Kapolei, Hawaii

   Hawaii — Hilo Videoconference Center
   Hilo State Office Building
   75 Aupuni Street, Basement
   Hilo, Hawaii

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

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

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (e.g., sign or foreign language or wheelchair accessibility), please contact:

Oahu — Emelinia Mauricio (808) 692-8058
Hawaii — Calvin Unoki (808) 933-0339, extension 101
Kauai — Iris Venzon (808) 241-3575, extension 101
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AFFIDAVIT OF PUBLICATION

IN THE MATTER OF
Statement of Public Notice

STATE OF HAWAII }
} SS.
City and County of Honolulu }

Doc. Date: FEB 19 2018 # Pages: 1

Notary Name: COLLEEN E. SORANAKA First Judicial Circuit

Doc. Description: Affidavit of Publication

[redacted] FEB 19 2018

Notary Signature Date

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-263 STATE OF HAWAII

Gwyn Pang being duly sworn, deposes and says that she is a clerk, duly authorized to execute this affidavit of Oahu Publications, Inc. publisher of The Honolulu Star-Advertiser, MidWeek, The Garden Island, West Hawaii Today, and Hawaii Tribune-Herald, that said newspapers are newspapers of general circulation in the State of Hawaii, and that the attached notice is true notice as was published in the aforementioned newspapers as follows:

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And that affiant is not a party to or in any way interested in the above entitled matter.

[redacted]
Gwyn Pang

Subscribed to and sworn before me this 19 day of February A.D. 20 18

[redacted]
Colleen E. Soranaka, Notary Public of the First Judicial Circuit, State of Hawaii
My commission expires: Jan 06 2020

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-263 STATE OF HAWAII

Ad # 0001073480

Statement of Public Notice
Section 1115(a) Renewal of Section 1115 Demonstration

The State of Hawai'i, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 Demonstration Project from the Centers for Medicare & Medicaid Services (CMS). The State is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. §431.408(a)(2)(ii).

The State is proposing to request approval from the federal Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) to extend and amend the QUEST Integration Demonstration under Section 1115(a) of the Social Security Act for an additional five years, and to amend Medicaid State Plan, as appropriate, in order to incorporate specific measures that will further transform and improve the current health delivery system for eligible Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration (Waiver) to be effective January 1, 2019, and continuing through December 31, 2024.

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Under the "QUEST Integration" renewal, the State requests approval from the federal government to continue to deliver services through managed care under existing waiver authorities in order to continue to implement and deliver coordinated care system services while slowing growth in costs, and will ask for new flexibilities to continue to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care, and to implement the following strategies:

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Goals	**Healthy Families and Healthy Communities and Achieving the Triple Aim - Better Health, Better Care, Sustainable Costs**			
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AFFIDAVIT OF PUBLICATION

IN THE MATTER OF
Statement of Public Notice

STATE OF HAWAII }
} SS.
City and County of Honolulu }

Doc. Date: FEB 19 2018 # Pages: 1

Notary Name: COLLEEN E. SORANAKA First Judicial Circuit

Doc. Description: Affidavit of Publication

[redacted] FEB 19 2018

Notary Signature Date

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[redacted]
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[redacted]
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My commission expires: Jan 06 2020

Ad # 0001073476

Statement of Public Notice
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AFFIDAVIT OF PUBLICATION

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STATE OF HAWAII }
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My commission expires: Jan 06 2020

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Ad # 0001073475

Statement of Public Notice
Section 1115(a) Renewal of Section 1115 Demonstration

The State of Hawai'i, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 Demonstration Project from the Centers for Medicare & Medicaid Services (CMS). The State is providing this abbreviated notice pursuant to CMS requirements in 42 C.F.R. §431.408(a)(2)(ii).

The State is proposing to request approval from the federal Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) to extend and amend the QUEST Integration Demonstration under Section 1115(a) of the Social Security Act for an additional five years, and to amend Medicaid State Plan, as appropriate, in order to incorporate specific measures that will further transform and improve the current health delivery system for eligible Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration (Waiver) to be effective January 1, 2019, and continuing through December 31, 2024.

For over two decades, Hawai'i's demonstration has efficiently and effectively delivered comprehensive benefits to a large number of beneficiaries, including expansion populations, through competitive managed care delivery systems. Under the renewal, "QUEST Integration" continues to build on this success by delivering services through managed care, while integrating the demonstration's programs and benefits to have a more patient-centered care delivery system and alignment of the demonstration with applicable requirements. All eligible beneficiaries will continue to be enrolled under "QUEST Integration", and access to services will be determined by clinical criteria and medical necessity. The renewal continues to incorporate the simplified Medicaid eligibility structure under the Affordable Care Act into Hawai'i's demonstration.

Under the "QUEST Integration" renewal, the State requests approval from the federal government to continue to deliver services through managed care under existing waiver authorities in order to continue to implement and deliver coordinated care system services while slowing growth in costs, and will ask for new flexibilities to continue to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care, and to implement the following strategies:

- Invest in primary care, prevention, and health promotion.
- Improve outcomes for High-Need and High-Cost individuals.
- Promote payment reform and financial alignment.
- Support locally driven initiatives to improve population health.

In addition, the Med-QUEST (MQD) will improve the health care delivery system by supporting the following foundational building blocks:

- Health Information Technology - Use data and analytics to transform and drive clinical care.
- Workforce Strategy - Increase workforce capacity and flexibility.
- Continuous Improvement - Performance measurement and evaluation.

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			

The waiver renewal goals and strategies will continue as documented in the current waiver. Hawai'i will request flexibility to make the following, but not limited to these 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 Managed Care Organizations (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.

For further details on the program descriptions, goals, and objective, please refer to the "Medicaid Innovation Initiative" located in the following link: https://medquest.hawaii.gov/en/resources/rules-and-policy.html.

The draft renewal application and the State's full public notice, which describe the demonstration and the proposed renewal in more detail, can be found at https://medquest.hawaii.gov/en/resources/rules-and-policy.html. Hard copies are available for review at the Department of Human Services, Med-QUEST, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, HI 96707.

Comments

We invite comments on this proposal. Please submit any comments or questions to Ms. Edie Mayeshiro by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at emayeshiro@dhs.hawaii.gov.

Comments will be accepted for consideration between February 17, 2018, and March 19, 2018 (30 days from the date of this notice).

Public Hearings

The State will hold two public hearings to solicit comments from interested parties on the proposed renewal:

1. March 2, 2018, from 8:00 am to 12:00 pm:

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

2. March 6, 2018, from 8:00 am to 12:00 pm:

   Oahu — Kakuhihewa Videoconference Center
   Kakuhihewa State Office Building
   601 Kamokila Boulevard, Room 167B
   Kapolei, Hawaii

   Hawaii — Hilo Videoconference Center
   Hilo State Office Building
   75 Aupuni Street, Basement
   Hilo, Hawaii

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

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

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (e.g., sign or foreign language or wheelchair accessibility), please contact:

Oahu	Emelinia Mauricio (808) 692-8058
Hawaii	Calvin Unoki (808) 933-0339, extension 101
Kauai	Iris Venzon (808) 241-3575, extension 101.
Maui	Agrifia Kristia Braquit (808) 243-5780, extension 101

NOTICE OF REQUEST FOR SECTION 1115(a) RENEWAL OF HAWAII'S SECTION 1115 DEMONSTRATION (11-W-00001/9)
2nd Notice

QUEST Integration Renewal Application

The State of Hawaii, Department of Human Services (the State) is proposing to request approval from the federal Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) to extend the "QUEST Integration" (Project Number 11-W-00001/9) Demonstration under Section 1115(a) of the Social Security Act for an additional five years in order to further transform and improve the healthcare delivery system for low-income Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration Project beginning January 1, 2019 and continuing through December 31, 2023.

The State previously issued public notice on February 17, 2018 and is reissuing notice to provide some additional information related to the financing approach, to share the interim evaluation results of the demonstration, to provide documentation of the annual post award forum, and to confirm our process for tribal consultation. The draft application has also been updated to provide more description of the state's objectives for the 1115 Demonstration Project.

Program Description, Goals, and Objectives
Originally implemented as the QUEST program in 1994, QUEST Integration is the current version of Hawaii's Section 1115 demonstration project to provide comprehensive benefits to its Medicaid enrollees through a competitive managed care delivery system. The provision of benefits through managed care has saved billions of dollars in State and federal funds and has enabled the State to use some of these savings to provide State-funded medical coverage to individuals not otherwise eligible for Medicaid.

Under the demonstration renewal, the State will request approval from the federal government to continue to deliver services through managed care under existing waiver authorities. The State also seeks to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care. Toward that end, the State 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.

The QUEST Integration Demonstration will be a vehicle to put the HOPE initiative into place. Under the renewal, MQD will continue the current programs and provide beneficiaries with access to the same single Medicaid benefit package that it offers currently, of which access to certain services is based on clinical criteria and medical necessity. The demonstration will also include coverage of community integration services (supportive housing services) (this request is currently under separate review with CMS, but would ultimately be included in the demonstration.)

The goal of the HOPE initiative and the new QUEST Integration demonstration 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 through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and a continued sustainable growth rate in Medicaid spending. More specifically, the goals include:

- Improve health outcomes for demonstration populations;
- Maintain a managed care delivery system that achieves appropriate utilization of the health care system and a slower rate of expenditure growth; and
- Support strategies and interventions targeting the social determinants of health.

To test those goals, MQD proposes the following evaluation hypotheses:

- Increasing utilization of 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.
- 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 high-needs, high-cost individuals.
- Implementing alternative payment methodologies (APMs) 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.
- 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.

For further details on the program descriptions, goals, and objective, please refer to the State's full public notice, the draft Demonstration renewal proposal, the Hawai‘i ‘Ohana Nui Project Expansion (HOPE) Program Vision Document, the Potential Initiatives Under HOPE document and relevant documents located in the following link: https://medquest.hawaii.gov/en/about/state-plan-1115.html.

First Comment Period (CLOSED)

The State's first public notice and comment period for the QUEST renewal began on February 17, 2018 and ended on March 23, 2018. On February 15, 2018, the State issued a full public notice document with a comprehensive description of the proposed draft Demonstration Project. On February 17, 2018, the State published an abbreviated public notice in the newspapers of widest circulation in each city with a population of 100,000 or more. Both the full and abbreviated public notices were consistent with 42 C.F.R. 431.408. On February 20, 2018 and March 1, 2018, the State used an electronic mailing list to notify potentially interested parties of the opportunity to review the public notice and provide comments.

As required, the State held two in-person public hearings to solicit public input and comment about the demonstration extension application:

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Commenters were allowed to appear by video chat at these hearings. The notice included contact information for individuals who could not attend and who would need accommodations in order to participate in the public forum. The State did not receive any calls, emails, or other forms of communication requesting accommodations.

Second Comment Period (OPEN)

The State invites the public to comment on the renewal application and documents relevant to the renewal application a second time. Copies of the draft demonstration renewal proposal and the attachments are on the Department's website at https://medquest.hawaii.gov/en/about/state-plan-1115.html.

Written requests for a copy of the draft demonstration renewal proposal, relevant documents and any corresponding comments or questions may be sent to Ms. Edie Mayeshiro by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at emayeshiro@dhs.hawaii.gov.

Comments will be accepted for consideration between July 31, 2018 and August 30, 2018. All comments must be submitted before or on the closing date in order to be considered.

Special accommodations (i.e., interpreter, large print or taped materials) will be arranged if requested no later than seven (7) working days before the comment period ends by calling 808-692-8058.

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR

AFFIDAVIT OF PUBLICATION

IN THE MATTER OF
Public Notice

STATE OF HAWAII)
) SS.
City and County of Honolulu)

Doc. Date: JUL 31 2018 # Pages: 1
Notary Name: COLLEEN E. SORANAKA First Judicial Circuit
Doc. Description: Affidavit of Publication
[redacted] JUL 31 2018
Notary Signature Date

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-263 STATE OF HAWAII

Gwyn Pang being duly sworn, deposes and says that she is a clerk, duly authorized to execute this affidavit of Oahu Publications, Inc. publisher of The Honolulu Star-Advertiser, MidWeek, The Garden Island, West Hawaii Today, and Hawaii Tribune-Herald, that said newspapers are newspapers of general circulation in the State of Hawaii, and that the attached notice is true notice as was published in the

Honolulu Star-Advertiser 0 times on:

MidWeek 0 times on:

The Garden Island 1 times on:
07/31/2018

Hawaii Tribune-Herald 0 times on:

West Hawaii Today 0 times on:

Other Publications: 0 times on:

And that affiant is not a party to or in any way interested in the above entitled matter.

[redacted]
Gwyn Pang

Subscribed to and sworn before me this 31 day of July A.D. 2018

[redacted]
Colleen E. Soranaka, Notary Public of the First Judicial Circuit, State of Hawaii
My commission expires: Jan 06 2020

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-263 STATE OF HAWAII

Ad # 0001120154 SP.NC

NOTICE OF REQUEST FOR SECTION 1115(a) RENEWAL OF HAWAII'S SECTION 1115 DEMONSTRATION (11-W-0001/9)
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The QUEST Integration Demonstration will be a vehicle to put the HOPE initiative into place. Under the renewal, MQD will continue the current programs and provide beneficiaries with access to the same single Medicaid benefit package that it offers currently, of which access to certain services is based on clinical criteria and medical necessity. The demonstration will also include coverage of community integration services (supportive housing services) (this request is currently under separate review with CMS, but would ultimately be included in the demonstration.)

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DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR

(TGI1120154 7/31/18)

AFFIDAVIT OF PUBLICATION

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[redacted]
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[redacted]
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My commission expires: Jan 06 2020

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Ad # 0001119049

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DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR
(HTH1119049 7/31/18)

AFFIDAVIT OF PUBLICATION

STATE OF HAWAII, } ss.
County of Maui. }

Rhonda M. Kurohara being duly sworn deposes and says, that she is in Advertising Sales of the Maui Publishing Co., Ltd., publishers of THE MAUI NEWS, a newspaper published in Wailuku, County of Maui, State of Hawaii; that the ordered publication as to NOTICE OF REQUEST FOR SECTION 1115(a)

of which the annexed is a true and correct printed notice, was published 1 time in THE MAUI NEWS, aforesaid, commencing on the 31st day of July, 2018, and ending on the 31st day of July, 2018, one day inclusive), to-wit: on July 31, 2018

and that affiant is not a party to or in any way interested in the above entitled matter.

This 1 page NOTICE OF REQUEST, dated July 31, 2018, was subscribed and sworn to before me this _____ day of July, 2018, in the Second Circuit of the State of Hawaii, by Rhonda M. Kurohara.

Notary Public, Second Judicial
Circuit, State of Hawaii

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The QUEST Integration Demonstration will be a vehicle to put the HOPE Initiative into place. Under the renewal, MQD will continue the current programs and provide beneficiaries with access to the same single Medicaid benefit package that it offers currently, of which access to certain services is based on clinical criteria and medical necessity. The demonstration will also include coverage of community integration services (supportive housing services) (this request is currently under separate review with CMS, but would ultimately be included in the demonstration.)

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- Improve health outcomes for demonstration populations;
- Maintain a managed care delivery system that achieves appropriate utilization of the health care system and a slower rate of expenditure growth; and
- Support strategies and interventions targeting the social determinants of health.

To test those goals, MQD proposes the following evaluation hypotheses:

- Increasing utilization of 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.
- 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 high-needs, high-cost individuals.
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For further details on the program descriptions, goals, and objective, please refer to the State's full public notice, the draft Demonstration renewal proposal, the Hawai'i 'Ohana Nui Project Expansion (HOPE) Program Vision Document, the Potential Initiatives Under HOPE document and relevant documents located in the following link: https://medquest.hawaii.gov/en/about/state-plan-1115.html.

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  Hawai'i Department of Human Services
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Hawai'i	Hilo State Office Building 75 Aupuni Street, Basement Hilo, Hawai'i
Kauai	Lihue State Office Building 3060 Eiwa Street, Basement Lihue, Hawai'i
Maui	Wailuku Judiciary Building 2145 Main Street, First Floor Wailuku, Hawai'i

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Second Comment Period (OPEN)

The State invites the public to comment on the renewal application and documents relevant to the renewal application a second time. Copies of the draft demonstration renewal proposal and the attachments are on the Department's website at https://medquest.hawaii.gov/en/about/state-plan-1115.html.

Written requests for a copy of the draft demonstration renewal proposal, relevant documents and any corresponding comments or questions may be sent to Ms. Edie Mayeshiro by mail to P.O. Box 700190, Kapolei, HI 96709-0190 or by email at emayeshiro@dhs.hawaii.gov.

Comments will be accepted for consideration between July 31, 2018 and August 30, 2018. All comments must be submitted before or on the closing date in order to be considered.

Special accommodations (i.e., interpreter, large print or taped materials) will be arranged if requested no later than seven (7) working days before the comment period ends by calling 808-692-8058.

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR

(MN: July 31, 2018)

AFFIDAVIT OF PUBLICATION

IN THE MATTER OF
Public Notice

STATE OF HAWAII)
) SS.
City and County of Honolulu)

Doc. Date: JUL 31 2018 # Pages: 1
Notary Name: COLLEEN E. SORANAKA First Judicial Circuit
Doc. Description: Affidavit of Publication
[redacted] JUL 31 2018
Notary Signature Date

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-263 STATE OF HAWAII

Gwyn Pang being duly sworn, deposes and says that she is a clerk, duly authorized to execute this affidavit of Oahu Publications, Inc. publisher of The Honolulu Star-Advertiser, MidWeek, The Garden Island, West Hawaii Today, and Hawaii Tribune-Herald, that said newspapers are newspapers of general circulation in the State of Hawaii, and that the attached notice is true notice as was published in the

Honolulu Star-Advertiser 0 times on:

MidWeek 0 times on:

The Garden Island 0 times on:

Hawaii Tribune-Herald 0 times on:

West Hawaii Today 1 times on:
07/31/2018

Other Publications: 0 times on:

And that affiant is not a party to or in any way interested in the above entitled matter.

[redacted]
Gwyn Pang

[redacted] this 31 day of July A.D. 20[redacted]

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-263 STATE OF HAWAII SP.NO.

Colleen E. Soranaka, Notary Public of the First Judicial Circuit, State of Hawaii
My commission expires: Jan 06 2020

Ad # 0001120147

SECTION 1115 DEMONSTRATION (11-W-0001/9)
2nd Notice

QUEST Integration Renewal Application

The State of Hawaii, Department of Human Services (the State) is proposing to request approval from the federal Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) to extend the "QUEST Integration" (Project Number 11-W-0001/9) Demonstration under Section 1115(a) of the Social Security Act for an additional five years in order to further transform and improve the healthcare delivery system for low-income Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration Project beginning January 1, 2019 and continuing through December 31, 2023.

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Program Description, Goals, and Objectives
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Under the demonstration renewal, the State will request approval from the federal government to continue to deliver services through managed care under existing waiver authorities. The State also seeks to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care. Toward that end, the State 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.

The QUEST Integration Demonstration will be a vehicle to put the HOPE initiative into place. Under the renewal, MQD will continue the current programs and provide beneficiaries with access to the same single Medicaid benefit package that it offers currently, of which access to certain services is based on clinical criteria and medical necessity. The demonstration will also include coverage of community integration services (supportive housing services) (this request is currently under separate review with CMS, but would ultimately be included in the demonstration.)

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- Improve health outcomes for demonstration populations;
- Maintain a managed care delivery system that achieves appropriate utilization of the health care system and a slower rate of expenditure growth; and
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To test those goals, MQD proposes the following evaluation hypotheses:

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DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR
(WHT1120147 7/31/18)

AFFIDAVIT OF PUBLICATION

IN THE MATTER OF
Public Notice

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[redacted]
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Subscribed to and sworn before me this 31 day of July A.D. 20[redacted]

[redacted]
Colleen E. Soranaka, Notary Public of the First Judicial Circuit, State of Hawaii
My commission expires: Jan 06 2020

COLLEEN E. SORANAKA NOTARY PUBLIC No. 90-263 STATE OF HAWAII

Ad # 0001120160 SP NO.

NOTICE OF REQUEST FOR SECTION 1115(a) RENEWAL OF HAWAI'I'S
SECTION 1115 DEMONSTRATION (11-W-0001/9)
2nd Notice

QUEST Integration Renewal Application

The State of Hawaii, Department of Human Services (the State) is proposing to request approval from the federal Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) to extend the "QUEST Integration" (Project Number 11-W-0001/9) Demonstration under Section 1115(a) of the Social Security Act for an additional five years in order to further transform and improve the healthcare delivery system for low-income Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration Project beginning January 1, 2019 and continuing through December 31, 2023.

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DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR
(SA1120160 7/31/18)

Attachment J

The following public notice was published on February 15, 2018 and maintained for the entire public comment period in a prominent location on https://medquest.hawaii.gov/en/about/state-plan-1115.html.

NOTICE OF REQUEST FOR SECTION 1115(a) RENEWAL OF HAWAII'S SECTION 1115 DEMONSTRATION (11-W-00001/9)

The State of Hawaii, Department of Human Services (the State), hereby notifies the public that it intends to seek a five-year renewal of its Section 1115 Demonstration from the Centers for Medicare & Medicaid Services (CMS). This renewal, which will be effective January 1, 2019, will be entitled "QUEST Integration."

A copy of the proposed renewal application will be available at the Department of Human Services, Med-QUEST Division, Policy and Program Development Office at 601 Kamokila Blvd., Room 518, Kapolei, Hawaii 96707, or https://medquest.hawaii.gov/en/resources/rules-and-policy.html. We are providing this notice pursuant to CMS requirements in 42 C.F.R. §431.408.

QUEST Integration Renewal Application

The State is proposing to request approval from the federal Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) to extend the QUEST Integration Demonstration under Section 1115(a) of the Social Security Act for an additional five years, and to amend the Medicaid State Plan, as appropriate, in order to incorporate specific measures that will further transform and improve the health delivery system for low-income Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration (Waiver) beginning January 1, 2019 and continuing through December 31, 2024.

Program Description, Goals, and Objectives

Originally implemented as the QUEST program in 1994, QUEST Integration is the current version of Hawaii's demonstration project to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. The provision of benefits through managed care has continued to save hundreds of millions of dollars in State and federal funds and has enabled the State to use some of these savings to provide coverage to individuals not otherwise eligible for Medicaid.

Under the "QUEST Integration" renewal, the State requests approval from the federal government to continue to deliver services through managed care under existing waiver authorities in order to continue to implement and deliver coordinated care system services while slowing growth in costs, and will ask for new flexibilities to continue to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care, and to implement the following strategies:

- Invest in primary care, prevention, and health promotion.
- Improve outcomes for High-Need and High-Cost individuals.
- Promote payment reform and financial alignment.
  Support locally driven initiatives to improve population health.

In addition, MQD will improve the health care delivery system by supporting the following foundational building blocks:

- Health Information Technology – Use data and analytics to transform and drive clinical care.
- Workforce Strategy – Increase workforce capacity and flexibility.
- Continuous Improvement – Performance measurement and evaluation.

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			

The waiver renewal goals and strategies will continue as documented in the current waiver. Hawai‘i will request flexibility to make the following but not limited to these 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.

For further details on the program descriptions, goals, and objective, please refer to the, "Medicaid Innovation Initiative" located in the following link: https://medquest.hawaii.gov/en/resources/rules-and-policy.html.

Beneficiary Impact, Eligibility Methodology, and Eligibility Requirements
QUEST Integration will continue to use the eligibility methodology called "modified gross adjusted income" (MAGI) for individuals who qualify under the MAGI groups. Eligibility for the aged, blind and disabled (ABD) groups will continue to be determined using current income and resource methodologies.

The State will continue to cover the following groups in QUEST Integration:

Mandatory State Plan Groups		
Eligibility Group Name	**Authority**	**Income Level and Other Qualifying Criteria**
Parents or caretaker relatives	§1902(a)(10)(A)(i)(I), (IV), (V) § 1931(b), (d) 42 C.F.R.§ 435.110	Up to and including 100% FPL
Pregnant Women	§1902(a)(10)(A)(i)(III)-(IV) 42 C.F.R. § 435.116	Up to and including 191% FPL
Poverty Related Infants	§ 1902(a)(10)(A)(i)(IV) § 1902(l)(1)(B) 42 C.F.R. § 435.118(c)	Infants up to age 1, up to and including 191% FPL
Poverty Related Children	§1902(a)(10)(A)(i)(VI)-(VII) §1902(l)(1)(C)-(D) 42 C.F.R. §435.118(a)	Children ages 1 through 18, up to and including 133% FPL
Low Income Adult Age 19 Through 64 Group	§1902(a)(10)(A)(i)(VIII) 42 C.F.R. §435.119(b)	Up to and including 133% FPL
Former Foster Children under age 26	§1902(a)(10)(A)(i)(IX)	No income limit
SSI Aged, Blind, or Disabled	§1902(a)(10)(A)(i)(II)(aa), as qualified by Section 1902(f) 42 C.F.R. §435.121	SSI-related using SSI payment standard
Section 1925 Transitional Medicaid, Subject to Continued Congressional Authorization	§1925 §1931(c)(2)	Coverage for one twelve month period due to increased earnings, or for four months due to receipt of child support, that would otherwise make the individual ineligible under Section 1931

Optional State Plan Groups		
Eligibility Group Name	**Authority**	**Income Level and Other Qualifying Criteria**
Aged or Disabled	§1902(a)(10)(ii)(X) §1902(m) 42 C.F.R. § 435.230(c)(vi)	SSI-related net income up to and including 100% FPL
Optional targeted low- income children	§1902(a)(10)(A)(ii)(XIV) Title XXI 42 C.F.R. § 435.229	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	§1902(a)(10)(A)(ii)(XVIII) §1902(aa)	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non- Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. § 435.301(b)(1) 42 C.F.R. §435.308 42 C.F.R. § 435.310	Up to and including 300% FPL, if spend down to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. §§435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology

Expansion Population	
Eligibility Group Name	**Income Level and Other 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 individuals receiving HCBS	Receiving HCBS and meet medically needy income standard using institutional rules for income, assets, and post-eligibility treatment of income
Medically needy ABD individuals whose spend-down exceeds the plans' capitation payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit

Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance	Younger than 26 years old; aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance); not eligible under any other eligibility group, or would be eligible under a different eligibility group but for income; were enrolled in the state plan or waiver while receiving assistance payments

Benefit Coverage

Under QUEST Integration, Hawaii will continue to offer one package consisting of full primary and acute State plan benefits and certain additional benefits based on clinical criteria and medical necessity:

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

Individuals who meet institutional level of care ("1147 certified") will have access to a wide variety of home and community based services (HCBS) and long-term services and supports (LTSS), including, but not limited to, specialized case management, home maintenance, personal assistance, adult day health, respite care, and adult day care. Moreover, Hawaii will continue to provide HCBS to certain individuals who are assessed to be at risk of deteriorating to institutional level of care, in order to prevent a decline in health status and maintain individuals safely in their homes and communities. These individuals (the "at risk" population) will have access to a set of HCBS that includes personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS), supportive housing services and skilled nursing.

This benefit structure is easier for beneficiaries to navigate, better equipped to serve patients with changing needs, and less burdensome for the State to administer.

Delivery System

Under QUEST Integration, the State will continue to provide most benefits through managed care, which will help ensure access to high-quality, cost-effective care. A discrete set of benefits will be provided fee-for-service.

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

Benefit(s)	Delivery System	Authority
State plan services	Managed Care - MCO	1115
QUEST Integration HCBS and long-term care benefits	Managed Care - MCO	1115
Cognitive rehabilitation therapy	Managed Care - MCO	1115 or State plan
Medical services to medically needy individuals who are aged, blind or disabled	Managed Care - MCO	1115
Medical services to medically needy individuals who are not aged, blind or disabled	Fee-for-service	State plan
Long-term care services for individuals with developmental disabilities (DD) or intellectual disabilities (ID)	Fee-for-service	Section 1915(c) waiver
Intermediate Care Facilities for the Intellectually Disabled (ICF-ID)	Fee-for-service	State plan
Medical services to applicants eligible for retroactive coverage only	Fee-for-service	State plan
Medical services under the State of Hawaii Organ and Tissue Transplant (SHOTT) program	Fee-for-service	State plan
Dental services	Fee-for-service	State plan
Targeted Case Management	Fee-for-service	State plan
School-based services	Fee-for-service	State plan
Early Intervention Services	Fee-for-service	State plan
Covered substance abuse treatment services provided by a certified substance abuse counselor	As described in the behavioral health protocol	1115
Specialized behavioral health services for qualified individuals with a SPMI, SMI, or SEBD	As described in the behavioral health protocol	1115 or State plan

Cost Sharing

The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan. The State plans to seek authority to continue to charge an enrollment fee to health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate (for the Medically Needy Aged, Blind, and Disabled), in the amount equal to the estimated spend-down or cost share amount.

Hypotheses and Evaluation Parameters

The waiver is a vehicle to test new delivery and payment innovations, and MQD will continue to test two overarching hypotheses about its demonstration:

- Capitated managed care delivers high quality care, while also slowing the rate of health care expenditure growth; 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.
    - Screening for health-related social needs and 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.
- 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.
- 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 health equity), increased regional collaboration, and improve coordination with other systems (e.g. hospitals).
- 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.

Waiver Authority

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

demonstration.

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

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

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

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

   To enable the State to maintain waiting lists, through a health plan, for home and community-based services (including services for the "at risk" population). No waiting list is permissible for other services for health plan enrollees.

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

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

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

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

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

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

Expenditure Authority

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

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

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

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

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

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

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

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

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

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

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

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

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

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, will apply to the demonstration beginning January 1, 2019, through December 31, 2024, except those waived or listed below as not applicable.

Medicaid Requirements Not Applicable to Demonstration Populations

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

1. Cost Sharing – Section 1902(a)(14)

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

Comments

We invite comments on this proposal. Please submit any comments or questions to Ms. Edie Mayeshiro by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at emayeshiro@dhs.hawaii.gov

Comments will be accepted for consideration between February 17, 2018 and March 19, 2018 (30 days from the date of this notice).

Public Hearing

The State will hold two public hearings to seek public input on this demonstration renewal application:

1. March 2, 2018 from 8:00 am to 12:00 pm:

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

2. March 6, 2018 from 8:00 am to 12:00 pm:

Oahu Kakuhihewa Videoconference Center
Kakuhihewa State Office Building
601 Kamokila Boulevard, Room 167B
Kapolei, Hawaii

Hawaii Hilo Videoconference Center
Hilo State Office Building
75 Aupuni Street, Basement
Hilo, Hawaii

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

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

If you require special assistance or auxiliary aids and/or services to participate in the public hearing (*e.g.*, sign or foreign language or wheelchair accessibility), please contact:

Oahu	Emelinia Mauricio (808) 692-8058
Hawaii	Calvin Unoki (808) 933-0339, extension 101
Kauai	Iris Venzon (808) 241-3575, extension 101
Maui	Agriffa Kristia Braquit (808) 243-5780, extension 101

at least 72 hours prior to the hearing for arrangements. The prompt submission of requests helps to ensure the availability of qualified individuals and appropriate accommodations.

The following public notice was published on July 31, 2018 and maintained for the entire public comment period in a prominent location on https://medquest.hawaii.gov/en/about/state-plan-1115.html.

NOTICE OF REQUEST FOR SECTION 1115(a) RENEWAL OF HAWAII'S SECTION 1115 DEMONSTRATION (11-W-00001/9)
2nd Notice

QUEST Integration Renewal Application

The State of Hawaii, Department of Human Services (the State) is proposing to request approval from the federal Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) to extend the "QUEST Integration" (Project Number 11-W-00001/9) Demonstration under Section 1115(a) of the Social Security Act for an additional five years in order to further transform and improve the healthcare delivery system for low-income Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration (Waiver) beginning January 1, 2019 and continuing through December 31, 2023.

The State previously issued public notice on February 17, 2018 and is reissuing notice to provide some additional information related to the financing approach, to share the interim evaluation results of the demonstration, to provide documentation of the annual post award forum, and to confirm our process for tribal consultation. The draft application has also been updated to provide more description of the state's objectives for the demonstration.

Program Description, Goals, and Objectives
Originally implemented as the QUEST program in 1994, QUEST Integration is the current version of Hawaii's Section 1115 demonstration project to provide comprehensive benefits to its Medicaid enrollees through a competitive managed care delivery system. The provision of benefits through managed care has saved billions of dollars in State and federal funds and has enabled the State to use some of these savings to provide State-funded medical coverage to individuals not otherwise eligible for Medicaid.

Under the renewal, MQD will continue its current programs and provide all beneficiaries enrolled under the demonstration with access to the same single benefit package, of which access to certain services will be based on clinical criteria and medical necessity. The benefit package will include benefits consisting of full State plan benefits and will offer certain additional benefits as described in the sections below and in our current Special Terms and Conditions.

MQD's strategic focus under the QUEST Integration demonstration will be the Hawai'i 'Ohana Nui Project Expansion (HOPE) initiative. Under the demonstration renewal, the State will request approval from the federal government to continue to deliver services through managed care under existing waiver authorities. The State also seeks to build on the state's history of providing the most vulnerable residents with effective, efficient, evidence-based health care.

The State's vision is that the people of Hawai'i embrace health and wellness and its mission is to empower Hawai'i residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha. This vision and mission will 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.

The HOPE initiative is focused on four key strategies. 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 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 QUEST Integration demonstration's managed care program will be the vehicle to turn the HOPE principles into reality. In the renewal, MQD will explore a number of different payment and delivery system reform approaches to effectuate the HOPE vision. Many of the approaches should be covered under our existing waiver and expenditure authorities and under state flexibilities found under federal regulations as outlined in the managed care rule.

Under the current demonstration, MQD's goals were:

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

- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to more appropriate utilization of the health care system.

In order to streamline the Demonstration's historical objectives with the HOPE Initiative's focus, MQD proposes the following objectives for the new Demonstration:

- Improve health outcomes for Demonstration populations;
- 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
- Support strategies and interventions targeting the social determinants of health.

For further details on the program descriptions, goals, and objective, please refer to the State's draft 1115 Demonstration renewal proposal and relevant attachments located in the following link: https://medquest.hawaii.gov/en/about/state-plan-1115.html.

Beneficiary Impact, Eligibility Methodology, and Eligibility Requirements
The State will continue to use the eligibility methodology called "modified gross adjusted income" (MAGI) for individuals who qualify under the MAGI groups. Eligibility for the aged, blind and disabled (ABD) groups will continue to be determined using current income and resource methodologies.

The State will continue to cover the following groups in QUEST Integration:

Mandatory State Plan Groups		
Eligibility Group Name	**Authority**	**Income Level and Other Qualifying Criteria**
Parents or caretaker relatives	§1902(a)(10)(A)(i)(I), (IV), (V) § 1931(b), (d) 42 C.F.R.§ 435.110	Up to and including 100% FPL
Pregnant Women	§1902(a)(10)(A)(i)(III)-(IV) 42 C.F.R. § 435.116	Up to and including 191% FPL
Poverty Related Infants	§ 1902(a)(10)(A)(i)(IV) § 1902(l)(1)(B) 42 C.F.R. § 435.118(c)	Infants up to age 1, up to and including 191% FPL
Poverty Related Children	§1902(a)(10)(A)(i)(VI)-(VII) §1902(l)(1)(C)-(D) 42 C.F.R. §435.118(a)	Children ages 1 through 18, up to and including 133% FPL
Low Income Adult Age 19 Through 64 Group	§1902(a)(10)(A)(i)(VIII) 42 C.F.R. §435.119(b)	Up to and including 133% FPL
Former Foster Children under age 26	§1902(a)(10)(A)(i)(IX)	No income limit

SSI Aged, Blind, or Disabled	§1902(a)(10)(A)(i)(II)(aa), as qualified by Section 1902(f) 42 C.F.R. §435.121	SSI-related using SSI payment standard
Section 1925 Transitional Medicaid, Subject to Continued Congressional Authorization	§1925 §1931(c)(2)	Coverage for one twelve month period due to increased earnings, or for four months due to receipt of child support, that would otherwise make the individual ineligible under Section 1931

Optional State Plan Groups		
Eligibility Group Name	**Authority**	**Income Level and Other Qualifying Criteria**
Aged or Disabled	§1902(a)(10)(ii)(X) §1902(m) 42 C.F.R. § 435.230(c)(vi)	SSI-related net income up to and including 100% FPL
Optional targeted low- income children	§1902(a)(10)(A)(ii)(XIV) Title XXI 42 C.F.R. § 435.229	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	§1902(a)(10)(A)(ii)(XVIII) §1902(aa)	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non- Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. § 435.301(b)(1) 42 C.F.R. §435.308 42 C.F.R. § 435.310	Up to and including 300% FPL, if spend down to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. §§435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology

Expansion Population	
Eligibility Group Name	**Income Level and Other 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 individuals receiving HCBS	Receiving HCBS and meet medically needy income standard using institutional rules for income, assets, and post-eligibility treatment of income

Medically needy ABD individuals whose spend-down exceeds the plans' capitation payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit

Benefit Coverage, Delivery System, & Cost Sharing

Under the renewal, Hawai'i will continue to provide one comprehensive set of benefits available to all demonstration populations. Hawai'i will continue to offer one primary and acute care services package consisting of full State plan benefits to all demonstration populations, with certain additional benefits available based on clinical criteria and medical necessity. This benefit structure will be easier for beneficiaries to navigate, better equipped to serve patients with changing needs, and less burdensome for the State to administer.

In the renewal, MQD will continue to provide a set of Home and Community Based Services (HCBS). Individuals who meet institutional level of care ("1147 certified") will have access to a wide variety of Long Term Support Services, including specialized case management, home maintenance, personal assistance, adult day health, respite care, and adult day care, among others. Moreover, Hawai'i will provide HCBS to certain individuals who are assessed to be at risk of deteriorating to institutional level of care, in order to prevent a decline in health status and maintain individuals safely in their homes and communities. These individuals (the "at risk" population) will have access to a set of HCBS that includes personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS), and skilled nursing, subject to limits on the number of hours of HCBS or the budget for such services. MQD intends to offer HCBS services as they are described in our current Special Terms and Conditions.

Hawai'i also will continue to include in the QI benefit package the following benefits, subject to clinical criteria and medical necessity, and as described in our Special Terms and Conditions:

- Cognitive rehabilitation therapy (either through the demonstration or the State plan);
- Substance abuse treatment services provided by a certified (as opposed to licensed) substance abuse counselor; and
- Specialized behavioral health services (Clubhouse, Supportive Employment, Peer Specialist, community integration services (supportive housing services) and Representative Payee) for qualified individuals with a Serious and Persistent Mental Illness (SPMI), Severe Mental Illness (SMI), or Serious Emotional or Behavioral Disorder (SEBD) (either through the demonstration or the state plan).

The State will continue to provide most benefits through managed care, which will help ensure access to high-quality, cost-effective care. A discrete set of benefits will be provided fee-for-

service.

The State will continue the cost-sharing policies it has employed under the current Demonstration. The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan. The State allows managed care capitation costs as an expense that can be counted toward meeting an enrollment fee in order to meet the spend-down obligation for Medically Needy Aged, Blind and Disabled health plan enrollees.

Under QUEST Integration, the State can charge an enrollment fee to health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate for the Medically Needy Aged, Blind, and Disabled, in the amount equal to the estimated spend-down or cost share amount or where applicable, the amount of patient income applied to the cost of long-term care.

The State's state plan does not currently have an enrollment fee for the Medically Needy Aged, Blind, and Disabled group.

Annual Enrollment and Annual Expenditures

Enrollment grew by 25 percent from October 2013 to March 2018, with the greatest increase in the Low Income Adult group during that time. The Low Income Adult group grew by approximately 65,000 individuals or 115 percent between October 2013 and March 2018. The total enrollment growth is comparable to historical enrollment growth.

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018 (est)
Average Monthly Enrollment	211,2015	235,206	260.457	272,218	287,902	292,423	307,303	325,151	346,357	353,032	361,113
Percent Growth Year over Year		11.4%	10.7%	4.5%	5.8%	1.6%	5.1%	5.8%	6.5%	1.9%	2.3%

From January 1, 2016 to December 31, 2017, there was an average of 353,032 individuals enrolled in the current demonstration (and covered in part by a federal match). During the five-year renewal period, the annual increase in enrollment is expected to be 2.5% per year for non-ABD recipients and 1% for ABD recipients. The estimated enrollment growth over the demonstration is described below.

	Estimated Enrollment Growth During the Demonstration				
	Growth in CY2019	Growth in CY2020	Growth in CY2021	Growth in CY2022	Growth in CY2023
Growth	8,275	8,474	8,679	8,888	9,102
Total Enrollment	369,388	377,862	386,541	395,429	404,531

Section 1115 waivers require states to demonstrate that actual expenditures do not exceed certain cost thresholds. i.e., they may not exceed what the costs of providing those services would have been under a traditional Medicaid fee-for-service program.

The State has proposed a capitation and trend rate request by Medicaid Eligibility Group (MEG) that demonstrates that the QUEST Integration has met this condition and generated savings for both the state and federal governments. Detailed information can be found in the budget neutrality sheets on the State's website at https://medquest.hawaii.gov/en/about/state-plan-1115.html. The State continues to use the same MEGs as the current waiver term. Cumulative savings from DY01 through the end of DY24 is approximately $6.5 billion.

The five year projection for the demonstration renewal is approximately $15.8 billion, inclusive of the Group VIII population. The without waiver estimate for the renewal is $26.8 billion.

	Estimated Spending During the Demonstration (including Group VIII)					
	CY2019	CY2020	CY2021	CY2022	CY2023	Total
Without Waiver	$4,081,250,424	$4,316,143,256	$4,565,622,025	$4,830,648,530	$5,112,250,874	$26,765,958,746
With Waiver	$2,416,681,076	$2,557,340,193	$2,706,674,404	$2,865,251,879	$3,033,679,738	$15,863,792,552

Hypotheses and Evaluation Parameters

MQD will work with stakeholders and CMS to translate our goals and model to appropriate and well defined waiver hypotheses. As a starting point, the State proposes the following evaluation hypotheses.

Demonstration Objectives	Evaluation Hypotheses	Potential Approaches
Improve health outcomes for Demonstration populations	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.	Measure intervention impacts on trends in utilization, targeted HEDIS and state-defined health care quality and outcome measures, and total cost of care per beneficiary. Data will be drawn from a variety of sources including: • Administrative data (i.e., claims; encounters, enrollment in Hawaii Prepaid Medical Management Information System (HPMMIS), health plan reports, etc.); • Electronic Health Records;
	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 high-needs, high-cost individuals.	

Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth.	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.	• Member and provider feedback (External Quality Review Organization (EQRO)-conducted surveys, grievances, Ombudsman reports); and • Other intera-gency data from other divisions within the Department of Human Services and potentially other agencies such as the Department of Health, Department of Education, and Department of Labor and Industrial Relations.
Support strategies and interventions targeting the social determinants of health.	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.	

Evaluation and greater use of data are a key building block of the HOPE initiative and MQD will work with CMS to design a robust and thoughtful evaluation strategy that will effectively measure the renewal demonstration. Within 120 days of approval of the terms and conditions for the Demonstration, MQD will develop a comprehensive draft evaluation plan for CMS's review. No later than 60 days after receiving comments on the draft evaluation plan from CMS, MQD will submit its final evaluation plan.

Waiver Authority

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

Current Waiver Authority	Status under Renewal
Medically Needy (Section 1902(a)(10)(C); **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.	Continue
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.	Continue
Retroactive Eligibility (Section 1902(a)(34)	Continue

To enable the state to limit retroactive eligibility to a ten (10) day period prior to application, or up to three months for individuals requesting long-term care services.	
Freedom of Choice (Section 1902(a)(23)(A)) To enable Hawai'i to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932.	Continue
Annual Redeterminations (Section 1902(a)(17) and Section 1902(a)(19)) To the extent necessary to enable the state to extend the eligibility span of enrollees who will need a redetermination between October 1, 2013, and December 31, 2013, to a reasonable date in 2014.	Discontinue
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.	Continue

Current Expenditure Authority	Status for Renewal
Managed Care Payments. Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m): Expenditures for capitation payments provided to managed care organizations (MCOs) in which the state restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.	Continue

Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and federal regulations at 42 CFR section 438.52.	
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.	Continue
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 f. Demonstration Population 6. Individuals who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical	Continue for Demonstration populations 1 through 5. Discontinue for Demonstration Populations 6 through 7.

assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not impose an asset limit on this population. Authority for this demonstration population expires December 31, 2013. g. Demonstration Population 7. Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Medicare part A or enrolled for benefits under Medicare part B and are not a mandatory state plan population and whose income (as determined using modified adjusted gross income) does not exceed 133 percent of the FPL, determined using modified adjusted gross income. Authority for this demonstration population expires December 31, 2013.	
Hospital Uncompensated Care Costs. Expenditures for actual uncompensated care costs incurred by certain hospital providers and nursing facility providers for inpatient and outpatient hospital services and long-term care services provided to the uninsured as well as Medicaid managed care and fee-for-service shortfalls, subject to the restrictions placed on hospital and nursing facility uncompensated care costs, as defined in the STCs and the CMS approved Certified Public Expenditures/Government-Owned Hospital Uncompensated Care Cost Protocol. This expenditure authority is effective through June 30, 2016.	Discontinue
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. 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.	Continue
PLACEHOLDER **Community Integration Services (CIS)** Hawai'i assumes that Community Integration Services would be an expenditure authority that would read:	Continue

Community Integration Services (CIS) described in the special terms and conditions are available for individuals 18 years or older who meet certain needs-based criteria as outlined in the Special Terms and Conditions.	
Additional Benefits: Expenditures to provide the following additional benefits. a. 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). i. Supportive Housing. ii. Supportive Employment. iii. 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.	Continue

First Comment Period (CLOSED)

The State's first public notice and comment period for the QUEST renewal began on February 17, 2018 until March 23, 2018. On February 17, 2018, the State published an abbreviated public notice in the newspapers of widest circulation in each city with a population of 100,000 or more, which included a description of the demonstration extension request; the location and internet address where copies of the renewal application were available for review and comment; the locations, dates, and times of two public hearings designed to seek public input on the extension application; and an active link to the full public notice document on the State's web site.

Public Comment Period 1

On February 20, 2018 and March 1, 2018, the State used an electronic mailing list to notify potentially interested parties of the opportunity to review the public notice and provide comments. On February 15, 2018, the State issued a full public notice document with a comprehensive description of the proposed QUEST waiver renewal. Consistent with 42 C.F.R. 431.408, the notice included the location and internet address where copies of the renewal application were available for review and comment; the dates for the public comment period;

postal and e-email addresses where written comments could be sent; and the locations, dates and times of the two (2) public hearing convened by the State to seek public input about the extension application. This public notice document was available in a prominent location at https://medquest.hawaii.gov/ for the duration of the comment period.

As required, the State held two in-person public hearings to solicit public input and comment about the demonstration extension application:

- March 2, 2018 from 8:00 am to 12:00 pm

  Hawai'i Department of Human Services
  1390 Miller Street, Conference Room 1 & 2
  Honolulu, Hawai'i

- March 6, 2018 from 8:00 am to 12:00 pm via teleconference at:

Oahu	Kakuhihewa Videoconference Center Kakuhihewa State Office Building 601 Kamokila Boulevard, Room 167B Kapolei, Hawai'i
Hawai'i	Hilo Videoconference Center Hilo State Office Building 75 Aupuni Street, Basement Hilo, Hawai'i
Kauai	Lihue Videoconference Center Lihue State Office Building 3060 Eiwa Street, Basement Lihue, Hawai'i
Maui	Wailuku Videoconference Center Wailuku Judiciary Building 2145 Main Street, First Floor Wailuku, Hawai'i

Commenters were allowed to appear by video chat at these hearings. The notice included contact information for individuals who could not attend and who would need accommodations in order to participate in the public forum. The State did not receive any calls, emails, or other forms of communication requesting accommodations. These formal public meetings supplemented several other meetings where MQD presented its vision for the waiver. These meetings included the following:

- November 20, 2017 – Act 43 Affordable Health Insurance Working Group Meeting. Responded to questions from legislative stakeholders.

- January 10, 2018, State of Reform 2018 Conference – Afternoon Keynote speaker. Presented "An Update from MQD" which covered the Vision document, the ACA Workgroup, and two upcoming events (public health week and 1115 Demonstration Extension plans).
- April 5, 2018, National Public Health Week Event –Featured speaker. Topics covered in addition to Vision document were "Changing our Future Together" and "Medicaid Initiatives to Support Healthy Families and Communities in Hawai'i ."
- April 23, 2018, Hawai'i Medical Education Council (HMEC) – HMEC is a Governor appointed council charged with monitoring healthcare workforce issues.)

Summary of Comments Received

MQD received comments from 35 organizations and individuals during the first comment period from across the state, including providers, hospitals, associations, community organizations, health plans, consumer advocates, and others. The commenters expressed their strong support for the QUEST waiver renewal and the integration of the HOPE vision into the demonstration. In particular, the stakeholders appreciated the emphasis on behavioral health integration, strategies for addressing the social determinants of health (SDOH), and a move toward value-based purchasing (VBP). The commenters expressed strong support for the restoration of the Medicaid dental benefit and the overall oral health initiative. They support the plans for payment transformation in primary care and recommend alignment across VBP strategies and MCOs in order to ensure consistency. Commenters also support the increased emphasis on performance measures and use of data to track outcomes and compliance. They recommend leveraging the HEDIS measure set in order to have a standard that will allow comparisons across health plans.

Several commenters noted that strategies for addressing the social determinants of health are already underway in several sectors. They raised the potential for duplication of effort and the need for a robust vetting process through a steering committee or other advisory body in order to ensure that the strategies are coordinated. The commenters commended MQD's focus on preventing homelessness through housing supports and family investment strategies as part of the overall SDOH approach. One commenter suggested that the state using mobile apps, text messaging, and other social media strategies for more effectively engaging with beneficiaries. The Collaborative Care Model and Project ECHO were both recommended as strategies to consider. Several commenters suggested that MQD augment its approach to achieving the Triple Aim by adopting a fourth "aim" to include provider satisfaction.

The commenters shared their concerns about the amount of time it will take to get the necessary resources in place to achieve the HOPE vision and noted that workforce issues are significant in Hawai'i. While enthusiastic about VBP, several stakeholders noted the need for a planful approach to implementation the need to provide flexibility for health plans. Some commenters expressed concerns that the responsibilities of MCOs will increase significantly without a corresponding increase in reimbursement. There were questions about the state's plan and process for implementation of the investments in primary care and noted that care management should be financed at the provider level rather than through the managed care plans. Some commenters raised concerns that the models that HOPE is based on do not directly translate to the rural landscape in Hawai'i or the health disparities and cultural needs of Native Hawai'ians.

They suggested that a combination of health home cultural proficiency and payment incentives designed to address chronic conditions at the first onset could help mitigate the disparities. Finally, some commenters suggested that the proposal needs to include more detail about concrete plans for implementation of the HOPE vision. They noted that most everyone would agree with the high-level concepts, but that it is important for stakeholders to have opportunities to be engaged in and weigh in on the details.

The state is still reviewing and considering the comments from the first comment period. MQD will incorporate the input received during the first comment period and the upcoming feedback it will receive during the second comment period into the final waiver application. Furthermore, MQD will describe the comments received and detail how MQD addressed the comments in the final renewal application.

Second Comment Period (OPEN)

The State invites the public to comment on the renewal application and documents relevant to the renewal application a second time. In addition to the draft renewal application, these documents are as follows:

A. Summaries of EQRO Reports and Quality Assurance Monitoring, and Other Information and Documentation Regarding Quality of and Access to Care
B. Interim Demonstration Evaluation Report
C. Hawai‘i Med-QUEST Division Quality Strategy
D. Current Special Terms & Conditions (2013 – 2018)
E. Documentation of Post-Award Forums
F. UCC Pool Evaluation
G. Budget Neutrality Charts
H. Electronic Mail Notice
I. Abbreviated Public Notice
J. Full Public Notice Document
K. Tribal Consultation
L. Hawai‘i Medicaid ‘Ohana Nui Project Expansion (HOPE) Project
M. Potential Initiatives Under HOPE

Copies of the proposed Waiver draft and the attachments are on the Department’s website at https://medquest.hawaii.gov/en/about/state-plan-1115.html.

Written requests for a copy of the draft demonstration renewal proposal, relevant documents and any corresponding comments or questions may be sent to Ms. Edie Mayeshiro by mail to P.O. Box 700190, Kapolei, HI, 96709-0190 or by email at emayeshiro@dhs.hawaii.gov.

Comments will be accepted for consideration between July 31, 2018 and August 30, 2018. All comments must be submitted before or on the closing date in order to be considered.

Special accommodations (i.e., interpreter, large print or taped materials) will be arranged if requested no later than seven (7) working days before the comment period ends by calling 808-692-8058.

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR

Attachment K

DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

CATHY BETTS
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Policy & Program Development Office
P. O. Box 700190
Kapolei, Hawai'i 96709-0190

January 12, 2018

Ms. Joelene K. Lono, Executive Director
Ke Ola Mamo
Native Hawaiian
Health Care System-Oahu
1505 Dillingham Boulevard, Room 205
Honolulu, Hawaii 96817

Dear Ms. Lono:

RE: EXTENSION AND AMENDMENT TO HAWAII 1115 DEMONSTRATION PROJECT

Pursuant to the tribal consultation requirements in Section 1902(a)(73) of the Social Security Act as amended by Section 5006(e)(2) of the American Recovery and Reinvestment Act of 2009, the Department of Human Services, Med-QUEST Division (MQD) is soliciting your expedited consultation of the State's intent to seek a five-year extension of the QUEST Expanded Section 1115 demonstration project from the Centers for Medicare and Medicaid Services.

The State is proposing to request approval from the federal Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) to extend and amend the QUEST Integration Demonstration under Section 1115(a) of the Social Security Act for an additional five years, and to amend Medicaid State Plan, as appropriate, in order to incorporate specific measures that will further transform and improve the current health delivery system for eligible Hawai'i residents. The State will request approval of a five-year extension of the 1115 Demonstration (Waiver) to be effective January 1, 2019 and continuing through December 31, 2024.

For over two decades, Hawaii's demonstration has efficiently and effectively delivered comprehensive benefits to a large number of beneficiaries, including expansion populations, through competitive managed care delivery systems. Under the renewal, "QUEST Integration" (QI) continues to build on this success by delivering services through managed care, while integrating the demonstration's programs and benefits to have a more patient-centered care delivery system and alignment of the demonstration with applicable requirements. All eligible beneficiaries will continue to be enrolled under QUEST Integration, and access to services will be determined by clinical criteria and medical necessity. The renewal continues to incorporate the simplified Medicaid eligibility structure under the Affordable Care Act into Hawaii's demonstration.

In addition to building on the success of QUEST Integration, the 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 that embrace health and wellness. The MQD mission is to empower Hawaii'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.

In order to achieve the 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, Prevention and Health Promotion, (2) Address the Needs of High-Needs/High-Cost Members, (3) Payment Reform, and (4) Supporting Community Driven Initiatives.

The goal of this 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, which in turn will 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 alone.

Enclosed is a copy of the vision document which provides more detail of our intent for your reference.

Please provide your written comments by February 15, 2018 to the:

Department of Human Services
Med-QUEST Division
P. O. Box 700190
Kapolei, Hawaii 96709-0190
Attention: Policy and Program Development Office

Should you have any questions or desire a meeting, please feel free to call Ms. Edie Mayeshiro at 692-8134 or email her at emayeshiro@dhs.hawaii.gov.

Thank you for your efforts, support, and advocacy for the American Indian and Alaska Native communities and your continuing support of our Medicaid programs.

Sincerely,

[redacted]

Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

Enclosure

DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

CATHY BETTS
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Policy & Program Development Office
P. O. Box 700190
Kapolei, Hawai'i 96709-0190

July 30, 2018

Ms. Joelene K. Lono, Executive Director
Ke Ola Mamo
Native Hawaiian
Health Care System-Oahu
1505 Dillingham Boulevard, Room 205
Honolulu, Hawaii 96817

Dear Ms. Lono:

RE: EXTENSION TO HAWAII 1115 DEMONSTRATION PROJECT

Pursuant to the tribal consultation and public transparency requirements in Section 1902(a)(73) and Section 1115 of the Social Security Act, the Department of Human Services, Med-QUEST Division (MQD), is soliciting your consultation of the State's intent to seek a five-year extension of the QUEST Integration Section 1115 Demonstration project from the Centers for Medicare and Medicaid Services.

A consultation letter dated January 12, 2018 was initially mailed to you to provide an opportunity for you and your organization to comment on the State's intent to seek an extension of the current section 1115 demonstration for the State of Hawai'i entitled "QUEST Integration" (Project Number 11-W-00001/9). We are providing a second public comment period to provide some additional information related to financing, the interim evaluation results of the demonstration, and the documentation of the annual post award forum. The draft 1115 Demonstration renewal application has also been updated.

To continue this process, the State requests your consultation on the draft 1115 Demonstration renewal application and its relevant attachments, of which copies are enclosed. Also enclosed is our revised public notice, which includes the "Annual Enrollment and Annual Expenditures." These documents will also be available for a second public notice period at https://medquest.hawaii.gov/en/about/state-plan-1115.html on July 31, 2018 through August 30, 2018.

The State would like to reiterate in this letter that the purpose of the extension of the QUEST Integration 1115 Demonstration is to continue to improve the current health delivery system for eligible Hawai'i residents. Under the 1115 Demonstration renewal, MQD will continue the current programs and provide all beneficiaries enrolled under the demonstration with access to a single benefit package, of which access to certain services will be based on clinical criteria and medical necessity. The State will request approval of a five-year extension of the 1115 Demonstration to be effective from January 1, 2019 to December 31, 2023.

In addition to continuing the success of the QUEST Integration Demonstration, MQD is committed to laying the foundation for innovative programs that support and create healthy families and healthy communities through the Hawai'i 'Ohana Nui Project Expansion (HOPE) program. HOPE is a five-year initiative to develop and implement a roadmap to achieve the State's vision of healthy families and healthy communities that embrace health and wellness. MQD's mission is to empower Hawai'i's residents to improve and sustain well-being by developing, promoting and administering innovative and high-quality healthcare programs with aloha.

The QUEST Integration Demonstration will be the vehicle that MQD will use to put the HOPE program into practice. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of health conditions, and a continued sustainable growth rate in healthcare spending.

Please provide your written comments by August 30, 2018 to the:

Department of Human Services
Med-QUEST Division
Attention: Policy and Program Development Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

Should you have any questions or desire a meeting, please feel free to call Ms. Aileen Joy C. Befitel at 692-8078 or email her at abefitel@dhs.hawaii.gov.

Thank you for your efforts, support, and advocacy for the American Indian and Alaska Native communities and your continuing support of our Medicaid programs.

Sincerely,

[redacted]

Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

Enclosures

Attachment L

2017

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 Hawaii'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

HAWAIʻI MEDICAID ʻOHANA NUI PROJECT EXPANSION (HOPE) PROJECT

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

The Hawaiʻi 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 Hawaiʻi ʻOhana 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

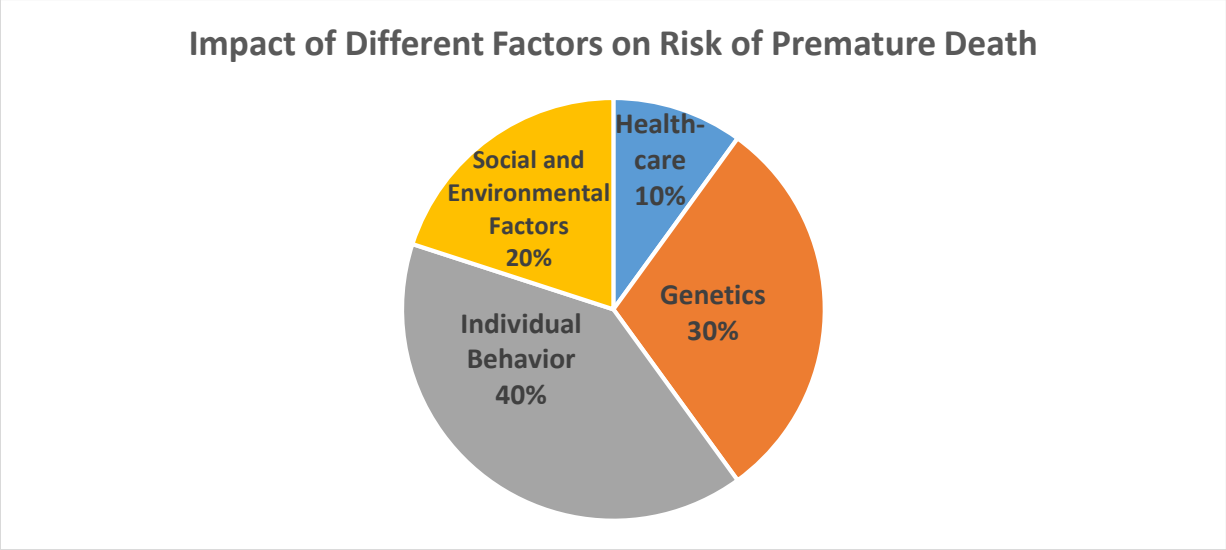
The Vision and Mission of Med-QUEST

MQD's vision is that the people of Hawaiʻi embrace health and wellness. MQD's mission is to empower Hawaii'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 2[iii]



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
Achieve or maintain top-quartile performance among states for adoption of best practices for outcomes in: • Health • Wellness • Health promotion • Disease prevention • Health improvement • Health-related social needs.	Achieve high standards for quality and patient experience, including at least: • 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.	Generate $X (number TBD) in cumulative savings by: • 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	• 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	• 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]

	• 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	• 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	*Hawai'i-Specific Data on High Costs* • 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]

National Data on High Costs

- 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]

Medicaid Cost Data – Hawai'i and National

- 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, communities, 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 AHARO Hawai'i,[xxx] Kalihi Ahupua'a Ride (KVIBE)[xxxi], Blue Zones project,[xxxii] MAHIE 2020,[xxxiii] Community First,[xxxiv] and the United Health Care Services' Accountable Health Communities Model.[xxxv] 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[xxxvi]

Economic Stability	**Neighborhood and Physical Environment**	**Education**	**Food**	**Community and Social Content**	**Health Care System**
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Safety	Early Childhood Education		Community Engagement	Provider Linguistic and Cultural Competency
Debt	Parks	Vocational Training		Discrimination	
Medical Bills	Playgrounds	Higher Education			Quality of Care
Support	Walkability				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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.[xxxvii] Further, underinvestment in primary care is one of four fundamental reasons that the U.S. health system ranks last among high-income countries.[xxxviii]

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.[xxxix]
- Individuals with a behavioral health conditions cost nearly four times more than individuals without behavioral health conditions.[xl]
- One in five Medicaid enrollees have a behavioral health condition, but account for almost half of total Medicaid expenditures.[xli]
- Disparities: Those with serious mental illness die on average 25 years earlier than those without, largely because of preventable chronic physical illness.[xlii]
- There is a large body of evidence showing that patients fare best when their physical and behavioral health needs are addressed in tandem.[xliii]
- 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.[xliv]

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.[xlv] 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.[xlvi] 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.[xlvii] 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[xlviii]:

- **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.
- Explore long-term payment that reward providers for good outcomes to match the long-term horizon of the chronically ill rather than focusing just on short-term payments on acute episodes.
- 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 Advanced Care Planning and 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.[xlix]

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.

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.[l] 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.

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[li] 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.[lii]

Table 2: HCP LAN Updated APM Framework[liii]

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 primary palliative care training for providers.
- 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.

- 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.

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.

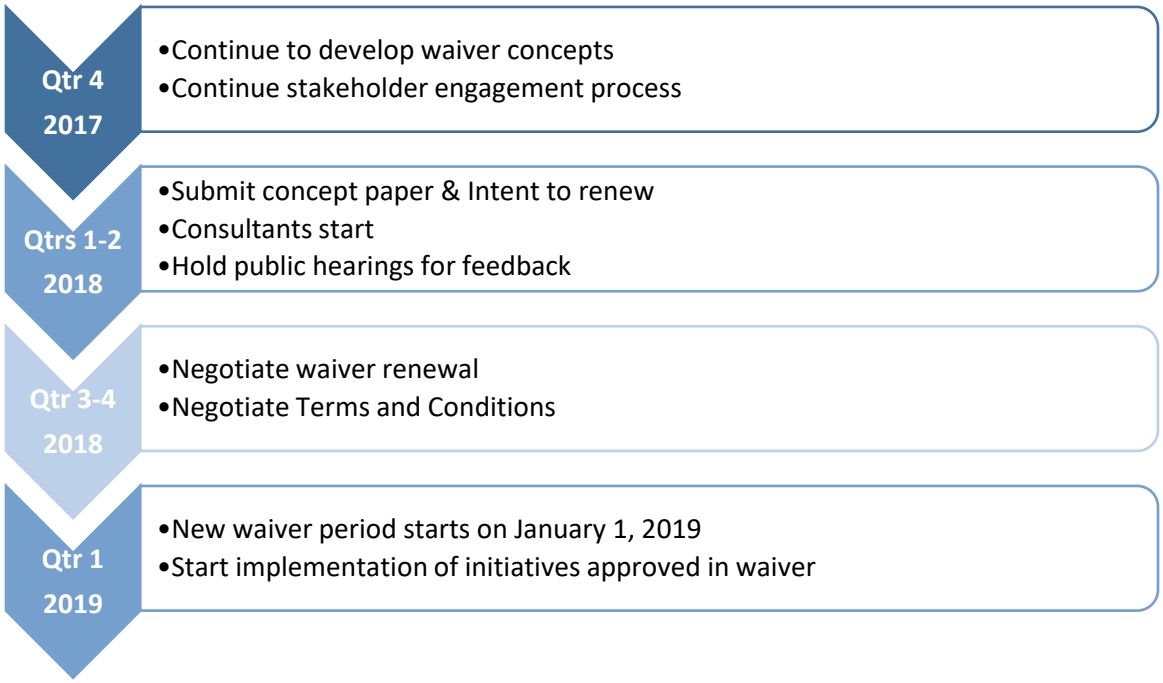
- Adoption and use of value-based payment arrangements will align MCO and their providers with health system transformation objectives and lead to improvements in quality, outcomes, and lowered expenditures.
- A move towards more outcomes-based measures that are tied to incentive programs will improve 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



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Attachment M

Potential Initiatives under HOPE

Value-Based Payment (VBP) and Alternative Payment Methodologies (APM)

Below are specific initiatives that MQD is interested in understanding and potentially incorporating into its managed care program.

- *Re-evaluate VBP and APM standards in the QUEST contract.* MQD's current managed care program employs a number of VBP and APM initiatives such as the promotion of primary care homes, hospital-based VBP, a mandate that 80 percent of MCO contracts with hospitals and primary care providers have VBP targets, and the promotion of shared savings arrangements with ACO-like entities. MQD also has the pay-for-performance capitation payment withhold program for MCO performance described in the previous section. MQD will review these requirements and see if they should be updated and modified in line with the HOPE vision. This will include reviewing primary care spending and primary care payment models.

- *Increase the use of health-related services and in-lieu services by MCOs*. MQD is interested in increasing MCO investment into health-related services and in-lieu of services. In-lieu of services are defined in 42 CFR 438.3. Health-related services or flexible services would be services that improve the health of beneficiaries but are not covered under Medicaid. This could include MCO participation in community-driven initiatives. In order to accomplish this, MQD understands that new capitation methodologies that reward MCOs for creative initiatives may be needed, such as changing MCO profit margins and including health-related services and in-lieu of services in MLR numerators.

- *Targeting payments to particular providers*. MQD is interested in promoting greater utilization of primary care and greater integration of behavioral health with primary care. MQD is interested in payment models through MCOs that would enhance payments to primary care practices and/or other provider groups. These payment models may fall under 42 CFR 438.6(c) or may fall under different authorities. These payment models could include incentive payments or alternative payment methodologies.

- *Incorporating the Social Determinants of Health (SDOH) into payment*. MQD is interested in incorporating SDOH into risk adjustment for capitation payments ***and*** into MCO payments to providers.

- *Developing a process where ACO-like entities can exist under MCOs.* In Hawai‘i, a number of organizations have sprung up that resemble ACOs – groups of providers that are willing to engage in care coordination and care management or organizations that wish to support providers in those activities. These entities may be better suited in some circumstances to provide care management and care coordination for beneficiaries at the point of care. MQD will work to see how ACOs could be financially supported through the managed care program.

High Needs High Cost (HNHC) Individuals

One of the HOPE priority projects is focused on individuals with the highest cost, most complex health and social needs. This is a priority because they are a vulnerable population that experiences significant

disparities, they use a majority of health care resources, and there is potential for a strong return on investment. The goals of this project include improving outcomes, and to use the accrued savings to support the sustainability of HOPE initiatives including investments in primary care, behavioral health integration, and health-related services.

MQD wants to explore opportunities to further develop MCO requirements and programs that can be leveraged to improve outcomes for HNHC individuals. Below are some of the areas MQD is interested in exploring.

- Service Coordination System (SCS). MCOs are required to have a SCS that is designed to address the needs of HNHC adults, adult and children with Special Health Care Needs (SHCN), beneficiaries with chronic conditions, those receiving LTSS, and other vulnerable populations. The MCOs are required to provide service coordination, conduct health and functional assessments, develop service plans, and other services. In addition, MCOs are required to identify beneficiaries whose utilization causes the beneficiary to be in the top five (5) percent of all MCO members by utilization frequency and/or expenditures, and provide service coordination.
- Other Quality Projects/Programs. MCOs are also required to have a disease management plan, quality plans, and other projects and programs that can be leveraged to improve outcomes for HNHC individuals.

One of the reasons MQD wants to reassess the MCO requirements for SCS and the other programs is because a significant amount of resources are used to staff and operate these programs. MQD wants to identify and implement best practices, maintain what is working, and eliminate ineffective, unnecessary and duplicative requirements. The goal is to implement evidence-based programs that are proven to be effective in addressing the Triple Aim as it related to HNHC individuals.

Behavioral Health Integration (BHI)

Another HOPE priority project is focused on promoting BHI across the continuum to improve outcomes for individuals with behavioral health conditions. 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. Other goals include integrating care with value-based payment structures, and screening, diagnosing, and treating conditions as early as possible.

Some of the specific areas MQD is exploring include:

- Research on evidence-based practices and best practices from other states.
- Developing payment models to reimburse PCPs and members of the interdisciplinary team for providing integrated services using the Collaborative Care Model (CoCM) and other evidence-based integration models.
- 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.
- Explore the development of a psychiatric consultation service that supports smaller and rural PCPs that are not affiliated with ACOs or with larger health care systems endowed with accessible behavioral health resources.

- Identifying 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.
- Identifying MCO requirements that will result in improved outcomes. This could include, but is not limited to, changes to MCO staffing requirements, and strategies on how to address the needs of individuals with co-morbid conditions.
- Developing program oversight and management for MCOs related to BHI.
- Identifying if MQD or MCO staffing changes are needed and position descriptions of new positions if appropriate.

Community Care Teams

Currently MQD requires the Managed Care Organizations (MCO) to provide care coordination and other services through the SCS. The MCOs tend to provide many of the services at the health plan level, and MQD received feedback from stakeholders that some of the services need to be based "on the ground" where the providers and members are located. MQD is exploring the development of Community Care Teams (CCTs) in collaboration with the MCOs to ensure that a narrow set of supports for primary care providers (PCPs) that treat patients with complex behavioral health needs are provided where patients are located. The goal of the locally-based CCTs is to support PCPs in delivering quality-driven, cost-effective and culturally appropriate patient-centered care.

One of the reasons MQD is exploring this option is because PCPs, especially PCPs in small and rural practices, have expressed hesitation to routinely screening patients for behavioral health conditions because of the added time required to treat and coordinate care for patients with moderate to serious behavioral health conditions. With limited referral options, the practice staff often spend hours attempting to locate resources for these patients, which places undue strain on practices with limited staffing resources. Currently the MCOs do not assist PCPs in providing this service. In appreciation for the scarcity of time and resources at most PCPs, MQD is currently exploring potential core services the CCT would provide to aid in the adoption of BHI.

Potential core services include triage and referral for patients with complex behavioral health conditions, and linkage to health-related social services. The goal of this service would be to assist PCPs with connecting patients with complex needs to appropriate medical and health-related resources in the community, thus allowing PCPs to focus more time on treating mild or moderate behavioral health conditions in the primary care setting.

Other potential non-core services. Depending on the needs of the community and the MCOs needs, the CCTs could also potentially provide:

- Outreach to individuals who need behavioral health services, but who have not yet presented in a primary care setting.
- Urgent intervention services to individuals who are in emotional or mental distress.
- Health promotion activities, such as health coaching and education.

Community Paramedicine

Community Paramedicine (CP) is an emerging field where Emergency Medical Technicians (EMT) and Paramedics operate in expanded roles in an effort to connect underutilized resources to underserved populations. Services CP programs typically provide include health assessments, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the Ambulance Medical Director. There is currently one CP program operating on a Neighbor Island that is targeting HNHN individuals, and individuals with behavioral health conditions. MQD would like to explore covering these services and supporting CP programs that target HNHC Medicaid beneficiaries.

Health Promotion and Prevention

Initiatives included in HOPE emphasize 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, QI plans will focus on more convenient access to routine primary and preventive services. Specific initiatives will include:

- *Community Health Workers*. MQD will create a community health workers benefit and will review whether CHW should provide or be part of a model that would provide care coordination and educational counseling, home visiting, group health education, lactation consultation, child development screening, diabetes prevention programs in a community setting, and science informed parenting education.
- *Diabetes Prevention*. MQD will offer a lifestyle change diabetes prevention benefit or initiative that incorporates education and is provided in a primary care setting.
- *Asthma Education (AS-ME).* MQD will develop and implement an AS-ME benefit that will be focused on assisting beneficiaries to self-monitor and control their symptoms in part through a written asthma action plan, goal setting, training, management skills, proper medication technique, and avoidance of environmental irritants.
- *Ornish Lifestyle Medicine*. MQD will develop and implement a benefit based on the Ornish Lifestyle Medicine model.
- *Project Extension for Community Healthcare Outcomes (ECHO).* MQD will seek to support and promote medical educational opportunities that increases workforce capacity to provide best-practice care to HNHC individuals.
- *Health Promotion in general*. MQD will identify and possibly implement other evidenced-based health promotion, health education, and prevention programs as time goes on. MQD will develop a process where MQD and the MCOs review the latest EBPs on a regular basis and make coverage decisions.

Dual Eligibles

In order to achieve the goals of the HOPE project, Hawai‘i intends to pilot polices that drive the integration and alignment between Medicare and Medicaid for individuals dually eligible for both programs. Hawai‘i currently includes dual eligibles in its managed care program for both physical health and long term services and supports, as well as mandates that plans in Hawai‘i offering MLTSS also offer a companion D-SNP product.

Existing authorities in this waiver proposal and federal Medicaid regulations should provide MQD with the flexibility needed for integration and alignment initiatives for managed care, value based purchasing, and care management for the Medicaid benefit. MQD will also work with colleagues in CMCS's State Demonstrations Group, the Medicare-Medicaid Coordination Office (MMCO), and the Center for Medicare & Medicaid Innovation (CMMI) to explore further authorities that could bring greater integration between the two programs.

In particular, MQD is interested in authorities that would bring more sustainability, coherence, and predictability toward enrollment in D-SNPs, including implementation of enrollment lock-in policies with opt-outs only for cause and allowing seamless conversion. CMS's recent proposed rule [CMS—4182—P] solicited comments on codifying seamless conversion for D-SNPs which may negate the need for a waiver to accomplish a seamless conversion policy. MQD may also seek seamless conversion for Medicaid full benefit dual eligibles both receiving and not receiving MLTSS. This policy would ensure that the state's dual eligibles utilizing behavioral health services not covered by Medicare are able to receive coverage in a D-SNP that would help coordinate physical and behavioral health services.

Finally, MQD intends to bring better coordination between the programs in the administration of the benefits. Strategies may include quality and performance measure alignment, integrating care management payments to providers where applicable, designing strategies that could reduce potentially avoidable inpatient hospitalizations from long term care settings, and broadening the scope of flexible supplemental benefits.

Future Initiative – Substance Use Disorder Residential Treatment

MQD is not requesting a waiver for SUD treatment in this demonstration proposal, but may submit an amendment if this 1115 renewal request is approved. Like other states and the federal government, Hawai‘i recognizes that access to care for substance use disorder (SUD) treatment is essential to raise health outcomes for beneficiaries, and to stem the tide of chronic addiction. Historically, Hawai‘i has supported a SUD delivery system through Medicaid-covered services, state-only funds, and grant funding. However, MQD has found it essential to expand the services eligible for reimbursement in order to meet a rising need for treatment, to more fully bring standardization and evidence based practices (EBPs) to service delivery, and to offer long term sustainability for providers.

Hawai‘i has yet to experience the opioid use disorder (OUD) epidemic to the degree experienced in other states, but history has shown that the state often experiences public health trends after they occur on the mainland. Hawai‘i views a future SUD amendment proposal as an opportunity to proactively address the opioid epidemic and to provide needed additional resources for the state's other SUD conditions, notably methamphetamine use.

A SUD waiver amendment would conform to the guidance in State Medicaid Director letter #17-003 (SMD #17-003).