Hawaii QUEST Integration
Quarterly Monitoring Report to CMS

Federal Fiscal Year 2021 3rd Quarter
(DY27 Q3)

Hawaii QUEST Integration
Section 1115 Quarterly Report
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I. Introduction

Hawaii's QUEST Integration (QI) is a Department of Human Services (DHS) and Med-QUEST Division (MQD) comprehensive section 1115 (a) Demonstration that expands Medicaid coverage to children and adults originally implemented on August 1, 1994. QUEST Integration uses capitated managed care as a delivery system unless otherwise indicated. Also, QI 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.

During the reporting period, MQD continued to focus on a comprehensive health care delivery system transformation, called the HOPE Initiative. "HOPE" stands for Hawaii-Medicaid Ohana-Nui Project Expansion, and the goal of the 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 continued sustainable growth rate in healthcare spending from reductions in unnecessary care and shifts of care to appropriate settings.

MQD awarded the new QI contract to five health plans. During this reporting period, MQD completed the Readiness Review.

MQD leadership continued targeted communications with QI health plans (Health Plans) during the Public Health Emergency (PHE). The Task Force began meeting three times a week in the spring of 2020. These have now been reduced to meeting once a week in the current quarter.

Although MQD resources and activities during this reporting period continued to be focused on issues and interventions related to COVID-19, and MQD continued to follow flexibilities afforded by CMS through the approved 1135, 1115, and 1915(c) waivers during the PHE, our focus shifted away from COVID prevention and PPE issues, and toward COVID vaccinations for the HCBS home-bound population. This was a continuation of the focus last quarter on populations specific to Medicaid that were high on the State vaccine priority list. Similar to our concerns that the HCBS population would have a hard time getting access to PPE, the HCBS population was again identified as a cohort that would require additional planning for a successful COVID-19 vaccine implementation.

MQD lead efforts to deliver in-home vaccinations for the fragile HCBS home-bound population. This population includes members residing in community care foster family homes, I/DD foster homes, and expanded adult residential care homes. The local pharmacy group administered the vaccinations on Oahu and Hawaii island. On Oahu, 1537 out of 1771 group homes (87% of the group homes) were completed. On the Hawaii island, 152 out of 168 group homes (90% of the group homes) were completed. For Kauai, the Kauai County organized the administration of the vaccines and completed over 90% of its 28 homes (22 CCFFHs, and 6 ARCHs). For Maui, up-to-date data is still pending, but efforts are underway.

MQD continued to project membership and budget items for 2021 and 2022 during this quarter for the state legislators. Although Medicaid membership is projected to increase through the end of 2021, and the 6.2% Federal Medical Assistance Percentage (FMAP) increase during the PHE helped with the budgetary pressures, the outlook for the programmatic budget appeared challenging over the next few years. Discussions with legislators continued through last quarter regarding adequate funding for the program.

In alignment with Hawaii statewide efforts to reduce the spread of COVID-19, MQD continued to enable its staff to work from home wherever feasible and practical. This was in recognition that each staff is going through different requirements and family situations, and that one size does not fit all. During August 2020, when Hawaii experienced a bump in COVID cases, there was a further move by staff away from working in the office toward working from home; this continued to be the case in the current quarter.

During this quarter, Hawaii intra-state travel was allowed to be exempted from quarantine with proof of vaccination.

II. Operational Updates

A. Administration

During the prior period, MQD worked with our Dental Third Party Administrator on an investigation of a "credible allegation of fraud" against several servicing dentists of the Hawaii Dental Clinic (HDC). A determination was made as of April 23, 2021 to suspend payments to five dentists in the HDC.

Contracts

MQD awarded Dental Third Party Administration RFP on April 28, 2021 to Hawaii Dental Services for a three years contract. During this period, MQD received supplemental contract approval from CMS for the 2018 CCS RFP.

In addition, MQD continues to meet and work with CMS on approval of the following:

- Previous QI contract Supplemental Changes 15 & 16, including revising the CAP rates for 2020 to include payment of the vaccination fee;
- New QI contract; and
- New CCS contract.

B. Policy and Program Development & Benefits

Transition of Cases

During the reporting period, an action plan for transition of cases continues to be worked on in preparation for the termination of the health pandemic emergency (HPE) period, which has been extended to September 20, 2021. MQD also worked on implementation of the CMS approved multiple submissions by the State of Hawaii for all Appendix K and other waiver provisions both internally and with the MCO's. We also continue to work with our eligibility branch and KOLEA team to process ex-parte cases while ensuring Medicaid enrollment continues for all beneficiaries during the PHE.

Compliance with Section 1115 Demonstration Special Terms and Conditions

CMS approved one document during the third quarter. The request for an extension to file our initial Spending Plan for Implementation of American Rescue Plan Act of 2021, Section 9817 was approved on June 1, 2021. This changed the due date from June 12, 2021 to July 12, 2021.

HOPE Initiative

MQD staff continues to work on the implementation of the HOPE initiative. One area of focus is on the high-needs/high-cost population. MQD staff worked on developing a draft community-based palliative care benefit and held a summit with over one hundred stakeholders to solicit feedback on the proposal. MQD intends to seek approval for benefit later in the year. Another area of focus is on improving children's health, and MQD submitted a CHIP Health Services Initiative State Plan Amendment that focus on providing vision exams and glasses to low-income children.

Monitoring implementation of eligibility provisions under the Family First Coronavirus Response Act (FFCRA) and Public Health Emergency (PHE)

Focus continues on various initiatives to ensure continued compliance with requirements associated with the 6.2% FMAP offered to states who abide by the provisions in the FFCRA, as well as oversight of the numerous waivers allowed under the PHE to ensure continuation of coverage for our beneficiaries and reduction of barriers to our applicants. Receiving the approval from CMS to extend the Hawaii QUEST Integration authorities in the 1115 Attachment K to be 6 months after the end of the PHE was useful and assisted us in continuing services to our HCBS members who are impacted by COVID-19. This has required enhanced collaboration and coordination with a wide diverse group in MQD including the KOLEA systems office, Eligibility Branch, Systems office and our Finance Office, as well as continuous guidance and dialogue with CMS, and has continued since last quarter. With the extension of the PHE thru September, 2021, we will continue to monitor and take actions on these provisions as appropriate, while also beginning discussions of best ways to transition back to "pre-COVID-19" rules and regulations once the PHE has ended.

Medicaid Eligibility Quality Control (MEQC) and the federal Payment Error Rate Measurement (PERM) program

The Booz Allen Hamilton, Eligibility Review Contractors (ERC) completed the report of findings and the appeal process was finalized in May 2021. On July 14, 2021, a PERM RY21 Overview of Findings and Corrective Action Plan (CAP0 requirements were shared with MQD Steering Committee to prepare for the nest steps. Total cases subjected for review were 302 out of the modified 465 samples pulled. The error findings could be due to a dollar error, technical error or both. An official Findings Summary Report is expected by the end of November 2021 and a CAP requirement is due within 90-days from the Findings Summary Report receipt date.

The CAP requires a Point of Contact who is responsible to design, implement, and monitor the Provider CAP, Claims Processing CAP, and the Eligibility Determination CAP. The Next CAP meeting with CMS is September 22, 2021.

On May 13, 2021, CMS announced that the MEQC RY21 sample-size has been reduced from 800 to 200 due to the continued Public Health Emergency (PHE). The Quality Control (QC) Office is in the process of reviewing cases however MQD has not received a report of findings to date. The department's Administrative Appeals Office agreed to mediate any difference resolutions between MQD and QC.

On August 3, 2021, MQD began discussion of the proposed new PERM/MEQC team and the necessity of a specialized team. The STC committed to engage stakeholders for further discussion and resolution in order to comply with the expectations of the PERM CAP requirements.

Hawaii State Plan Amendments

PPDO completed the following SPAs for this quarter:

- **SPA 21-0001 Optional State Supplementary Payment** Approved 05/03/21
  Effective January 2021, Supplemental Security Income beneficiaries received a 1.3% Cost of Living Adjustment increase from the Social Security Administration. Therefore, this amendment is required to increase the monthly income standards for Domiciliary Care Type I from $1434.90 to $1445.90 and for Domiciliary Care Type II from $1542.90 to $1553.90.

- **SPA 21-0008 COVID Vaccine Emergency SPA** Approved 05/07/21
  This amendment to the Medicaid State Plan adds new verbiage to Section 7-General Provisions, 7.5. Medicaid Disaster Relief for the COVID-19 National Emergency, Section E-Payments (page 7). Hawaii is selecting Option 2, which will increase payment reimbursement rates for COVID vaccine administration. It also requests for modification of the public notice and tribal consultation requirements.

- **SPA 21-0004 Ticket to Work and Work Incentives Group** Approved 05/10/21
  This amendment to the Medicaid State Plan creates a new eligibility group. This group, also identified under the "Ticket to Work and Work Incentives Improvement Act" authority, allows individuals with a disability at least 19 years of age but less than 65 years of age whose income is below 138% of the Federal Poverty Level and applicable Household size a resource standard equal to three (3) times the SSI resource limit adjusted annually by the increase in the consumer price index to qualify and or keep their Medicaid coverage.

- **SPA 21-0002 Smoking Cessation** Approved 05/20/21
  This amendment to the Medicaid State Plan removes limits for smoking cessation counseling and pharmacotherapy, which are currently set at two quit attempts per year, unless approved using a prior authorization process. This will allow smoking cessation services to be provided based on medical need without the need for additional authorizations.

- **SPA 21-0003 Smoking Cessation ABP** Approved 06/14/21
  The amendment to the Medicaid State Alternative Benefit Plan removes limits for smoking cessation counseling and pharmacotherapy, which are currently set at two quit attempts per year, unless approved using a prior authorization process. This will allow smoking cessation services to be provided based on medical need without the need for additional authorizations.

Policy and Program Directives (PPDs) and Forms

The following PPDs were issued during this quarter.

- **21-003** 04/01/2021
  MEDICAL MASS CHANGE 03/21 DUE TO THE INCREASE IN THE FEDERAL POVERTY LEVELS FOR 2021.

To inform providers of specific policy changes, the following provider memos were released during this period:

- **QI-2116** Implementation of all Patients Refined Diagnosis Related Groups (APR DRG
- **QI-2115** Auto Assignment Algorithm for Quest Integration (QI) Members effective July 1, 2021 - December 31, 2021
- **QI-2113** Medicaid Fee-For-Service Rates effective July 1, 2021
- **QI-2112** Medicaid Fee-For-Service Hospice Nursing Facilities Rates effective July 1, 2021 - December 31, 2021
- **QI-2111** Community Integration Services (CIS) Rapid Cycle Assessments (RCAs)
- **QI-2109** Hospice for Members Receiving Home and Community Based Services (HCBS)
- **QI-2108A** Payment Suspension to Providers (Hawaii Dental Clinic) (Addendum to QI-2108)
- **QI-2108** Payment Suspension to Providers (Hawaii Dental Clinic)
- **QI-2107A** Covid-19 Pandemic Action Plan for QI Health Plans - Part VI (Addendum to QI-2107)
- **QI-2107** Covid-19 Pandemic Action Plan for QI Health Plans - Part VI
- **QI-2106** Medicaid Rural Health Clinic Prospective Payment System Dental Rates for Kahuku Medical Center - Effective October 12, 2020 through December 31, 2021
- **QI-2105** Community Integration Services (CIS) Implementation Guidelines: Overview, Member Eligibility, Service Delivery, Coordination & Reimbursement

PPDO continues the work of ensuring programs and policies align with State initiatives and continues to broaden collaborative efforts with other divisions, offices and other both public and private entities, and continues to be a collaborative member of the KALO leadership teams.

Additional Work Projects

PPDO partners with the Health Care Services Branch and Clinical Standards Branch on various projects, initiatives, and issues that have direct impact on benefits in the 1115 Demonstration Waiver and the 1915C Waiver. This quarter we continue the work on implementation of the pilot program for alignment with the Dual Special Needs Plan population, continued to address issues related to Hospice Services, Medication Assisted Treatment, application of EPSDT benefits, and telehealth. We also worked on various sections related to the American Rescue Plan Act including section 9811 (100% FMAP for vaccine administration), 9815 (100% FMAP for services received through Native Hawaiian health care systems) and 9817 (10% point FMAP for HCBS). Med-QUEST continues collaboration with the Department of Education for Administrative Medicaid Claiming. Specifically, continued work on the Random Moment in Time sampling plan for Administrative Claiming and drafting of the school health services SPA with CMS, and helping DOE providers comply with Medicaid requirements to for school-based services Efforts continue to engage with other DOE staff offices whose participation is integral to this work.

C. Availability and Access of Covered Services & Network Adequacy

During the start of the PHE in 2020, in-person SC visits were prohibited with only a few exceptions. In this quarter, MQD issued guidance for plans to resume in-person service coordinator (SC) visits for certain HCBS members. This guidance was issued because of a concern that these members had not received an in-person SC visit for up to 15 consecutive months.

MQD continued the extension of the HCBS level-of-care assessment waiver for an additional six months during this quarter. These extensions began in 2020 out of a concern to minimize in-person contact that typically occurs during these level of care assessments.

Also, MQD continues regular meetings with sister divisions that are a part of the Hawaii Department of Health (DOH), including Child and Adolescent Mental Health Division (CAMHD), Alcohol and Drug Abuse Division (ADAD), Adult Mental Health Division (AMHD), and Developmental Disabilities Division (DDD). The goal of these meetings is to align and coordinate the behavioral health services that QI members receive with existing services that are available through DOH. These productive meetings have continued to inform QI RFP language changes.

D. Pertinent Legislative or Litigation Activity

There are a number of ongoing workgroups that were established by the legislature that MQD is participating in including: Earned Income Disregard Program; Intellectual and Developmental Disabilities Medicaid Waiver Administrative Claiming Special Fund which requires MQD and DOH to engage with stakeholders to develop and distribute information about accessing Medicaid services; and a Behavioral Health Care Workgroup.
MQD was notified during the 3rd quarter of FFY 2019 of being party to a lawsuit along with the Children and Adolescent Mental Health Division, Dept. of Health for the provision of mental health services for a child/young adult. In this quarter, MQD filed a Motion for Summary Judgement on February 3, 2021 to dismiss this case. As part of this motion, depositions of MQD staff were planned for the future.

MQD has been pursuing litigation regarding a drug, Plavix, for which MQD believes the manufacturers withheld critical information on drug efficacy as it relates to patient ethnicity. Several key MQD employees were deposed in the 2nd quarter of FFY 2020. On February 15, 2021 the judge in the Plavix case found in favor of the State of Hawaii, and awarded $834 million in civil penalties against the Defendants. It is assumed that there will be an appeal by the defendant.

The Liberty Dialysis trial, related to inappropriate billing of dialysis services, was re-scheduled for January 2022. Outcome is pending.

E. Public Forums

In accordance with 42 CFR 431.420 (c), the State held its annual public forum for the QUEST Integration Section 1115 Demonstration Project on Wednesday, May 5, 2021 at 6:00 p.m. during the Med-QUEST Healthcare Advisory Committee Meeting (MHAC) meeting. During this public forum we reported out on various issues including our mission, increased enrollment, the supportive housing benefit under community integration services and the added community transition services that includes transitional case management services, housing quality and safety improvement services, legal assistance and securing house payments. We also reviewed the approvals by CMS during the past year, such as, the Hawaii Behavioral Health Services Protocol, the Demonstration Waiver Evaluation Design, various Appendix K's during the PHE and the PHE 1115 Demonstration Waiver Evaluation Design.

No comments were received by the public regarding the information presented. Comments were received from the MHAC members regarding how long the Demonstration Project lasts and the process the State follows if changes will be made to the next Demonstration Project. The State explained that the Demonstration Project is for five years and that the State can do amendments to the Demonstration Project as needed. MHAC members also commented on the enrollment numbers and why there was an increase during the PHE. The State explained that during the PHE the State will not terminate any Medicaid members unless they request termination, move out of state, or are deceased. The State also commented that the majority of the increase in enrollment was with the Low Income Adult population and that we anticipate higher enrollment in Medicaid for at least one more year.

III. Grievances, Appeals & State Fair Hearing

A. Member Grievances

The following tables provide grievance and appeal events received during this reporting period.

1. Grievances to MQD Health Care Services Branch (HCSB)

April 2021 – June 2021 Types of Member Grievances to HCSB	
Description: The following are grievances received by the HCSB of MQD. These DO NOT include the grievances received by the Health Plans, which are reported in a separate table below.	
Health Plan Policy	3
Provider/Provider Staff Behavior/Services	9
Transportation Customer Service	5
Treatment Plan/Diagnosis	0
Fraud and Abuse of Services	1
Billing/Payments	3
Member Rights	8
Medication	1
General Information	6
Forward to Other Departments	0
Total	**36**

Some grievances fit into multiple categories.

Month	# of Member Grievances to HCSB by Month
April 2021	13
May 2021	14
June 2021	9
Total	**36**

Status of Member Grievances Addressed by HCSB					
		Apr 2021	May 2021	Jun 2021	**TOTAL**
Received		**13**	**14**	**9**	**36**

Status					
Referred to Subject Matter Expert		8	3	2	13
Health Plan resolved with Members		0	0	0	0
Member withdrew grievance		0	0	0	0
Resolution in Health Plan favor		0	0	0	0
Resolution in Member's favor		0	0	0	0
Still awaiting resolution		5	11	7	23
Return to Health Plan awaiting Resolution Letter		0	0	0	0
Carry-over from previous Quarter		0	0	0	0

2. Grievances to Health Plans

Types of Member Grievances Reported to Health Plans	
	Apr – Jun 2021
	Total = 566
Provider Policy	9
Health Plan Policy	21
Provider/Provider Staff Behavior	125
Health Plan Staff Behavior	42
Appointment Availability	14
Network Adequacy/ Availability	2
Waiting Times (office, transportation)	156
Condition of Office/ Transportation	8
Transportation Customer Service	56
Treatment Plan/Diagnosis	22
Provider Competency	35
Interpreter	0
Fraud and Abuse of Services	3
Billing/Payments	35
Health Plan Information	7
Provider Communication	23
Member Rights	8

Status of Member Grievances Reported to Health Plans	
	Apr – Jun 2021
	Total
Total number filed during the reporting period	**448**
Status received from Health Plans	
Total number that received timely acknowledgement from health plan	428
Total number not receiving timely acknowledgement from health plan	20
Total number expected to receive timely acknowledgement during next reporting period	11
Total number that received timely decision from health plan	414
Total number not receiving timely decision from health plan	12
Total number expected to receive timely decision during next reporting period	13
Total number currently unresolved during the reporting period	30

B. Member Appeals and State Fair Hearings

1. Appeals to Health Plans

During April – June 2021, there were a total of 321 Appeals submitted with the Health Plans.

Types of Member Appeals to Health Plans		
		Apr – Jun 2021
Service denial		54
Service denial due to not a covered benefit		5
Service denial due to not medically necessary		265

Service reduction, suspension or termination		0
Payment denial		1
Timeliness of service		0
Prior authorization timeliness		0
Other		0

Status of Member Appeals to Health Plans		
		Apr – Jun 2021
Total number filed during the reporting period		321
Status received from Health Plans		
Total number that received timely acknowledgement from health plan		284
Total number not receiving timely acknowledgement from health plan		36
Total number expected to receive timely acknowledgement during next reporting period		33
Total number that received timely decision from health plan		278
Total number not receiving timely decision from health plan		34
Total number expected to receive timely decision during next reporting period		41
Total number currently unresolved during the reporting period		41
Total number overturned		140

2. Appeals to the State (State Fair Hearings)

For April - June 2021, there was a total of seven (7) Appeals submitted to AAO. Six (6) were resolved, and we are awaiting one (1) resolution.

Types of Member Appeals to State Administrative Appeals Office (AAO)					
		Apr 2021	May 2021	Jun 2021	**TOTAL**
Medical		2	1	1	4
Home and Community Based Services (HCBS)		0	0	0	0
Van Modification		0	0	0	0
Applied Behavioral Analysis (ABA)		0	0	0	0
Durable Medical Equipment		0	0	0	0
Reimbursement		0	1	0	1
Medication		1	1	0	2
Miscellaneous		0	0	0	0

Status of Member Appeals to State Administrative Appeals Office (AAO)					
		Apr 2021	May 2021	Jun 2021	**TOTAL**
Submitted		3	3	1	7
Status received from AAO					
Department of Human Services (DHS) resolved with health plan or Department of Health Developmental Disabilities Division (DOH-DDD) in Member's favor prior to going to hearing		3	2	1	6
Dismiss as untimely filing		0	0	0	0
Member withdrew hearing request		0	0	0	0
Resolution in DHS' favor		0	0	0	0

Resolution in Member's favor		0	0	0	0
Still awaiting resolution		0	0	1	1

IV. Health Plan Enrollment and Disenrollment

The Customer Service Branch (CSB), Eligibility Branch (EB), and Health Care Outreach Branch (HCOB) remain committed to assist community members complete their Medicaid application and pre-enroll in a QI health plan. Since federal fiscal year 2021, Med-QUEST continued to enhance technology and completed the installation of Voice over Internet Protocol (VoIP) in Service Centers located in Kauai, Kailua-Kona and Maui. VoIP increased the amount of staff available to answer calls from the public, whether working in-office or remotely, to complete the application intake process by phone. A pre-selection of QI plan completes the application and ensures immediate enrollment when applicant is deemed eligible for Medicaid. HCOB manages community activity and ensures navigators follow the same process as Med-QUEST staff with assisting the public.

In December 2020, Med-QUEST added a webform to its online version of the Medicaid application which allows applicants to pre-select a QI health plan for each household member that applied. The webform is processed by CSB upon receipt. CSB takes necessary action to honor beneficiary choice if form received after business hours.

A. Health Plan Enrollment Summary

The 2020 QI Annual Plan Change was October 1 through 31, enrollments applied January 1, 2021. Beneficiaries were mailed an enrollment packet in September. Of the 365,306 beneficiaries eligible to participate during the annual plan change, 5,316 (1.24%) elected to enroll in a different health plan for the 2021 benefit year (January to December 2021). The table below is a summary of the annual plan change activity by QI health plan and service area. The numbers reflect new members each plan gained January 1, 2021.

MAGI Excepted	Oahu	Kauai	Hawaii	Maui	Molokai	Lanai	Total
AlohaCare	57	7	3	13	2	1	83
HMSA	174	12	29	37	2	0	337
Kaiser	40	0	0	26	0	0	320
Ohana Health Plan	37	3	5	3	0	0	114
UnitedHealthcare Community Plan	329	7	15	15	2	0	416
Total	637	29	52	94	6	1	819
Beneficiaries w/APC Choice	1.10%	0.05%	0.09%	0.16%	0.01%	0.00%	1.41%
MAGI	Oahu	Kauai	Hawaii	Maui	Molokai	Lanai	Total
AlohaCare	466	85	199	100	33	6	889
HMSA	1632	167	509	218	10	1	3426
Kaiser	535	3	0	280	0	0	3355
Ohana Health Plan	46	1	15	8	0	0	888
UnitedHealthcare Community Plan	129	3	36	15	0	0	253

Total	2808	259	759	621	43	7	4497
Beneficiaries w/APC Choice	0.91%	0.08%	0.25%	0.20%	0.01%	0.00%	1.46%

B. Health Plan Disenrollment Summary

	# of Beneficiaries	Reason
Beneficiaries that requested plan-to-plan change with cause	7	**7 Continuity of Care** ○ 2 beneficiaries primary care physician not participating with QI plan ○ 1 Pregnant woman in third trimester ○ 2 clients in behavioral health therapy. ○ 1 client in long term care ○ 1 client in Medical Treatment
Beneficiaries that requested plan-to-plan change from health plan	93	**Loss / Gain** AlohaCare 21 / 22 HMSA 8 / 30 Kaiser 2 / 26 Ohana Health Plan 39 / 1 UnitedHealthcare Community Plan 23 / 14 Total 93 / 93 **Reason** PCP Continuity 36 LTC Placement 4 Behavioral Therapy 1 Specialist* 25 TPL** 19 Seek service outside Kaiser network 5 Family Continuity 3 Total 93 *Cardiologist, Obstetrician **Commercial TPL and Medicare Advantage

V. Number of Beneficiaries who Chose an MCO and Number of Beneficiaries who Changed MCO After Auto-Assignment

A. Beneficiary Choice of Health Plan Exercised

April 2021 – June 2021	Number of Beneficiaries
Chose a health plan when they became eligible	**4089**
Automatically assigned when they became eligible	**5104**
Changed their health plan after being automatically assigned	**1707**
Beneficiaries in the ABD program who changed their health plan within days 61 to 90 after confirmation notice was issued	**11**

During this reporting period, 5,104 individuals chose their health plan since they became eligible in the previous quarter, 1,707 changed their health plan after being automatically assigned. In addition, 11 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

VI. Demonstration Enrollment

A. Enrollment Counts

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**Jan 2021 – March 2021**	**Jan 2021 – March 2021**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	392,063	129,748
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	128,600	41,953
Aged	Aged w/Medicare Aged w/o Medicare	100,005	33,364

Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	77,999	26,451
Expansion State Adults	Expansion State Adults	395,509	130,387
Newly Eligible Adults	Newly Eligible Adults	85,922	28,184
Optional State Plan Children	Optional State Plan Children	0	0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,963	647
Medically Needy Adults	Medically Needy Adults	0	0
Demonstration Eligible Adults	Demonstration Eligible Adults	0	0
Demonstration Eligible Children	Demonstration Eligible Children	0	0
VIII-Like Group	VIII-Like Group	0	0
UCC-Governmental	UCC-Governmental	0	0
UCC-Governmental LTC	UCC-Governmental LTC	0	0
UCC-Private	UCC-Private	0	0
CHIP	CHIP (HI01), CHIPRA (HI02)	85,162	28,735
Total		**1,267,223**	**419,469**

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	232,163
Title XXI funded State Plan	28,735
Title XIX funded Expansion	158,571
Enrollment current as of	06/30/2021

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	**Month 1**	**Month 2**	**Month 3**	**Total for Quarter Ending 03/31/21**
EG 1 – Children	**129,914**	**131,214**	**130,935**	**392,063**
EG 2 – Adults	**43,194**	**43,667**	**43,131**	**129,692**
EG 3 – Aged	**33,164**	**33,481**	**33,360**	**100,005**

EG 4 – Blind/Disabled	**26,290**	**26,479**	**25,230**	**77,999**
EG 5 – VIII-Like Adults	**0**	**0**	**0**	**0**
EG 6 – VIII Group Combined	**160,779**	**162,313**	**158,339**	**481,431**

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 03/31/21
State Plan Children	**129,914**	**131,214**	**130,935**	**392,063**
State Plan Adults	**42,549**	**42,703**	**42,477**	**127,729**
Aged	**33,164**	**33,481**	**33,360**	**100,005**
Blind or Disabled	**26,290**	**26,479**	**25,230**	**77,999**
Expansion State Adults	**132,128**	**133,563**	**129,818**	**395,509**
Newly Eligible Adults	**28,651**	**28,750**	**28,521**	**85,922**
Optional State Plan Children	**0**	**0**	**0**	**0**
Foster Care Children, 19-20 years old	**645**	**664**	**654**	**1,963**
Medically Needy Adults	**0**	**0**	**0**	**0**
Demonstration Eligible Adults	**0**	**0**	**0**	**0**
Demonstration Eligible Children	**0**	**0**	**0**	**0**
VIII-Like Group	**0**	**0**	**0**	**0**
UCC-Governmental	**0**	**0**	**0**	**0**

UCC-Governmental LTC	0	0	0	0
UCC-Private	0	0	0	0

C. Enrollment in Behavioral Health Programs

Point-in-Time (1st day of last month in reporting quarter)

Program	# of Individuals
Community Care Services (CCS) Adult (at least 18 years old) QI beneficiaries with a serious mental illness (SMI) or serious and persistent mental illness (SPMI) who meet the program criteria, receive all behavioral health services through the CCS program.	**4,945**
Early Intervention Program (EIP/DOH) Infant and toddlers from birth to 3 years old receive services to assist in the following developmental areas: physical (sits, walks); cognitive (pays attention, solves problems); communication (talks, understands); social or emotional (plays with others, has confidence); and adaptive (eats, dresses self).	**694**
Child and Adolescent Mental Health Division (CAMHD/DOH) Children and adolescents age 3 years old to 18 or 20 years old (depending on an educational assessment), receive behavioral health services utilizing Evidence-Based Practices and an Evidence-Based Services Committee, from the state Department of Health.	**855**

D. Enrollment in Long Term Services and Supports (LTSS)

Long Term Services and Supports (LTSS) enrollment reported by the Health Plans are as follows.

Health Plan	Apr 2021	May 2021	Jun 2021*
Aloha Care	455	425	
HMSA	636	632	638
Kaiser	324	330	
Ohana	2444	2382	
United Healthcare	2235	2289	
Total	**6094**	**6058**	**638**

*Data unavailable. Data compiled for this table is taken from QUEST Integration Dashboards. QUEST Integration Dashboards are no longer reported to MQD from the Health Plans as of July 1, 2021. June data for LTSS enrollment are usually reported in the following July QUEST Integration Dashboards. HMSA happened to provide its June LTSS enrollment data in its June 2021 QUEST Integration Dashboard.

VII. Outreach, Innovative Activities, and Beneficiary Support System

The COVID-19 pandemic continues to be challenging for Hawaii residents especially those who are most vulnerable in the state, such as the homeless, Micronesians, immigrants and justice involved populations. The Health Care Outreach Branch (HCOB) continues to work with our community partners to provide education, support and guidance in assisting residents to apply for Medicaid for those who currently do not have any health coverage. During this time we continue to target our outreach within the Micronesian communities as they have been greatly impacted by the COVID-19 pandemic. Our goal is to educate them about the restoration of Medicaid benefits to their community and apply them to Medicaid if they are eligible.

HCOB is connecting and working with more grassroot organizations who are in the community providing services, such as, Project Vision Hawaii's HieHie mobile hot water private showers, along with other street outreach partners to address the unique needs of everyone. At many events one may find health care services, applications for Medicaid, food stamps, housing referrals, documentations assistance is provided all in one location.

We continue to work with social workers within justice involved and other public institutionalized populations to ensure their transition on and off Medicaid benefits is a smoother process.

VIII. Delivery of Long Term Services and Supports (LTSS)

The LTSS category includes a number of different provider types such as Community Care Foster Family Homes (CCFFHSs), Extended Adult Residential Care Homes (EARCHs), ICF DD/ID facilities and nursing facilities.
For April - June 2021, there were 380 adverse events from the Health Plan, 20 adverse events from Nursing Facilities, and 7 adverse events from ICF DD/ID for a total of 407 adverse events.

Apr 2021 – Jun 2021	Health Plan	Nursing Facility	ICF DD/ID	TOTAL
Fall	122	14	0	**136**
Hospital	74	0	1	**75**
Death	21	0	0	**21**

Emergency Room Visit	86	0	5	**91**
Injury	72	5	0	**77**
Med Error	5	0	1	**5**
Aspiration	0	1	0	**2**
TOTAL	**380**	**20**	**7**	**407**

IX. State Efforts Related to the Collection and Verification of Encounter Data and Utilization Data

During FFY 2021 3rd Quarter MQD initiated a new contract with a documentation consultant who will support MQD in the policy re-alignment exercise described in FFY 2021 2nd Quarter Report. This consultant will document current alignment between policy and data validation edits to identify any misalignments that result in encounters pending. The consultant will conduct a needs assessment, followed by facilitation activities with stakeholders to develop solutions, and action planning to implement the solutions developed. During FFY 2021 3rd Quarter the consultant established the initial repositories and templates for this project; the consultant will deliver findings for the needs assessment on a monthly basis going forward.

This quarter MQD continued its work with AHCCCS and a consultant to support specialized systems documentation work focused on identifying discrepancies and errors in MQD's encounter validation process that are contributing to pends. During FFY 2021 3rd quarter MQD conducted one-time refreshes to internal reference tables used in encounter validation and instituted new processes to ensure our internal reference tables remain updated systematically going forward. This project will ensure encounters due not pend unnecessarily and that MQD staff will save time researching individual codes missing from internal reference tables.

MQD continues to conduct a monthly encounter validation meeting with all participating MCOs to address major issues in encounter data submission or validation. During FFY 2021 3rd Quarter this meeting focused on the introduction of new encounter data validation edits related to the implementation of APR DRG pricing, the provision of services by Non-Emergency Medical Transportation providers, and the limited use of "unspecified" diagnosis codes. During this quarter's meetings MQD also worked with MCOs to improve encounter data submission guidance for newly established programs including the Community Integration Services.

X. Impact of Demonstration in Providing Insurance Coverage

This section is new and will be populated in future reports. Data is not currently available for this section.

XI. Performance Metrics & Quality Assurance and Monitoring

A. Quality Activities (April – June 2021)

The External Quality Review Organization (EQRO) oversees the health plans for the Quest Integration (QI) and Community Care Services (CCS) programs. Health Services Advisory Group (HSAG), the EQRO, performed the following activities this quarter:

1. Validation of Performance Improvement Projects (PIPs)

MQD's EQRO validates PIPs to ensure the health plans designed, conducted, and reported the projects in a methodologically sound manner consistent with the CMS protocols for PIPs.

April

- Received Modules 4 and 5 from the health plans by 04/16/21.
- Provided technical assistance to Kaiser, Ohana, Ohana CCS, and AlohaCare upon request.

May

- Attended MCO Report Review meeting organized by Ranjani Starr (MQD) on 05/14/21.
- Participated in PIP topics discussion meeting with the MQD/HAO on 05/24/21.
- Conduct Modules 4 and 5 validations.

June

- Sent the Module 4 and 5 validation tools to the MQD and plans on 06/04/21.
- Participated in PIP topic work group meeting with the MQD/HAO on 06/09/21 and 06/24/21.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

MQD's EQRO validates the HEDIS and non-HEDIS state-defined measure rates required by the MQD to evaluate the accuracy of the results. The EQRO continues to assess the PM results and their impact on improving the health outcomes of members. The EQRO conducts 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.

April

- Received preliminary rates from MCO's on 04/16/21.
- Completed preliminary rate review on 04/30/21.

May

- Received Attachment 1: Final Numerator Compliant Counts for all hybrid measures and exclusions from MCOs on 05/07/21.
- Provided MRRV measure selection letters to MCOs on 05/11/21.
- Received Attachment 2: MR Numerator Positive Care Listings for selected MRRV measure and Attachment 3: MR Exclusion Case Listings for all exclusions from MCOs on 05/12/21.
- Received selected charts/medical records from MCOs on 05/17/21.
- Provided MRRV results and completed all corrective actions and follow-up requests on 05/24/21.

June

- Received final rates and State-required patient-level detail (PLD) file from MCOs on 06/01/21.
- Received signed Management Representation Letter from MCOs on 06/14/21.
- Approved MCOs final rate submissions on 06/14/21.

3. Compliance Monitoring

MQD's EQRO evaluates the health plans' compliance with federal Medicaid managed care regulations and State contract provisions for organizational and structural performance.

April

- Provided technical assistance on CAPs for KFHP on 04/02/21 and 04/06/21.

May

- Received resubmission of CAPs from KFHP on 05/14/21.
- Reviewed KFHP CAPs and sent CAP documents to the MQD for review on 05/26/21.

June

- Received feedback from the MQD regarding KFHP CAPs and notified KFHP that all CAPs were successfully completed and closed on 06/02/21.

4. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The EQRO conducts CAHPS surveys of the Child QI health plans and Children's Health Insurance Program (CHIP) populations to learn more about members' experiences with care.

April

- Sent weekly disposition reports to MQD.
- Mailed second postcard reminders to non-respondents on 04/01/21.
- Refreshed phone number files prior to computer assisted telephone interviewing (CATI) using Telematch on 04/14/21.
- Began CATI for non-respondents on 04/15/21.
- Performed CATI monitoring of survey vendor on 04/21/21.

May

- Completed CATI for non-respondents on 05/06/21.
- Notified the MQD that the survey field closed on 05/07/21.
- Received data files from subcontractor on 05/21/21.
- Submitted final disposition report to MQD on 05/24/21.
- Submitted Medicaid survey data to NCQA for all QI health plans on 05/24/21.
- Notified the MQD that NCQA data submission was completed on 05/26/21.

June

- Sent CAHPS Health Plan Database submission memo, Data Use Agreement (DUA), and the Association for Community Affiliated Plan (ACAP) authorization form to the MQD on 06/07/21.
- Received confirmation the MQD re-activated the CAHPS Health Plan Survey Database account and all required forms on 06/24/21.
- Performed Star Report survey data analysis on 06/30/21.
- Prepared respondent-level data files and data dictionary for the MQD on 06/30/21.

5. Provider Survey

April

- This activity was postponed due to COVID-19 and the EQRO's findings of other states receiving only 2% Response Rate.

May

- MQD and the EQRO discussed survey administration timeline on 05/05/21.
- EQRO sent an updated timeline to MQD on 05/10/21.
- EQRO sent updated sample frame creation instructions to MQD on 05/17/21.
- MQD sent the sample frame files to the EQRO on 05/26/21.

June

- EQRO reviewed sample frame files on 06/02/21.
- EQRO sent sample frames to subcontractor on 06/08/21.
- MQD received an updated timeline from the EQRO on 06/09/21.
- EQRO submitted updated survey notification documents to the MQD on 06/15/21.
- EQRO submitted reminder email notification language to the MQD for approval on 06/16/21.
- MQD provided approval for the email notification language on 06/22/21.
- Survey samples were selected on 06/23/21.
- EQRO notified the MQD that the samples were selected on 06/24/21.
- EQRO submitted final, formatted mail materials to the MQD on 06/28/21.
- EQRO submitted 2021 Kaiser and non-Kaiser survey instruments to the health plans on 06/28/21.

6. Annual Technical Report

MQD's EQRO aggregates and analyzes the health plans' performance data across mandatory and optional activities and prepare an annual technical report. The EQRO uses the Centers for Medicare & Medicaid Services' (CMS') external quality review (EQR) protocols update when preparing this report.

April

- Began drafting the 2021 HI EQR Technical Report template.

May

- Continue drafting the 2021 HI EQR Technical Report template.
- Sent *Follow-up to Prior EQRO Recommendations* documentation request to health plans on 05/03/21.

June

- Submitted report template to the MQD on 06/29/21 for review and feedback.

7. Technical Assistance

At the state's direction, the EQRO may provide technical guidance to groups of MCOs, PIHPs, PAHPs, or PCCM entities as described at 42 CFR §438.310(c)(2).

April

- Conducted Hospital P4P update meetings with HAO on 04/08/21, 04/20/21, and 04/27/21.
- Participated in CMS technical assistance call with the MQD regarding the EQR technical reports on 04/05/21.

May

- Conducted Hospital P4P update meetings with HAO on 05/04/21, 05/11/21, and 05/18/21.
- Participated in meeting with HAO regarding MCO Report Manual on 05/14/21.
- Submitted Hospital P4P enhanced scope of work budget to the MQD and HAO on 05/19/21 and received approval to use the general technical assistance budget on 05/19/21.

June

- Participated in meeting with HAO regarding MCO P4P program on 06/01/21.
- Conducted Hospital P4P update meetings with the HAO on 06/01/21, 06/08/21, 06/15/21, 06/22/21, and 06/29/21.
- Participated in Hospital P4P measure discussion with Healthcare Association of Hawaii (HAH) and the MQD on 06/22/21.

XII. Budget Neutrality and Financial Reporting Requirements

The Budget Neutrality Workbook for the quarter ending March 31, 2021 was submitted to CMS by the May 31, 2021 deadline. The Budget Neutrality Workbook for the quarter ending June 30, 2021 will be submitted separately by the August 31, 2021 deadline.

XIII. Evaluation Activities and Interim Findings

During FFY 2021 3rd quarter, MQD's Health Analytics Office (HAO) worked closely with the University of Hawaii Evaluation team (MQD's external evaluators) to provide training to MQD and Health Plan staff on new reporting templates, clinical data collection tools, and other assessments created in FFY 2021 2nd quarter. These included trainings focused on data collection on value-based purchasing, alternative payment models, special health care needs populations; LTSS populations; and CIS populations; social determinants of health and health disparities; and the advancing primary care initiative. Additionally, the University of Hawaii Evaluation Team has been preparing for the CIS rapid cycle assessments scheduled to begin July 2021. Meetings with Health Plans, housing service providers, and other stakeholders are scheduled for July 2021 and November 2021. Data from these reports and RCAs are forthcoming.

The University of Hawaii now has access to MQD data.

XIV. Other

Asset Verification Service (AVS) System

Med-QUEST is working with the New England States Consortium Systems Organizations (NESCSO) for the implementation of an asset verification service (AVS) system leveraging NESCSO's contract with Public Consulting Group (PCG). Med-QUEST, NESCSO, and PCG held a Kick-off Meeting on April 16, 2020 to initiate the project and successfully implemented an AVS Portal on July 27, 2020. On December 21, 2020, Med-QUEST implemented the first of two phases to integrate the interface between the State's medical eligibility system and the asset verification service. Phase II was implemented on February 22, 2021, introducing more automation to the verification and eligibility process.

Phase I implemented an interface between the Medicaid system and the AVS system to facilitate automated requests to and from the AVS system. AVS response data is presented to workers in the Medicaid system for their review. Phase II automated the verification and eligibility steps of the process, eliminating the need for workers to manually review AVS response data.

AVS Integration Phase I requests electronic asset verification at time of application, renewal, and changes in circumstances for all individuals subject to asset verification under section 1940 of the Social Security Act. Phase I also includes integration of a monthly bank file listing all financial institutions available via the AVS, data conversion of existing bank information to aid in verification of existing beneficiary asset information, and a number of enhancements to the user interface that include new task workflows and views to display AVS data. Phase II introduced intelligent rules for automated verification and eligibility determinations triggered by logic and rules that will evaluate asset details against thresholds and holding/transfer periods.

In a letter dated June 28, 2021, CMS notified the State of Hawaii that CMS finds the state in compliance with the requirements in section 1940 of the Social Security Act (the Act) to implement an asset verification system for individuals applying for or receiving medical assistance, on the basis of being aged 65 or older, blind, or disabled.

Provider Management System Upgrade (PMSU)

In partnership with Arizona Health Care Cost Containment System (AHCCCS), MQD has moved forward with upgrading existing provider management software. A PMSU vendor, CNSI, was selected in FFY 2018 quarter three, and we received approval of this vendor contract in FFY 2019 quarter one. The Internal Verification & Validation (IVV) vendor was selected in FFY 2018 quarter four, to monitor the PMSU project. The initial go-live date of August 26, 2019 was postponed until March 2, 2020, to account for unforeseen complexities in business rules development and software coding and implementation. The go-live date was then postponed to April 13, 2020 to ensure thorough testing of the system. As we approached April 13, MQD and AHCCCS decided to postpone the go-live date due to the COVID-19 public health emergency (PHE). The final go-live date was August 3.

MQD named the PMSU project, Hawaii's Online Kahu Utility (HOKU). Hoku, in Hawaiian means guiding star. Kahu, in Hawaiian means caretaker or pastor, one who looks after their flock. Med-QUEST providers are caretakers looking after and taking care of members. MQD communicated an addendum memo (QI-2006B) to the MCOs and providers that included information about the new go-live date, updated registration in HOKU by waves, updated information about training materials and schedule and what an application ID is.

MQD issued a request for proposal in 2019 to secure a vendor for our Provider Enrollment and Revalidation contract. MQD awarded the contract to Koan, with an effective contract date of January 1, 2020. With the Provider Enrollment and Revalidation contract, Koan is responsible with managing MQD's provider hotline, imaging (scanning) provider applications and assisting with screening and inputting provider enrollment and revalidation applications.

HOKU's go-live date was August 3, 2020. In preparation of the go-live date, MQD worked in partnership with AHCCCS and CNSI to perform test cases and discuss system defects. Once HOKU went live, MQD conducted various training sessions and provided training materials (YouTube videos and PPT slide decks). During the first few months of HOKU's go-live period, MQD and Koan staff began to learn how to navigate HOKU, review applications and approve/deny applications in the live environment. MQD and Koan began meeting daily to discuss issues and ask questions, and also meet with CNSI a few times each week to discuss identified issues and request assistance for specific application review steps. As issues are identified and confirmed, MQD creates an incident ticket in CNSI's JIRA website. Once a ticket is created, CNSI triages the issue and responds/updates MQD.

MQD launched HOKU in phases (Waves) to prevent an overflow of applications entering the system at once. Before each Wave, MQD worked with our vendor, Cardinal, to mail the Application ID correspondences to each provider prior to each Wave start date. The Application ID letter informs the provider of their Application ID number and about registering in HOKU. The PMSUP vendor, CNIS, emailed Application ID letters to providers that MQD had an email address for.

Our goal is to get majority of our providers in HOKU and tremendously decrease paper applications. MQD & Koan staff continued to become familiar with the HOKU system on how to review and process applications. As staff reviewed different provider types, some situations and/or issues were identified. These were brought up with CNSI during our meetings each week and triaged for a solution or added to a future HOKU release. After finalized testing of defects and enhancements, CNSI continues to incorporate the fixes in HOKU releases (updates). Once the system is updated; the information is passed on to MQD and Koan staff.
MQD has been collaborating with the MCOs and will be using their assistance to reach out to providers that have not yet registered in HOKU. This will help to increase the number of providers that register in HOKU.

MQD's goal is to increase the throughput of applications in HOKU. To achieve that, MQD has been working with a heavy focus on a few key areas.

- **HI's Priorities**
  - MQD is prioritizing our needs and ensuring CNSI is aware of the changes that are needed for HI business going forward.

- **Group Billers**
  - MQD is focusing on getting Group Biller applications approved to ensure the process of approving the Rendering/Servicing providers associated with a Group Biller is streamlined.

- **Training**
  - Koan hired an additional seven (7) individuals mid-June and they are currently in the training phase.

- **Business Processes**
  - With an online enrollment system and additional staffing, MQD has been reviewing business processes and revising them to meet business needs, while ensuring that State and Federal guidelines are followed.

- **HOKU System Improvements**
    - Continuously focusing on HOKU system issues/enhancements will improve and increase the productivity of reviewers.

Below is a snapshot of the provider application statistics at the end of June.

Application Status	Number of Applications	Description
In Process	1,577	Number of applications providers are currently working on in HOKU but have not yet submitted.
In Review	1,968	Number of applications providers submitted in HOKU and are awaiting State Review.
Approved	1,888	Number of applications State reviewed and approved.

Electronic Visit Verification (EVV)

In accordance with the 21st Century Cures Act, Med-QUEST Division (MQD) is working towards the implementation of Electronic Visit Verification (EVV). In the federal fiscal year (FFY) 2021 Quarter 3 (Q3), MQD continued to collaborate with Arizona Health Care Cost Containment System (AHCCCS) towards implementation.

During this quarter, MQD continued the soft launch of EVV with the MCOs and provider agencies. Stakeholder communications and training continued through multiple methods.

MQD's future EVV work plans include: Monitoring of EVV utilization across the MCOs and provider agencies. Continual outreach activities are scheduled multiple times a month with MCOs and provider agencies to ensure full EVV utilization. The team will continue working with the IV&V provider to ensure the Medicaid Enterprise Certification Lifecycle requirements are met as well as ensuring a successful implementation and certification of the EVV solution.

APRIL

During the month of April 2021, achieved 97% EVV adoption and utilization across all Hawaii provider agencies. No new authorizations were approved or extended for the remaining 3% of provider agencies. Resolved a technical issue preventing self-directed members from logging in. Held multiple 1-on-1 provider agency review sessions to discuss EVV visit statuses. Met with the state's EVV Vendor Sandata to review change request requirements. Met with a provider agency to review initial EVV claims validation results. Identified remaining missing member in the EVV solution and resolved with the Member Eligibility team. Continued outreach by holding multiple DDD/Home Health/Home Care provider agency meetings and training sessions to review the EVV program.

MAY

During the month of May 2021, established a reporting process with the MCOs to monitor the claims validated against the EVV visits. Continued outreach by holding meetings with the MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV project deliverables and timelines. Aligning with the Open Model approach, Alternate EVV vendor meetings continued.

JUNE

During the month of June 2021, created a weekly DDD EVV Claims Validation Report that is sent to provider agencies calling out specific claim line items that are failing the soft-edit validation. Sandata fixed the Visit Verification Exception allowing agencies to acknowledge visit issues. This informs provider agencies about issues that need to be addressed with additional training. Created a report (CMS EVV KPI #3) in the Sandata reporting engine DOMO that indicates the percent of visits that reached a verified state automatically. The June results of auto verification achieved the benchmark of 85%. Determined the Hard Edit date needed to move from 7/1/21 to 9/1/21 due to technical issues encountered by the EVV vendor. The technical issue is related to the authorizations not loading and is a roadblock stopping the Hard Edit date from being implemented. An authorization establishes the relationship between the Provider, Member, and Service before a visit can reach a status that suffices as approval for EVV claim validation.

Clinical Care Guidelines

Work this quarter included issues related to appropriate coverage, care continuity, and COVID-19 public health emergency (PHE) concerns. MQD issued in June a third iterative memo to our contracted health plans (HPs), hospitals, and long term care providers clarifying and updating the definitions related to subacute facilities and level of care. The memo is a result of ongoing collaboration with stakeholder long term care facilities and the Healthcare Association of Hawai'i to ensure that beneficiaries are receiving care in the most appropriate setting and to address hospital waitlist issues.

To ensure continuity of care, MQD jumped into collaboration with our contracted HPs and the Hawai'i Department of Health (DOH) upon learning of the imminent shutdown this quarter of an assisted living facility where seventy percent of the affected residents were beneficiaries. MQD and partners ensured the timely and person-centered relocation of these individuals.

During this quarter and through the PHE, MQD continued to endorse the use of proper safety and infection-based precautions for beneficiaries receiving home and community-based services and residing in community care foster family homes (CCFFHs) by working with DOH and CCFFH caregiver associations to distribute another mass shipment of free personal protective equipment to all CCFFHs in Honolulu county, where the majority of CCFFHs are located. Planning is underway for distribution to CCFFHs in Hawai'i's other three counties: Hawai'i, Maui and Kaua'i.

MQD also recognized that even during the pandemic, certain flexibilities could begin unwinding to improve quality of care. A memo issued in April advised contracted HPs and their contracted community case management agencies that in-person services as required by contract shall resume – recognizing that at this point in time, with previously provided trainings and reinforcement of practicing effective infection precautions and the improved availability of PPE, health and safety concerns could satisfactorily be addressed while resuming in-person services. The memo is a culmination of the collaboration with our HPs throughout previous quarters.

Finally, another flexibility extended during the PHE was expanded telehealth coverage. In this quarter, MQD continued to allow telehealth coverage flexibilities while also continuing plans for post-pandemic telehealth policy.

MQD Workshops and Other Events

Focus:	National Center on Advancing Person-Centered Practices and Systems (NCAPPS): Stakeholders Engagement		
For:	**Self-advocates, Advisory, Councils, State Agencies, MCOs, and other Stakeholders**		
Speaker	NCAPPS SME Bob Sattler, SDA and Janis Tandora, Yale University	**Location**	Zoom
Length	3.5 hours	**Date**	June 18, 2021
Attendees	Approximately 40+		
Description	Developing a Road Map to a Person-Centered System Bringing the Systems Leaders of Hawaii together for an exciting opportunity to design an integrated road map to a Person-Centered Service and Support System across collaborating state agencies and health plans. A workday to improve opportunities to work together, see where we have alignment and where we must take a different path. This planning and visioning session is designed for decision makers of the system that can commit to taking the road map and make it a reality for Hawaii and must include people with lived experience. • Review of Common Values • Learning about the 9 Pillars of a Person-Centered System Overview • Introduction to the Participant Engagement Guide		

Focus:	LTC Eligibility and Disabled Adult Child (DAC)		
For:	**1915c I/DD Waiver Case Managers**		
Speaker	Aileen Manuel DHS/MQD	**Location**	Zoom
Length	1.0 hours	**Date**	June 22, 2021
Attendees	Approximately 15+		
Description	• Review of LTC eligibility • Identifying DAC • DAC case reviews • Learning how to assist the participants/families with DAC entitlement benefits.		

Focus:	National Center on Advancing Person-Centered Practices and Systems (NCAPPS): Stakeholders Engagement		
For:	**Office of Aging: Self-advocates, Advisory, and Councils**		
Speaker	NCAPPS SME Bob Sattler	**Location**	Zoom
Length	1.0 hours	**Date**	June 30, 2021
Attendees	Approximately 40+		
Description	• Introduction to NCAPPS • Review national core competencies		

	• Discuss core competency alignment to current processes and identify areas for improvement • Gather stakeholder input on core competencies

A. Attachments

Attachment A: QUEST Integration Dashboard for April 2021 – June 2021
The QUEST Integration Dashboard compiles monthly data submitted by the Health Plans to MQD, regarding enrollment, network providers, call center calls, medical claims, prior authorizations, non-emergency transports, grievances, appeals, and utilization.

Attachment B: Up-To-Date Budget Neutrality Summary
The Budget Neutrality Summary (worksheet) for the quarter ending 03/31/2021 is attached. The Budget Neutrality Summary for the quarter ending 06/31/2021 will be submitted by the 08/31/2021 deadline.

Attachment C: Budget Neutrality Workbook
The Budget Neutrality Workbook for the quarter ending 03/31/2021 is attached. The Budget Neutrality Workbook for the quarter ending 06/31/2021 will be submitted by the 08/31/2021 deadline.

B. MQD Contact(s)

Jon D. Fujii
Health Care Services Branch Administrator
601 Kamokila Blvd. Ste. 506A
Kapolei, HI 96707
808 692 8083 (phone), 808 692 8087 (fax)

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Apr-21 AlohaCare	Apr-21 HMSA	Apr-21 Kaiser	Apr-21 Ohana	Apr-21 UNITED	May-21 AlohaCare	May-21 HMSA	May-21 Kaiser	May-21 Ohana	May-21 UNITED	Jun-21 AlohaCare	Jun-21 HMSA	Jun-21 Kaiser	Jun-21 Ohana	Jun-21 UNITED
# Members															
Medicaid	71.537	190.641	43305	29203	###### ###	71.924	191.848	43680	29139	###### ###	72.515	193.125	44047	29216	###### ##
Duals	4.213	7.898	1999	9291	###### ###	4.273	8.108	2032	9292	###### ###	4.342	8.316	2096	9308	###### ##
Total	75.750	198.539	45304	38494	57.610	76.197	199.956	45712	38431	57.869	76.857	201.441	46143	38524	58.141
# Network Providers															
PCPs	891	1.095	209	798	848	887	1.088	204	799	845	888	1.078	214	800	861
PCPs - (accepting new members)	762	753	179	584	584	759	739	172	583	587	760	735	183	584	605
Specialists	2.880	3.138	548	1551	1.727	2.880	3.155	542	1551	1.728	2.890	3.166	538	1553	1.745
Specialists (accepting new members)	2.072	3.138	548	991	1.463	2.074	3.155	542	991	1.461	2.085	3.166	538	991	1.483
Behavioral Health	933	1.732	235	680	1.071	934	1.714	240	680	1.060	922	1.718	232	681	1.071
Behavioral Health (accepting new members)	855	1.732	235	619	1.031	856	1.714	240	619	1.020	848	1.718	232	619	1.029
Hospitals	25	26	14	24	23	25	26	14	24	23	25	26	14	24	22
LTSS Facilities (Hosp w/ NF unit/NF)	50	46	21	38	43	50	46	21	38	43	50	46	21	38	43
Residential Setting (CCFFH, E-ARCH, and ALF)	643	620	149	1054	1.192	637	619	156	1055	1.192	501	618	161	1055	1.193
HCBS Providers (except residential settings and LTSS facilities)	103	134	66	92	84	103	134	61	92	83	103	134	63	92	83
Ancillary & Other (All provider types not listed above, incl Phcy, Lab, Therapists, Hospice, HHA)	2.192	2.477	240	1788	1.849	2.213	2.459	233	1788	1.846	2.198	2.479	218	1788	1.864
Total # of providers	7.717	9.268	1482	6.025	6.837	7.729	9.241	1471	6.027	6.820	7.577	9.265	1461	6.031	6.882
Call Center															
# Member Calls	5.426	9.784	515	5.421	3.721	4.789	9.105	458	4732	3.223	4.918	9.667	472	5216	3.521
Avg. time until phone answered	0:00:21	0:00:43	0:00:08	0:00:26	0:00:18	0:00:36	0:00:27	0:00:07	0:00:31	0:00:24	0:00:17	0:00:17	0:00:09	0:00:25	0:00:06
Avg. time on phone with member	0:05:55	0:07:14	5:51	0:08:04	0:07:12	0:07:58	0:07:05	5:57	0:07:57	0:07:54	0:05:28	0:07:15	5:59	0:08:00	0:08:56
% of member calls abandoned (member hung up)	1.58%	3.72%	1%	3%	1.50%	1.25%	2.32%	1%	2%	2.10%	1.08%	1.66%	1%	2%	0.30%
# Provider Calls	6.377	5.325	68	3.252	1.921	5.801	4.935	77	2941	1.800	6.747	5.437	104	2742	1.820
Avg. time until phone answered	0:00:18	0:00:57	0:00:02	0:00:10	0:00:04	0:00:19	0:00:29	0:00:06	0:00:11	0:00:02	0:00:20	0:00:25	0:00:07	0:00:08	0:00:02
Avg. time on phone with provider	0:06:43	0:09:01	4:55	0:08:20	0:07:06	0:06:31	0:08:14	6:37	0:08:42	0:07:30	0:06:32	0:08:10	4:10	0:08:42	0:06:46
% of provider calls abandoned (provider hung up)	0.99%	4.24%	0%	1%	0.21%	1.52%	2.41%	0%	2%	0.44%	1.60%	1.89%	0%	1%	0.10%
Medical Claims- Electronic															
# Submitted, not able to get into system	2.293	3.274	0	2635	1.273	2.073	4.369	0	5288	4.895	2.193	2.323	0	2615	4.138
# Received	60.211	196.781	39559	54510	84.960	62.689	199.148	47533	110054	93.371	61.106	202.494	45197	52887	87.869
# Paid	54.183	199.293	35875	44431	79.706	54.284	175.316	41941	94478	88.899	65.599	168.855	41976	46173	72.052
# In Process	12.208	58.567	2476	14308	14.098	15.908	67.633	4268	26754	4.567	5.539	88.047	2033	11606	10.315
# Denied	4.843	17.103	1208	7969	11.716	4.351	14.766	1324	19422	14.417	5.478	13.225	1188	9331	11.145
Avg time for processing claim in days	6	9	2	7	7	5	10	2	6.3	7	5	10	2	6.3	7
% of electronic claims processed in 30 days	98%	97%	99.92	100%	100	99%	97%	99.96	100%	100	99%	97%	99.95	100%	100
% of electronic claims processed in 90 days	100%	100%	100	100%	100	100%	100%	100	100%	100	100%	100%	100	100%	100
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	120	1.066	1	114	40	187	953	5	188	863	164	1.004	7	160	508
# Received	14.701	17.328	28	3758	6.548	13.879	15.933	24	6072	7.429	14.348	18.021	30	3329	8.324
# Paid	10.681	15.525	7	2774	7.600	12.108	16.018	9	4353	6.756	15.108	12.254	6	2517	6.381
# In Process	7.436	15.180	3	1445	959	6.781	12.603	1	2362	884	3.075	16.279	0	1418	1.384
# Denied	2.341	2.811	18	931	2.023	2.384	2.492	14	1501	1.694	2.781	2.091	24	894	1.980
Avg time for processing claim in days	13	24	6	11.65	6	12	23	13	11	6	12	24	3	11.5	6
% of electronic claims processed in 30 days	97%	88%	100.00	100%	100	97%	90%	95.65	100%	100	97%	89%	96.67	100%	100
% of electronic claims processed in 90 days	99%	99%	100.00	100%	100	99%	99%	100.00	100%	100	99%	97%	100.00	100%	100
Prior Authorization (PA)- Electronic															
# Received	302	3144	818	436	1.042	266	3186	659	444	877	298	2936	790	839	876
# In Process	57	638	15	384	0	38	591	37	364	0	33	326	18	779	0
# Approved	236	2.763	791	451	939	218	2.896	603	401	791	248	2.832	750	841	767
# Denied	78	278	12	23	103	88	337	19	16	86	72	369	22	10	109
Avg time for PA in days	0	5	3	5	2	0	4	3	5	1	0	5	3	7	1
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1.675	480	0	900	1.180	1.547	412	0	779	1.097	1.662	498	0	865	1.133
# In Process	299	14	0	795	0	254	30	0	655	0	283	20	0	796	0
# Approved	1.273	463	0	873	1.065	1.207	371	0	739	990	1.303	479	0	825	1.036
# Denied	203	33	0	29	115	153	24	0	21	107	197	29	0	30	97
Avg time for PA in days	1	5	0	4	2	1	4	0	4	0	1	3	0	5	2
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	1.419	5.133	619	4003	8.599	1.829	5.051	552	3824	8.280	1.624	5.606	547	4038	8.584
Air (by segment)	444	811	188	279	309	453	838	211	287	315	449	1.000	190	252	361
Public Transportation Pass (bus pass & handivan coupons)	357	1.134	152	1310	984	499	1.011	626	1333	961	428	1.128	518	1258	976
# Member Grievances															
# Received	64	11	38	22	15	24	19	22	30	36	37	12	32	37	41
# Resolved	64	13	23	4	28	34	12	34	11	20	29	18	31	14	43
# Outstanding	34	10	28	114	9	24	17	16	133	25	32	11	23	156	23
# Provider Grievances															
# Received	119	4	81	0	0	130	3	66	0	1	126	4	45	0	2
# Resolved	131	3	68	0	0	117	2	64	0	1	101	3	43	0	0
# Outstanding	39	5	13	0	0	52	6	2	0	0	77	7	2	0	2
# Member Appeals															
# Received	2	74	0	3	22	4	53	0	7	9	5	93	0	6	14
# Resolved	3	71	1	3	13	4	48	0	4	18	4	79	0	6	14
# Outstanding	2	20	0	2	11	2	25	0	5	2	3	39	0	1	2
# Provider Appeals															
# Received	7	14	0	64	48	4	14	0	74	33	10	18	0	126	27
# Resolved	5	24	0	35	56	1	10	0	88	35	5	14	0	2	35
# Outstanding	2	24	0	55	35	5	28	0	2	33	10	32	0	0	25
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	58	78	3	82	46	62	75	4	92	50	67	74	4	77	45
Inpatient Acute Days * (A) - per 1,000	290	259	26	533	363	338	252	29	698	389	373	244	21	466	320
Readmissions within 30 days* (A)	37	195	22	52	15	75	165	28	41	21	50	168	22	38	27
ED Visits * (C) - per 1,000**	383	139	23	492	414	392	112	26	468	424		175	25		
# Prescriptions (C) - per 1,000	6.727	8.849	502	10.131	8.754	6.298	8.754	467	9.960	8.555	6.693	8.837	494	10.188	8.705
Waitlisted Days * (A) - per 1,000	41	4	1	24	99	36	4	1	9	110	33	5	0	2	131
NF Admits * (A)	37	18	7	8	33	39	4	6	8	33	44	21	2	12	33
# Members in NF (non-Medicare paid days) (C)**	234	338	100	602	633	225	337	95	562	648		345	n/a		
# Members in HCBS **(C)- note: member can be included in more than one category listed below	221	298	224	1842	1602	200	295	235	1820	1641		293	n/a		
# Members in Residential Setting **(C)	136	154	106	489	847	134	154	111	462	843		147	n/a		
# Members in Self-Direction **(C)	75	108	63	640	296	76	106	65	652	296		101	n/a		
# Members receiving other HCBS **(C)	88	109	161	1202	1306	66	102	170	1168	1345		91	n/a		
# Members in At-Risk ** (C)	867	979	154	853	1275	878	971	155	846	1269		979	n/a		
# Members in Self-Direction **(C)	317	368	37	349	424	321	371	39	342	434		390	n/a		
# Members receiving other HCBS **(C)	335	777	117	455	851	343	775	116	441	835		753	n/a		

Jul-21 AlohaCare	Jul-21 HMSA	Jul-21 Kaiser	Jul-21 Ohana	Jul-21 UNITED	Aug-21 AlohaCare	Aug-21 HMSA	Aug-21 Kaiser	Aug-21 Ohana	Aug-21 UNITED	Sep-21 AlohaCare	Sep-21 HMSA	Sep-21 Kaiser	Sep-21 Ohana	Sep-21 UNITED

Oct-21 AlohaCare	Oct-21 HMSA	Oct-21 Kaiser	Oct-21 Ohana	Oct-21 UNITED	Nov-21 AlohaCare	Nov-21 HMSA	Nov-21 Kaiser	Nov-21 Ohana	Nov-21 UNITED	Dec-21 AlohaCare	Dec-21 HMSA	Dec-21 Kaiser	Dec-21 Ohana	Dec-21 UNITED

(* non-Medicare) (**lag in data of two months)

Legend:
ALF= Assisted Living Facilities
CCFFH= Community Care Foster Family Homes
E-ARCH= Expanded Adult Residential Care Homes
ED= Emergency Department
FQHC= Federal Qualified Health Center
HCBS= Home and Community Based Services
HHA= Home Health Agencies
Hosp= Hospital
LTSS= Long-Term Services and Supports
NF=Nursing Facility

Other HCBS at-risk= Adult Day Care, Adult Day Health, Home Delivered Meals, Personal Care, Personal Emergency Response System, and Skilled Nursing.

PCP= Primary Care Provider
QI= QUEST Integration
Residential setting= CCFFH, ARCH/E-ARCH, and ALF

CMS 1500- physicians, HCBS providers eg.case management agencies, CCFFH/EARCH/ALF, home care agencies , etc.
CMS UB04- nursing facilities, FQHC, hospitals

Many health plans report utilization or frequency of services on a Per 1000 members basis. This allows for a consistent statistical comparison across health plans and time periods. It is the use or occurrence (of a service, procedure, or benefit) for every 1,000 members on an annualized basis. This enables health plans of different sizes to be compared and to compare different time periods (by annualizing). An example would be "80 hospital admissions per thousand members." This means that for every 1,000 members 80 are admitted to a hospital every year, so a health plan with 100,000 members would have 8,000 admissions in one year.

QUEST Integration Health Plan Demographic Information by Island

as of: 6/30/2021

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	512	79	26	13	66	89	103	888
PCPs - (accepting new members)	**432**	**69**	**23**	**11**	**55**	**77**	**93**	**760**
Specialists*	2122	289	6	0	181	88	204	2890
members)	**1548**	**184**	**4**	**0**	**126**	**65**	**158**	**2085**
Behavioral Health*	577	128	11	3	46	85	72	922
Behavioral Health (accepting new members)	**526**	**119**	**11**	**3**	**43**	**80**	**66**	**848**
Hospitals	12	2	1	1	3	1	5	25
LTSS Facilities (Hosp./NF)	29	3	0	1	7	6	4	50
Residential Setting (CCFFH, E-ARCH, and ALF)	420	22	1	0	6	37	15	501
HCBS Providers (except residential settings and LTSS facilities)	45	19	5	3	8	17	6	103
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1496	237	25	14	147	136	143	2198
Totals	**5213**	**779**	**75**	**35**	**464**	**459**	**552**	**7577**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	43698	9471	2337	502	6382	7333	7134	**76857**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	85	120	90	39	97	82	69	87

Note: RFP requirement is 300 members for every PCP

HMSA

	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	696	89	11	15	67	102	108	1,088
PCPs - (accepting new members)	444	64	9	10	47	76	89	**739**
Specialists*	1,891	321	49	44	189	334	327	3,155
members)	**1,891**	**321**	**49**	**44**	**189**	**334**	**327**	**3,155**
Behavioral Health*	1,074	205	6	5	95	190	139	1,714
Behavioral Health (accepting new members)	**1,074**	**205**	**6**	**5**	**95**	**190**	**139**	**1,714**
Hospitals	13	2	1	1	3	1	5	26
LTSS Facilities (Hosp./NF)	28	2	1	0	5	5	5	46
Residential Setting (CCFFH, E-ARCH, and ALF)	489	32	1	0	12	63	22	619
HCBS Providers (except residential settings and LTSS facilities)	56	17	9	7	12	22	11	134
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,636	256	21	12	148	168	218	2,459
Totals	**5.883**	**924**	**99**	**84**	**531**	**885**	**835**	**9.241**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	118546	15028	973	207	13639	30370	21193	**199,956**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	170	169	88	14	204	298	196	184

Note: RFP requirement is 300 members for every PCP

KAISER

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	153	61						214
PCPs - (accepting new members)	132	51						**183**
Specialists*	446	92						538
members)	446	92						**538**
Behavioral Health*	192	40						232
Behavioral Health (accepting new members)	192	40						**232**
Hospitals	12	2						14
LTSS Facilities (Hosp./NF)	20	1						21
Residential Setting (CCFFH, E-ARCH, and ALF)	145	16						161
HCBS Providers (except residential settings and LTSS facilities)	51	12						63
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	155	63						218
Totals	**1174**	**287**	**0**	**0**	**0**	**0**	**0**	**1461**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	30609	15534						**46143**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	200	255	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	216

Note: RFP requirement is 300 members for every PCP

OHANA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	541	55	8	10	70	78	38	800
PCPs - (accepting new members)	402	34	8	10	58	42	30	**584**
Specialists*	1170	108	13	4	113	76	69	1553
members)	706	88	13	4	53	66	61	**991**
Behavioral Health*	475	50	4	0	34	74	44	681
Behavioral Health (accepting new members)	440	34	3	0	34	68	40	**619**
Hospitals	11	2	1	1	3	1	5	24
LTSS Facilities (Hosp./NF)	23	3	1	1	5	2	3	38
Residential Setting (CCFFH, E-ARCH, and ALF)	885	41	0	0	18	86	25	1055
HCBS Providers (except residential settings and LTSS facilities)	51	8	2	0	4	21	6	92
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1128	180	15	6	131	172	156	1788
Totals	**4284**	**447**	**44**	**22**	**378**	**510**	**346**	**6031**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	23949	3906	402	100	2178	4808	3181	**38524**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	44	71	50	10	31	62	84	48

Note: RFP requirement is 300 members for every PCP

UNITED HEALTHCARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	581	70	12	6	67	89	68	893
PCPs - (accepting new members)	415	40	7	6	60	50	50	**628**
Specialists*	1350	172	66	11	117	234	194	2.144
members)	1110	156	48	11	109	217	178	**1,829**
Behavioral Health*	771	240	62	63	174	234	201	1.745
Behavioral Health (accepting new members)	742	234	62	63	170	230	197	**1,698**
Hospitals	9	2	1	1	3	3	3	22
LTSS Facilities (Hosp./NF)	27	3		1	5	6	1	43
Residential Setting (CCFFH, E-ARCH, and ALF)	983	53	1		23	110	23	1,193
HCBS Providers (except residential settings and LTSS facilities)	47	12	1		8	18	6	92
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1351	249	16	17	143	190	161	2,127
Totals	**5.119**	**801**	**159**	**99**	**540**	**884**	**657**	**8.259**

* A provider may be counted once per island that they provide services.

# Members by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members	37,837	5,017	281	109	3,269	7,485	4,143	**58.141**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	65	72	23	18	49	84	61	65

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls as of: 6/30/2021

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	75	9	2	0	4	6	2	**98**
Network (provider look up, access)	83	13	1	2	11	12	1	**123**
Primary Care Physician Assignment or Change	238	18	4	2	9	35	11	**317**
NEMT (inquiry, scheduling) *-monthly report*	1332	101	58	24	39	309	81	**1944**
Authorization/Notification (prior auth status)	483	25	3	0	10	44	12	**577**
Eligibility (general plan eligiblity, change request)	745	47	2	4	16	40	17	**871**
Benefits (coverage inquiry)	250	35	2	1	7	34	12	**341**
Enrollment (ID card request, update member information)		14	2	0	0	1	3	**2**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	251	14	0	0	4	14	6	**289**
Billing/Payment/Claims	481	18	0	4	14	24	10	**551**
Appeals	7	0	0	0	0	1	2	**10**
Complaints and Grievances	7	3	0	0	0	2	0	**12**
Other	267	37	2	1	18	36	20	**381**
Totals	**4,219**	**334**	**76**	**38**	**132**	**558**	**177**	**5,516**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	13	4	0	0	1	1	5	24
Network (provider look up, access)	146	16	0	0	10	30	20	222
Primary Care Physician Assignment or Change	1375	161	4	8	166	226	242	2182
NEMT (inquiry, scheduling) *-monthly report*	447	132	61	11	116	395	289	1451
Authorization/Notification (prior auth status)	57	13	0	0	5	29	10	114
Eligibility (general plan eligiblity, change request)	252	40	1	0	38	57	45	433
Benefits (coverage inquiry)	258	56	3	2	35	45	44	443
Enrollment (ID card request, update member information)	854	112	5	1	55	232	136	1395
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	54	8	0	0	4	18	7	91
Billing/Payment/Claims	248	39	0	0	31	33	39	390
Appeals	1	0	0	0	0	1	1	3
Complaints and Grievances	11	1	0	0	0	2	1	15
Other	610	125	10	5	74	181	126	1131
Totals	**4326**	**707**	**84**	**27**	**535**	**1250**	**965**	**7894**

KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	0	0						**0**
Network (provider look up, access)	41	7						**48**
Primary Care Physician Assignment or Change	1	0						**1**
NEMT (inquiry, scheduling) *-monthly report*	0	0						**0**
Authorization/Notification (prior auth status)	0	0						**0**
Eligibility (general plan eligiblity, change request)	106	26						**132**
Benefits (coverage inquiry)	220	54						**274**
Enrollment (ID card request, update member information)	0	0						**0**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	0	0						**0**
Appeals	0	0						**0**
Complaints and Grievances	1	0						**1**
Other	99	21						**120**
Totals	**468**	**108**	**0**	**0**	**0**	**0**	**0**	**576**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	200	42	2	0	11	60	14	**329**
Network (provider look up, access)	43	6	1	0	2	11	3	**66**
Primary Care Physician Assignment or Change	77	11	2	0	2	10	6	**108**
NEMT (inquiry, scheduling) *-monthly report*	1652	256	28	7	32	484	168	**2627**
Authorization/Notification (prior auth status)	12	10	1	5	4	22	8	**62**
Eligibility (general plan eligiblity, change request)	42	7	0	0	1	9	2	**61**
Benefits (coverage inquiry)	188	31	4	1	11	38	15	**288**
Enrollment (ID card request, update member information)	224	36	7	0	12	63	16	**358**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	113	19	3	0	8	40	10	**193**
Billing/Payment/Claims	21	5	0	0	1	6	4	**37**

	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Appeals	8	1	0	0	0	1	4	**14**
Complaints and Grievances	11	2	0	0	7	2	3	**25**
Other	1033	187	20	5	44	243	89	**1621**
Totals	**3,624**	**613**	**68**	**18**	**135**	**989**	**342**	**5,789**

UNITED HEALTHCARE

Summary of Calls by Island	**Oahu**	**Maui**	**Molokai**	**Lanai**	**Kauai**	**East Hawaii**	**West Hawaii**	**Totals**
Pharmacy - (claim, coverage, access)	153	16	1	3	8	19	18	**218**
Network (provider look up, access)	86	19	3	0	3	20	7	**138**
Primary Care Physician Assignment or Change	0	0	0	0	0	1	1	**2**
NEMT (inquiry, scheduling) *-monthly report*	99	14	5	3	7	23	11	**162**
Authorization/Notification (prior auth status)	17	9	0	0	4	22	4	**56**
Eligibility (general plan eligiblity, change request)	371	62	1	0	20	65	49	**568**
Benefits (coverage inquiry)	555	69	3	6	39	92	43	**807**
Enrollment (ID card request, update member information)	122	27	1	1	8	17	26	**202**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	105	14	0	1	9	31	12	**172**
Billing/Payment/Claims	15	3	0	0	1	2	0	**21**
Appeals	11	2	0	0	1	3	1	**18**
Complaints and Grievances	12	1	0	0	0	0	0	**13**
Other	1039	156	6	2	83	197	88	**1571**
Totals	**2,585**	**392**	**20**	**16**	**183**	**492**	**260**	**3,948**

Health plan shall highlight changes made for the previous month(s)	
# Members	Description of Information to Include
Medicaid	Number of members receiving QI benefit package who do not have Medicare primary
Duals	Number of members receiving dual benefits
Total	Total number of members
# Network Providers	**Providers count on the "Dashboard" sheet should be un-duplicated. The providers counts on the "HP Demographics by Island" sheet may be duplicated when an individual provider serves multiple islands. Providers such as pharmacy services may be counted based upon number of locations. Non-Hawaii based network providers shall be excluded from all counts.**
PCPs	PCP count includes PCPs in the clinics. Utilize the definition provided on the Report Tool
PCPs - (accepting new members)	Number of PCPs (includes PCPs in clinics) accepting new members
Specialists	All specialists as defined in Section 40.220
Specialists (accepting new members)	Number of Specialists accepting new members
Behavioral Health	All behavioral health providers as defined in Section 40.220
Behavioral Health (accepting new members)	Number of Behavioral Health providers accepting new members
Hospitals	All hospitals
LTSS Facilities (Hosp./NF)	All facilities that have residents receiving LTSS (both hospital-based and free-standing nursing facilities)
Residential Setting (CCFFH, E-ARCH, and ALF)	All residential settings (CCFFH, E-ARCH, and ALF)
HCBS Providers (except residential settings and LTSS facilities)	All other HCBS providers as defined in Section 40.220 excluding those that are residential settings of LTSS facilities
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	All ancillary providers to include pharmacies, laboratories, therapists, hospice, home health agencies.
Total # of providers	Total of all providers listed
	Note: all providers in the QI network should be included. There should be no duplication of provider counts per category. If type is not listed, add provider type to the "Ancillary & Other" section.
Call Center	
# Member Calls	# of calls received from members
Avg. time until phone answered	Average time until phone was answered in seconds
Avg. time on phone with member	Average time on the phone with member in minutes and seconds
% of member calls abandoned (member hung up)	Percent of member calls abandoned
# Provider Calls	# of calls received from providers
Avg. time until phone answered	Average time until phone was answered in seconds
Avg. time on phone with provider	Average time on the phone with provider in minutes and seconds
% of provider calls abandoned (provider hung up)	Percent of provider calls abandoned
Medical Claims- Electronic	**Note: (1) A " Processed claim" is a QI claim (not based on # of items/lines in the claim) that "PAID" or "DENIED" in the reporting period. Health plan shall determine how a claim is considered "PAID" or "DENIED". (2) When a single claim that has multiple RECEIVED/PAID/DENIED dates, health plan should use the LAST DATE that the final "PAID" or "DENIED" item/line is made for the 30/90 days calculation because this will be a "completely" processed claim.**
# Submitted, not able to get into system	# of claims submitted that do not get into the system
# Received	# of claims received in the month
# Paid	# of claims paid in the month
# In Process	# of claims in process at the end of the month
# Denied	# of claims denied in the month
Avg time for processing paid claim in days	Average time it took to process paid claims in days
% of claims processed in 30 days	% of electronic claims processed in 30 days
% of claims processed in 90 days	% of electronic claims processed in 90 days
(month to date)	
Medical Claims- Paper	
# Submitted, not able to get into system	# of claims submitted that do not get into the system
# Received	# of claims received in the month
# Paid	# of claims paid in the month

Measure	Definition
# In Process	# of claims in process at the end of the month
# Denied	# of claims denied in the month
Avg time for processing paid claim in days	Average time it took to process paid claims in days
% of claims processed in 30 days	% of paper claims processed in 30 days
% of claims processed in 90 days	% of paper claims processed in 90 days
(month-to-date)	
Prior Authorization (PA)- Electronic	
# Received	# of PAs received in the month
# In Process	# of PAs in process in the month
# Approved	# of PAs approved in the month
# Denied	# of PAs denied in the month
Avg time for PA in days	Average time it took to process PAs in days
(month to date)	
Prior Authorization (PA)- Paper and Telephone	
# Received	# of PAs received in the month
# In Process	# of PAs in process in the month
# Approved	# of PAs approved in the month
# Denied	# of PAs denied in the month
Avg time for PA in days	Average time it took to process PAs in days
(month-to-date)	
# Non-Emergency Transports	
Ground (# of round trips)	# of ground trips for non-emergency transports. A roundtrip is counted as one (i.e., to MD appointment and home is one (1) trip not two (2) trips)
Air (by segment)	# of air trips (by segment) for non-emergency transports i.e. fly from Maui to HNL and back count as 2 segments
Public Transportation Pass (bus pass & handivan coupons)	# of bus passes or handivan coupons issued
# Member Grievances	
# Received	# of member grievances received in the month
# Resolved	# of member grievances resolved in the month
# Outstanding	# of outstanding member grievances at the end of the month Note: The number of member grievances outstanding in this month is the number of member grievances outstanding in the prior month plus the number of member grievances received in this month minus the number of member grievances resolved in this month.
# Provider Grievances	
# Received	# of provider grievances received in the month
# Resolved	# of provider grievances resolved in the month
# Outstanding	# of outstanding provider grievances at the end of the month Note: The number of provider grievances outstanding in this month is the number of provider grievances outstanding in the prior month plus the number of provider grievances received in this month minus the number of provider grievances resolved in this month.
# Member Appeals	
# Received	# of member appeals received in the month
# Resolved	# of member appeals resolved in the month
# Outstanding	# of outstanding member appeals at the end of the month Note: The number of member appeals outstanding in this month is the number of member appeals outstanding in the prior month plus the number of member appeals received in this month minus the number of member appeals resolved in this month.
# Provider Appeals	
# Received	# of provider appeals received in the month
# Resolved	# of provider appeals resolved in the month
# Outstanding	# of outstanding provider appeals at the end of the month Note: The number of provider appeals outstanding in this month is the number of provider appeals outstanding in the prior month plus the number of provider appeals received in this month minus the number of provider appeals resolved in this month.
Utilization - based on Auth (A) or Claims (C)	
Inpatient Acute Admits * (A) - per 1,000	# of inpatient acute admits (based on authorizations) in the month per 1,000 members

Inpatient Acute Days * (A) - per 1,000	# of inpatient acute days (based on authorizations) in the month per 1,000 members
Readmissions within 30 days* (A)	# of readmissions within thirty (30) days in the month based upon authorizations
ED Visits* (C) - per 1,000**	# of ER visits in the previous month (based upon claims) per 1,000. For example, if reporting is on September 15th for August, provide data for July ER visits.
# Prescriptions (C) - per 1,000	# of prescriptions in the month (based upon claims) per 1,000 members
Waitlisted Days* (A) - per 1,000	# of waitlisted days in the month (based upon authorizations) per 1,000 members
NF Admits * (A)	Authorized Non-Medicare nursing facility admissions
# Members in NF (non-Medicare paid days)**(C)	Non-Medicare paid days (claims based)
# Members in HCBS **(C)	# of members in HCBS (exclúdes members in at-risk) in the month (based upon claims). Member can be included in more than one category listed below. Note: (1) The listing of HCPCS codes listed on the LTSS Report (Tab D. Auth by Service Code) shall be used to determine those HCPCS codes categorized as 'HCBS' (2) The # of members in HCBS (C) will be based solely on paid claims during the reporting period. This determination will be made irrespective of the member's "1148" status/facility code (e.g. "299")
# Members in Residential Setting **(C)	# of HCBS members in Residential Setting (based upon claims). Note: Based solely on paid claims against HCPCS S5140, T2033 and T2031.
# Members in Self-Direction **(C)	# of HCBS members in Self-Direction (based upon claims)
# Members receiving other HCBS **(C)	# of HCBS members receiving other HCBS servcies (based upon claims) as defined in Section 40.740.3
# Members in At-risk**(C)	# of members in At-risk in the month (based upon claims). Note: The population of At-risk members will be based on a member having an active "at-risk" coded 1147 (i.e. Level of Care Approval Status = 11). Only those with paid claims against HCBS codes noted above shall be included.
# Members in Self-Direction ** (C)	# of At-risk members in Self-Direction in the month (based upon claims)
# Members receiving other HCBS** (C)	# of At-risk members receiving other HCBS services (based upon claims)
	Note: Non-Medicare is for acute, ED, and prescriptions. Health plans should report on acute waitlisted, Medicaid primary NF, and all HCBS (even if these individuals are duals).

(*Non-Medicare) (**lag in data of two months)

Legend:
ALF= Assisted Living Facilities
CCFFH= Community Care Foster Family Homes
E-ARCH= Expanded Adult Residential Care Homes
ED= Emergency Department
FQHC= Federal Qualified Health Center
HCBS= Home and Community Based Services
HHA= Home Health Agencies
Hosp= Hospital
LTSS= Long-Term Services and Supports
NF=Nursing Facility
Other HCBS at-risk= Adult Day Care, Adult Day Health, Home Delivered Meals, Personal Care, Personal Emergency Response System, and Skilled Nursing.
PCP= Primary Care Provider
QI= QUEST Integration
Residential setting= CCFFH, ARCH/E-ARCH, and ALF

Attachment B

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	26
Budget Neutrality Reporting End DY	30

Actuals + Projected

Without-Waiver Total Expenditures

			26	27	28	29	30	Total
Medicaid Per Capita								
EG 1 - Children	1	**Total**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		PMPM	$448.48	$452.96	$457.49	$462.07	$466.69	
		Mem-Mon	1,402,624	1,584,774	1,624,394	1,665,004	1,706,629	
EG 2 - Adults	2	**Total**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		PMPM	$925.47	$959.72	$995.23	$1,032.05	$1,070.24	
		Mem-Mon	420,331	514,393	527,253	540,435	553,945	
EG 3 - Aged	3	**Total**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		PMPM	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66	
		Mem-Mon	339,459	332,843	336,172	339,533	342,929	
EG 4 – Blind/Disabled	4	**Total**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		PMPM	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25	
		Mem-Mon	285,411	319,294	322,487	325,712	328,969	
TOTAL			**$ 2,431,735,669**	**$ 2,761,178,875**	**$ 2,895,171,196**	**$ 3,035,941,601**	**$ 3,183,838,560**	**$ 14,307,865,902**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 397,553,231	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,559,343,894
EG 2 - Adults	2		$ 168,737,450	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,182,305,177
EG 3 - Aged	3		$ 398,923,394	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,193,860,672
EG 4 – Blind/Disabled	4		$ 479,051,292	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,171,315,967
TOTAL			**$ 1,444,265,366**	**$ 1,647,483,576**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,526,353,551**

Savings Phase-Down

Medicaid Per Capita			26	27	28	29	30	TOTAL
		Savings Phase-Down						
EG 1 - Children	1	**Without Waiver**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		With Waiver	$ 397,553,231	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 231,495,581	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 173,621,685	$ 236,014,446	$ 244,334,666	$ 252,953,883	$ 261,869,576	
		Savings Phase-Down						
EG 2 - Adults	2	**Without Waiver**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		With Waiver	$ 168,737,450	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 220,266,281	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 165,199,710	$ 206,452,113	$ 219,443,384	$ 233,250,960	$ 247,929,298	
		Savings Phase-Down						
EG 3 - Aged	3	**Without Waiver**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		With Waiver	$ 398,923,394	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 259,345,315	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 194,508,987	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ 193,054,616	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 479,051,292	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 276,363,127	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 207,272,345	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 740,602,727**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,336,134,264**

			26	27	28	29	30	Total
BASE VARIANCE			**$ 246,867,576**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,445,378,088**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								**$ 1,445,378,088**

Cumulative Target Limit

			26	27	28	29	30	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 1,691,132,942	$ 3,617,040,343	$ 5,635,956,498	$ 7,752,550,357	$ 9,971,731,639	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,822,659	$ 54,255,605	$ 56,359,565	$ 38,762,752	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (246,867,576)	$ (525,291,401)	$ (817,376,414)	$ (1,123,825,662)	$ (1,445,378,088)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1	**Total**	$ 1,269,833,094	$ 1,473,435,080	$ 1,582,760,393	$ 1,700,212,480	$ 1,826,368,919	
		PMPM	$899.37	$942.54	$987.78	$1,035.20	$1,084.89	
		Mem-Mon	1,411,914	1,563,260	1,602,341	1,642,400	1,683,460	
TOTAL			**$1,269,833,094**	**$1,473,435,080**	**$1,582,760,393**	**$1,700,212,480**	**$1,826,368,919**	**$7,852,609,967**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1		$648,239,510	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 648,239,510**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,338,459,437**
HYPOTHETICALS VARIANCE 1			**$ 621,593,584**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,514,150,530**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ -	$ 1,565,282	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon		1,261	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 1,565,282**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 17,850,382**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ -	$ 1,523,155	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ -**	**$ 1,523,155**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 17,368,379**
HYPOTHETICALS VARIANCE 2			**$ -**	**$ 42,126**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 482,003**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1	**Total**	$ -	$ 4,268,958	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon		1,261	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 4,268,958**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 48,682,806**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ -	$ 4,154,060	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ -**	**$ 4,154,060**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 47,368,306**
HYPOTHETICALS VARIANCE 3			**$ -**	**$ 114,897**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,314,500**

PRA Disclosure Statement

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Budget neutrality is a Federal policy that governs the Federal expenditures for1115 demonstrations. It is assured by placing an upper limit on the amount of Federal Financial Participation (FFP) the state can receive during the demonstration. The upper limit represents what the state could have received in the absence of the 1115 demonstration.

The Budget Neutrality workbook will assist in collecting standardized data in order to determine financial performance for the demonstration in terms of budget neutrality.

The workbook has two major groups of tabs: the first group collects and calculates Without Waiver (WOW) numbers, and the second group calculates With Waiver (WW) numbers. Data is collected per each demonstration Medicaid Eligibility Group (MEG), by demonstration year (DY). A Medicaid section 1115 demonstration is considered budget neutral if the Federal title XIX match, or funding received by the state (i.e., "with waiver" expenditures) do not exceed what the state would have (or could have) received without the demonstration (i.e., "without waiver" expenditures). The workbook provides the ability to evaluate any variance between WW and WOW calculations.

The workbook consists of 15 tabs which contain different types of data and calculations. The following color schema is applied to the tabs:

Blue	Information populated in the Budget Neutrality workbook template based on the demonstration's approved STC
Red	Information populated by states on a quarterly basis or per the reporting requirements defined in the STC
Green	Information automatically populated based on the input from other worksheets

Note: Overview and Dropdowns tabs are read-only, no data entry is required. The Dropdowns tab displays the values used to build the dropdowns menus thoroughout the workbook, including the list of active waivers for the demonstration.

Data Entry — Within the tabs where a State User populates information (C Report, Total Adjustments, WW Spending Projected, MemMon Actual, MemMon Projected, and Summary TC tabs), yellow highlighted cells denote where data entry may be needed (depending on DY being updated).

Pre-populated values in the downloaded Budget Neutrality workbook template

The original workbook entries are based on the STCs and other demonstration approval documentation. These entries are made on the DY Def, MEG Def, WOW PMPM & Agg, Program Spending Limits, and Summary TC tab (Phase-Down Percentage and Cumulative Target Percentage fields).

The MEG Def tab defines MEGs as Medicaid populations (core demonstration populations), Hypothetical populations (when a demonstration has separate budget neutrality agreements) and Tracking Only populations (for example, "pass-through" populations). The MEG Def tab also defines how expenditure numbers are calculated for a MEG (Per Capita vs. Aggregate) and the applicable scenarios (WOW, WW, or both). Also, the tab contains indicators defining MEG characteristics such as expenditure caps or applicability of savings phase-down calculations.

Calculating With Waiver (WW) numbers

WW numbers for each active DY of a demonstration are calculated based on a combination of actual WW expenditures, projected future expenditures, and any adjustments entered by a State User. The actual WW expenditures are copied from the Schedule C of the MBES CMS-64 report to the workbook (C Report tab). These numbers are automatically transferred to the C Report Grouper tab, where waiver expenditures are grouped by MEGs. The numbers are also transferred to the WW Spending Actual tab, which factors in adjustments entered on the Total Adjustments tab to calculate total actual WW expenditures. The WW Spending Total tab displays the actual WW expenditures plus future projected expenditures (transferred from the WW Spending Projected tab). Finally, the total WW actual and projected numbers are transferred to the Summary TC (Total Computable) tab (into the With-Waiver Total Expenditures section).

Calculating Without Waiver (WOW) numbers

WOW numbers can be obtained either one of two ways: using Aggregate or Per Capita calculations. If total projected expenditures for a MEG is known and the expenditure calculation type is defined as 'Aggregate' on the MEG Def tab, the total projected expenditure amount is entered for each active DY. However, if the expenditure calculation type is defined as 'Per Capita', total projected expenditures are derived by multiplying per member per month (PMPM) costs by the actual number of member months.

Both Aggregate and PMPM numbers are populated on the WOW PMPM & Agg tab. The number of actual member months (number of beneficiaries times the number of months enrolled) are entered by a State User on the MemMon Actual tab for each DY. On the MemMon Projected tab, State User enters projected numbers. The totals for actual and projected member months are calculated on the MemMon Total tab. WOW aggregate, PMPM and member month data is then moved to the the Without-Waiver Total Expenditures section of the Summary TC tab, where final calculations are performed.

Based on information from all tabs, the WW and WOW numbers are compared to determine the budget neutrality status of the demonstration.

Below are the definitions for the tabs of the workbook which require data entries from State User.

On top of the C Report tab, enter data in the following highlighted cells:

'Data Pulled On:' - enter the date the source file used to enter data on this tab was pulled
'For the Time Period Through :' - enter the date through which the source file data was pulled
Reporting DY' - enter the Demonstration Year (DY) for which data is being reported. Entered DY value must align with DYs from the DY Def tab.
Reporting Quarter' - enter a number of the quarter (values 1 through 4) for which data is being reported.

Notes:
- Dates must be entered in the following format: mm/dd/yyyy
- Reporting DY and Reporting Quarter entries affect which portion of the 'Medicaid Aggregate' and 'Medicaid Aggregate - WOW only' amounts for a DY will be calculated as Actuals, and which will be calculated as Projected
- Entry for each of these four fields is required for the workbook submission. If any field is not populated, you will receive an error and the document will not be uploaded to the system.

State User enters information on the following tabs:

C Report Tab

Open Schedule C of the CMS 64 Expenditure Report. Under your state, locate expenditure data for the specific demonstration.
From this location on the CMS 64 Expenditure Report, copy expenditure data cells for all DYs (active and non-active). On the C Report tab, paste the data into the correct cell/row. Repeat the copy and paste process for MAP Waivers section (Total Computable and Federal Share) and ADM Waivers section (if applicable). Verify that the pasted numbers are correctly aligned with the Waiver Name values.

Total Adjustments tab

When adjustments are relevant for a demonstration, enter the actual numbers of total contributions to the reported expenditures, per each MEG, for the reporting quarter. Add new reported adjustments to any existing numbers for previous quarters for the reported DY.
Note: Any adjustments that reduce expenditures must be entered as negative numbers (for example, -$10,000).

WW Spending Projected tab

Enter projected annual expenditures for each MEG for the active DYs of a demonstration.
For each reporting quarter, update the projected numbers so they reflect only future quarter projections. Please see the example for the MemMon Projected tab.

MemMonth Actual tab

For each MEG, calculate the actual number of member months for the reported quarter and add this number to the previously entered number for the same DY. For example, for Q3 reporting period, add Q3 member months to the existing number for the same MEG and DY and enter the result into the same cell.

MemMonth Projected tab

For each MEG, enter projected (future) annual member months for all active DYs of the demonstration. Adjust future DY numbers as needed.
For the current DY, enter only the number that reflects future quarters. For example, for Q3 reporting, only enter the projected number for Q4. There should be no projected numbers for completed (actual) DYs.

Summary TC tab

In the Net Variance section, for each DY, enter estimated numbers in row '1115A Dual Demonstration Savings (state preliminary estimate)'.
In the next row, '1115A Dual Demonstration Savings (OACT certified)' enter certified numbers.
Both estimated and certified numbers must be negative, as dual demonstration savings numbers reduce the Net Variance amount.

Demonstration Years Definitions

DY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Start Date	8/1/1994	8/1/1995	8/1/1996	8/1/1997	9/1/1998	9/1/1999	9/1/2000	9/1/2001	9/1/2002	9/1/2003	9/1/2004	9/1/2005	9/1/2006	9/1/2007	9/1/2008
End Date	7/31/1995	7/31/1996	7/31/1997	7/31/1998	8/31/1999	8/31/2000	8/31/2001	8/31/2002	8/31/2003	8/31/2004	8/31/2005	8/31/2006	8/31/2007	8/31/2008	8/31/2009

DY	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Start Date	9/1/2009	9/1/2010	9/1/2011	9/1/2012	10/1/2013	1/1/2014	1/1/2015	1/1/2016	1/1/2017	1/1/2018	8/1/2019	8/1/2020	8/1/2021	8/1/2022	8/1/2023
End Date	8/31/2010	8/31/2011	8/31/2012	8/31/2013	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	7/31/2019	7/31/2020	7/31/2021	7/31/2022	7/31/2023	7/31/2024

Enter any general comments / notes:

MEG Definitions

	MEG Name	MEG Description	Savings Phase-Down	Expenditures Subject to Cap?	Hypothetical Populations Included in Calculations?	Start DY	Start Date	End DY	End Date
	Medicaid Per Capita								
1	EG 1 - Children		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
2	EG 2 - Adults		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
3	EG 3 - Aged		Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
4	EG 4 – Blind/Disabled	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.	Savings Phase-Down	No	N/A	*1*	*8/1/1994*	*25*	*7/31/2019*
					N/A				
	Medicaid Per Capita - WOW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate - WOW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Medicaid Aggregate - WW only								
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
			N/A		N/A				
	Hypothetical 1 Per Capita				Hypothetical Test 1				
1	EG 5 – Group VIII	Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act	N/A	No	Yes	*20*	*10/1/2013*	*20*	*12/31/2013*
			N/A						
			N/A						
	Hypothetical 1 Aggregate								
			N/A						
			N/A						
			N/A						
	Hypothetical 2 Per Capita				Hypothetical Test 2				
1	EG 6 - CIS	Expenditures related to the CIS benefits of pre-tenancy supports and tenancy supports; excludes expenditures related to the Community Transition Services Pilot Program.	N/A	No	Yes	*26*	*8/1/2019*	*30*	*7/31/2024*
			N/A						
			N/A						
	Hypothetical 2 Aggregate								
			N/A						
			N/A						
			N/A						
	Hypothetical 3 Per Capita				Hypothetical Test 3				
1	EG 7 – CIS Community Transition Pilot	Expenditures related to the Community Transition Services Pilot Program.	N/A	No	Yes	*26*	*8/1/2019*	*30*	*7/31/2024*
			N/A						
			N/A						
	Hypothetical 3 Aggregate								
			N/A						
			N/A						
			N/A						
	Tracking Only								

WOW PMPMs and Aggregates

Medicaid Per Capita		26	27	28	29	30
EG 1 - Children	1	$448.48	$452.96	$457.49	$462.07	$466.69
EG 2 - Adults	2	$925.47	$959.72	$995.23	$1,032.05	$1,070.24
EG 3 - Aged	3	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66
EG 4 – Blind/Disabled	4	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25

Hypothetical 1 Per Capita		26	27	28	29	30
EG 5 – Group VIII	1	$899.37	$942.54	$987.78	$1,035.20	$1,084.89

Hypothetical 2 Per Capita		26	27	28	29	30
EG 6 - CIS	1	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15

Hypothetical 3 Per Capita		26	27	28	29	30
EG 7 – CIS Community Transition Pilot	1	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67

Program Spending Limits

						TOTAL
Program Name and Associated MEGs	**26**	**27**	**28**	**29**	**30**	
Spending Cap						
						$ -
Expenditures Subject to Cap						
Variance						$ -
Over or Under	.	.	.	.	.	.

Date Pulled On:	5/4/2021	Reporting DY:	27
For the Time Period Through:	3/31/2021	Reporting Quarter:	3

Paste all information related to the demonstration from Schedule C of the CMS 64 Waiver Expenditure Report.
1. On the Schedule C Report, locate rows relevant to all expenditures for a specific demonstration.
2. Complete two rounds of copy/paste starting from the cell in column A (Waiver Name).
· MAP Waivers/ Total Computable section – into cell A100
· MAP Waivers/ Federal Share section – into cell A200
3. If ADM waivers are applicable to the demonstration, complete two more rounds of copy/paste starting from the cell in column A (Waiver Name).
· ADM Waivers/ Total Computable section – cell A300
· ADM Waivers/ Federal Share section – cell A400

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13
1,115	0	70,981,761	0	0	0	0	0	0	0	0	0	0	0	0
1902 R 2	0	173,206,589	0	0	0	0	(28,108)	0	0	0	0	0	0	0
1902 R 2X	0	(8,243,749)	0	0	0	0	0	0	0	0	0	0	0	0
1902R2	0	121,392	0	0	0	0	0	0	0	0	0	0	0	0
AFDC	0	148,069,654	0	0	0	0	0	0	0	0	0	0	0	0
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Breast Cervical Cancer Treatment (BCCT)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CURRENT	0	493,934,086	0	0	0	0	1,661,326	159,616,917	75,521,154	0	0	0	0	0
CURRENT POP	0	272,778,438	0	0	0	0	0	0	0	0	0	0	0	0
Current-Hawaii Quest	0	0	0	0	0	0	0	0	40,064,795	0	0	0	0	0
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
Expansion State Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HawaiiQuest-1902(R)(2)	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
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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
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
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	56,504	120,767
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MFCP	0	0	0	0	0	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
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	76,678	103,084
Others	0	288,512,308	0	0	0	0	786,332	56,430,712	30,507,680	0	0	0	0	0
Others-Hawaii Quest	0	0	0	0	0	0	0	0	13,142,103	0	0	0	0	0
OthersX	0	(15,309,727)	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	0	(2,751)	798,681
RAACP	0	0	0	0	0	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
State Plan Adults	0	0	0	0	0	0	0	0	(10)	218	99	39,158	111,982,730	118,021,622
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
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	7,500,002	0	0
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	17,822,210	0	0
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	15,688,221	22,546,108
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	0	0
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	10,056,500	3,403,710
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
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

Waiver Name	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1902 R 2	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1902 R 2X	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1902R2	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
AFDC	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Aged w/Mcare	(295)	121,279,464	314,952,648	350,714,627	326,518,117	349,156,948	184,750,729	364,919,440	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Aged w/o Mcare	0	2,424,989	17,555,107	24,914,002	19,728,957	24,483,589	14,925,306	37,994,810	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
B/D w/Mcare	(13,736)	31,794,652	74,760,519	81,089,359	77,504,607	88,201,319	49,105,356	98,847,286	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
B/D w/o Mcare	(28,991)	81,514,842	211,664,665	248,689,322	257,028,809	282,670,355	148,440,400	290,201,052	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Breast Cervical Cancer Treatment (BCCT)	0	(2)	4,053	545,332	904,018	750,145	365,104	585,588	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CURRENT	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CURRENT POP	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Current-Hawaii Quest	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Demo Elig Adults	154,209,257	177,392,619	201,628,981	238,945,778	244,752,485	227,394,155	43,950,943	52,948	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Expansion State Adults	0	0	0	0	0	0	0	191,925,290	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
FosterCare(19-20)	91,499	83,366	94,158	137,403	73,022	176,324	173,482	703,614	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HawaiiQuest-1902(R)(2)	33,061	26,332	8,001	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HCCP	135,520	683,159	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HealthQuest-Current	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
HealthQuest-Others	0	0	0	0	0	0	0	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Med Needy Adults	115,693	58,345	117,005	109,837	8,305	0	0	0	0	0	0	0	0	0	0	0	0	586,456	586,456
Med Needy Children	0	7,715	3,960	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11,675	11,675
MFCP	122,839	581,513	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	704,352	704,352
Newly Eligible Adults	0	0	0	0	0	0	1,331	217,050,612	165,225,916	110,172,746	126,903,675	190,927,684	117,104,618	99,828,205	0	0	0	1,027,214,787	1,027,214,787
NH w/o W	5,100,418	16,199,737	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21,300,155	21,300,155
Opt St Pl Children	80,075	257,166	253,182	31	0	0	0	0	0	0	0	0	0	0	0	0	0	770,216	770,216
Others	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	0	0	0	0	0	0	0	0	0	13,142,103	13,142,103
OthersX	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	5,696,094	14,348,747	23,867,636	30,465,656	27,968,205	76,432,838	26,173,447	99,296	0	0	0	0	0	0	0	0	0	205,847,849	205,847,849
RAACP	7,862,479	17,432,949	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,295,428	25,295,428
St Pl Adults-Preg Immig/COFAs	0	0	24,990	2,628,840	2,628,927	2,873,646	987,921	1,532,245	1,448,764	2,048,646	2,315,023	4,043,498	3,123,271	1,593,659	0	0	0	25,249,430	25,249,430
State Plan Adults	109,034,691	128,225,118	131,863,143	123,596,289	112,790,909	130,112,852	80,834,554	202,315,960	172,913,238	169,042,108	182,723,816	256,085,507	165,603,256	135,709,061	0	0	0	2,330,894,319	2,330,894,319
State Plan Children	155,392,585	168,853,209	202,959,370	213,968,923	187,874,968	215,942,758	106,595,493	248,491,952	306,184,516	316,589,798	372,171,569	596,149,528	395,808,823	278,844,837	0	0	0	4,129,839,012	4,129,839,012
Supp. - Private	0	0	0	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	0	0	0	0	0	0	17,822,210	17,822,210
UCC-Governmental	18,919,184	16,356,580	24,507,605	34,064,491	48,859,842	12,164,879	5,856,911	10,090,466	6,184,588	981,179	0	0	0	0	0	0	0	216,220,054	216,220,054
UCC-GOVT LTC	0	0	0	0	609,561	0	0	0	0	0	0	0	0	0	0	0	0	609,561	609,561
UCC-Private	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	0	0	0	0	0	355,642,946	355,642,946
VIII-Like Group	0	0	0	0	0	0	71,468,225	(8,863)	0	0	0	0	0	0	0	0	0	71,459,362	71,459,362
Total	464,250,373	785,020,500	1,211,765,023	1,357,369,890	1,307,250,732	1,449,178,427	773,323,644	1,746,955,632	1,886,418,458	1,978,888,489	2,102,497,561	3,209,375,028	2,131,893,159	1,654,729,929	0	0	0	26,104,502,669	26,104,502,669

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13
1,115	0	35,490,882	0	0	0	0	0	0	0	0	0	0	0	0
1902 R 2	0	86,769,823	0	0	0	0	(14,054)	0	0	0	0	0	0	0
1902 R 2X	0	(4,205,136)	0	0	0	0	0	0	0	0	0	0	0	0
1902R2	0	60,696	0	0	0	0	0	0	0	0	0	0	0	0
AFDC	0	74,034,827	0	0	0	0	0	0	0	0	0	0	0	0
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Breast Cervical Cancer Treatment (BCCT)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CURRENT	0	[illegible]	0	0	0	0	[illegible]	83,526,544	40,668,142	0	0	0	0	0
CURRENT POP	0	[illegible]	0	0	0	0	0	0	0	0	0	0	0	0
Current-Hawaii Quest	0	0	0	0	0	0	0	0	22,572,505	0	0	0	0	0
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
Expansion State Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HawaiiQuest-1902(R)(2)	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	0	0	166	20,369	256,468	0	0
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HealthQuest-Current	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	4,903,637	36,087,606	132,768,282	165,985,082	231,578,381	(1,365,848)	0
HealthQuest-Others	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	1,733,011	11,768,154	36,642,802	60,584,431	55,313,761	(363,962)	0
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	32,497	68,553
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MFCP	0	0	0	0	0	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
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	44,819	59,404
Others	0	[illegible]	0	0	0	0	[illegible]	29,580,209	16,428,385	0	0	0	0	0
Others-Hawaii Quest	0	0	0	0	0	0	0	0	7,404,260	0	0	0	0	0
OthersX	0	[illegible]	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	0	(1,583)	454,606
RAACP	0	0	0	0	0	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
State Plan Adults	0	0	0	0	0	0	0	0	(6)	125	52	22,986	65,812,117	68,288,552
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
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	4,385,251	0	0
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	10,614,749	0	0
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	9,212,484	13,041,165
UCC-GOVT LTC	0	0	0	0	0	0	0	0	0	0	0	0	0	0
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	5,787,516	1,958,835
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	119,743,378	135,002,643	169,413,692	226,620,677	303,853,039	261,079,907	262,434,464

Waiver Name	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	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	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(4,205,136)	(4,205,136)
1902R2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	60,696	60,696
AFDC	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	(199)	81,134,508	211,362,743	229,319,379	165,433,841	179,767,116	95,671,244	189,594,079	162,182,080	173,947,428	181,187,273	304,996,007	211,983,415	154,740,592	0	0	0	2,341,319,506	2,341,319,506
Aged w/o Mcare	0	1,622,988	11,822,762	16,022,396	9,984,628	12,621,590	7,728,650	19,714,968	25,630,796	25,194,791	30,421,066	46,083,675	37,068,807	35,968,316	0	0	0	279,885,433	279,885,433
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	(249,679)	(273,613)	(218,333)	(324,766)	(277,623)	(19,044)	0	0	0	(1,363,058)	(1,363,058)
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	(7,720)	(24,377)	(34,310)	(23,817)	(9,392)	0	0	0	0	(99,616)	(99,616)
B/D w/Mcare	(9,251)	21,277,328	49,857,636	52,547,252	39,129,038	45,400,574	25,392,157	51,341,230	86,036,126	85,942,520	84,861,936	134,761,847	86,415,218	63,545,299	0	0	0	826,498,910	826,498,910
B/D w/o Mcare	(19,525)	54,511,233	141,799,152	161,274,589	130,207,936	145,622,789	76,872,883	150,336,274	149,646,906	167,640,879	186,541,259	256,705,808	189,311,617	150,217,006	0	0	0	1,960,668,806	1,960,668,806
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	(171,495)	(180,813)	(203,447)	(216,481)	(166,339)	(10,739)	0	0	0	(949,314)	(949,314)
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	(32,236)	(40,358)	(84,504)	(125,175)	(45,986)	(1,347)	0	0	0	(329,606)	(329,606)
Breast Cervical Cancer Treatment (BCCT)	0	(1)	2,754	361,286	592,247	495,478	241,945	376,274	201,477	152,695	77,771	62,536	4,877	31,952	0	0	0	2,601,291	2,601,291
CURRENT	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	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	0	0	0	0	0	0	0	0	0	22,572,505	22,572,505
Demo Elig Adults	87,642,204	114,378,784	135,452,513	154,819,222	123,131,082	116,746,726	22,522,276	27,511	(3,183)	397	0	0	0	0	0	0	0	904,977,344	904,977,344
Expansion State Adults	0	0	0	0	0	0	0	157,575,707	316,564,065	458,125,253	498,122,382	734,461,321	483,878,865	409,823,844	0	0	0	3,058,551,437	3,058,551,437
FosterCare(19-20)	51,916	53,413	63,415	89,013	36,291	90,804	89,632	365,633	326,044	480,663	723,548	1,274,696	996,095	766,068	0	0	0	5,407,231	5,407,231
HawaiiQuest-1902(R)(2)	18,679	19,755	5,389	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,029,695	4,029,695
HCCP	76,578	438,797	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	515,375	515,375
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	592,242,508	592,242,508
HealthQuest-Others	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	174,521,683	174,521,683
Med Needy Adults	68,082	38,985	78,049	64,590	4,238	0	0	0	0	0	0	0	0	0	0	0	0	354,994	354,994
Med Needy Children	0	5,196	2,666	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,862	7,862
MFCP	69,404	368,050	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	437,454	437,454
Newly Eligible Adults	0	0	0	0	0	0	1,331	217,032,614	165,225,680	110,132,233	120,601,049	178,699,247	106,748,146	89,835,536	0	0	0	988,275,836	988,275,836
NH w/o W	2,881,647	10,235,011	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,116,658	13,116,658
Opt St Pl Children	45,487	166,217	170,408	21	0	0	0	0	0	0	0	0	0	0	0	0	0	486,356	486,356
Others	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	0	0	0	0	0	0	0	0	0	7,404,260	7,404,260
OthersX	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	3,232,556	9,373,768	16,050,472	19,640,154	13,856,685	39,331,445	13,397,540	51,580	0	0	0	0	0	0	0	0	0	115,387,223	115,387,223
RAACP	4,442,944	10,922,768	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,365,712	15,365,712
St Pl Adults-Preg Immig/COFAs	0	0	16,829	1,707,938	1,317,977	1,473,988	508,843	795,482	764,288	1,111,786	1,270,634	2,194,658	1,790,423	945,702	0	0	0	13,898,548	13,898,548
State Plan Adults	61,892,816	82,540,889	88,651,957	80,730,594	56,365,779	66,741,085	41,647,599	104,818,328	90,882,653	91,217,054	100,152,370	138,670,344	94,529,089	80,459,443	0	0	0	1,313,423,826	1,313,423,826
State Plan Children	88,086,005	108,850,847	136,539,237	138,140,612	92,677,457	110,463,464	54,513,113	128,897,353	161,395,719	171,534,913	204,150,083	323,461,654	226,459,657	165,398,979	0	0	0	2,322,582,574	2,322,582,574
Supp. - Private	0	0	0	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	0	0	0	0	0	0	10,614,749	10,614,749
UCC-Governmental	10,762,501	10,040,250	16,505,872	22,280,473	24,838,917	6,249,536	3,037,111	5,240,639	3,261,810	529,641	0	0	0	0	0	0	0	125,000,399	125,000,399
UCC-GOVT LTC	0	0	0	0	307,706	0	0	0	0	0	0	0	0	0	0	0	0	307,706	307,706
UCC-Private	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	0	0	0	0	0	190,760,884	190,760,884
VIII-Like Group	0	0	0	0	0	0	37,060,184	(4,595)	0	0	0	0	0	0	0	0	0	37,055,589	37,055,589
Total	263,479,344	510,938,536	813,433,104	881,694,769	657,883,822	745,135,931	399,268,014	1,068,840,348	1,206,703,201	1,321,117,892	1,407,568,777	2,120,681,554	1,438,686,869	1,151,701,607	0	0	0	16,214,376,805	16,214,376,805

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
[illegible]	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	39,312,729	11,586,429
[illegible]	0	0	0	0	0	0	0	0	0	0	0	0	0	0	755,748	34,375,214
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

Waiver Name	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
[illegible]	43,993,148	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	89,286,976	67,576,059	0	0	0	1,107,157,732	1,107,157,732
[illegible]	12,833,291	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47,964,253	47,964,253
Total	56,826,439	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	89,286,976	67,576,059	0	0	0	1,155,121,985	1,155,121,985

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
[illegible]	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	20,907,343	6,121,891
[illegible]	0	0	0	0	0	0	0	0	0	0	0	0	0	0	377,874	17,784,187
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

Waiver Name	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
[illegible]	25,253,918	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	61,050,371	44,720,001	0	0	0	762,109,902	762,109,902
[illegible]	6,534,554	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,696,615	24,696,615
Total	31,788,472	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	61,050,371	44,720,001	0	0	0	786,806,517	786,806,517

C Report Grouper

MAP Waivers Only

Total Computable

MEG Names		C Report Waiver Names	26	27	28	29	30
Medicaid Per Capita							
EG 1 - Children	1	FosterCare(19-20)	$1,744,408	$1,291,304			
EG 1 - Children	1	State Plan Children	$395,808,823	$278,844,837			
EG 2 - Adults	2	State Plan Adults	$165,603,256	$135,709,061			
EG 2 - Adults	2	Breast Cervical Cancer Treatment (BCCT)	$10,923	$45,195			
EG 2 - Adults	2	St PI Adults-Preg Immig/COFAs	$3,123,271	$1,593,659			
EG 3 - Aged	3	Aged w/Mcare	$370,600,025	$260,815,533			
EG 3 - Aged	3	Aged w/o Mcare	$64,660,810	$60,672,652			
EG 3 - Aged	3	Aged with Medicare - MFP	($490,186)	($31,916)			
EG 3 - Aged	3	Aged without Medicare - MFP	($17,253)				
EG 4 – Blind/Disabled	4	B/D w/Mcare	$151,206,371	$107,110,921			
EG 4 – Blind/Disabled	4	B/D w/o Mcare	$331,779,319	$253,455,104			
EG 4 – Blind/Disabled	4	Blind/Disable without Medicare - MFP	($294,330)	($17,997)			
EG 4 – Blind/Disabled	4	Blind/Disabled with Medicare - MFP	($81,788)	($2,258)			
Hypothetical 1 Per Capita							
EG 5 – Group VIII	1	VIII-Like Group					
EG 5 – Group VIII	1	Expansion State Adults	$531,134,892	$455,415,629			
EG 5 – Group VIII	1	Newly Eligible Adults	$117,104,618	$99,828,205			
Hypothetical 2 Per Capita							
EG 6 - CIS	1	EG 6 - CIS					
Hypothetical 3 Per Capita							
EG 7 – CIS Community Transition Pilot	1	EG 7 – CIS Community Transition Pilot					
TOTAL			$2,131,893,159	$1,654,729,929			

Adjustments made to the reported expenditures

Enter total adjustments made to the expenditure numbers, including adjustments to the previous reporting periods.
Positive adjustments increase expenditures, and negative adjustments decrease expenditures.
Enter adjustments for every MEG for which adjustments were made or are planned.
Helpful Hint: Remember to enter total adjustments as positive or negative (for example, -$10,000 reflects a decrease in expenditures).

		26	27	28	29	30	Description (type of collection, time period, CMS-64 reporting line, etc.)
Medicaid Per Capita							
EG 1 - Children	1						
EG 2 - Adults	2						
EG 3 - Aged	3	-$35,830,002	-$23,712,011				Cost share
EG 4 – Blind/Disabled	4	-$3,558,280	-$2,137,551				Cost share
Hypothetical 1 Per Capita							
EG 5 – Group VIII	1		-$9,130				Cost share
Hypothetical 2 Per Capita							
EG 6 - CIS	1						
Hypothetical 3 Per Capita							
EG 7 – CIS Community Transition Pilot	1						

WW Spending - Actual

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	$397,553,231	$280,136,141			
EG 2 - Adults	2	$168,737,450	$137,347,915			
EG 3 - Aged	3	$398,923,394	$297,744,258			
EG 4 – Blind/Disabled	4	$479,051,292	$358,408,219			
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$648,239,510	$555,234,704			
Hypothetical 2 Per Capita						
EG 6 - CIS	1					
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1					
TOTAL		**$ 2,092,504,876**	**$ 1,628,871,237**	**$ -**	**$ -**	**$ -**

WW Spending - Projected

Enter projected spending for the demonstration which includes the remaining quarters of the current DY and all future DYs.
Enter the projected annual expenditures for each DY per MEG for the active DYs.
For the current DY, only future quarters should have projected spending information. Do not include expenditures that were reported as actuals.

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1		$123,017,162	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2		$81,055,852	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3		$143,650,396	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4		$226,123,634	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1		$270,755,594	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1		$1,523,155	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		$4,154,060	$13,386,875	$14,380,181	$15,447,190

WW Spending - Total

Total Computable

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	$397,553,231	$403,153,303	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2	$168,737,450	$218,403,767	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3	$398,923,394	$441,394,654	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4	$479,051,292	$584,531,853	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$648,239,510	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1		$1,523,155	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		$4,154,060	$13,386,875	$14,380,181	$15,447,190
TOTAL		**$ 2,092,504,876**	**$ 2,479,151,090**	**$ 2,632,405,315**	**$ 2,782,912,389**	**$ 2,942,576,003**

Member Months - Actual

Enter actual member months (number of beneficiaries times the number of enrolled months) for quarters to date for each active DY.
For the reported quarter, add the actual number of member months per each MEG to the previous actual number. The number should equal the total of ALL actual member months.
Note: Depending of the specifics of the state, you can use Total member months or Average monthly unduplicated counts. Whichever definition is used, it must be applied consistently.
Helpful Hint: When updating a DY, remember to enter actual member months for the reported quarter along with actuals for prior quarter(s). Retroactive adjustments may affect the entries.

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	1402624	1009624			
EG 2 - Adults	2	420331	319245			
EG 3 - Aged	3	339459	246705			
EG 4 – Blind/Disabled	4	285411	201738			
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	1411914	1164172			
Hypothetical 2 Per Capita						
EG 6 - CIS	1					
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1					

Member Months - Projected

Enter/adjust projected member months based on reported actuals.
Enter projected number of member months for each active DY per MEG for the demonstration.
For the current DY, enter only the number that reflects projections for future quarters of the DY.
Do not include member months for either the current reporting quarter or past quarters.

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1		575150	1624394	1665004	1706629
EG 2 - Adults	2		195148	527253	540435	553945
EG 3 - Aged	3		86138	336172	339533	342929
EG 4 – Blind/Disabled	4		117556	322487	325712	328969
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1		399088	1602341	1642400	1683460
Hypothetical 2 Per Capita						
EG 6 - CIS	1		1261	3877	3974	4073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		1261	3877	3974	4073

Member Months - Total

		26	27	28	29	30
Medicaid Per Capita						
EG 1 - Children	1	1,402,624	1,584,774	1,624,394	1,665,004	1,706,629
EG 2 - Adults	2	420,331	514,393	527,253	540,435	553,945
EG 3 - Aged	3	339,459	332,843	336,172	339,533	342,929
EG 4 – Blind/Disabled	4	285,411	319,294	322,487	325,712	328,969
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	1,411,914	1,563,260	1,602,341	1,642,400	1,683,460
Hypothetical 2 Per Capita						
EG 6 - CIS	1		1,261	3,877	3,974	4,073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		1,261	3,877	3,974	4,073

Budget Neutrality Summary

The Budget Neutrality Reporting Period dropdown menu allows for selection of a specific reporting period, by Demonstration Year.
By changing these settings, you change the view for which Demonstration Years will be used in calculating Budget Neutrality.
Selecting the 'Reset to Defaults' button will reset the Reporting DY values back to the demonstration's current Period of Performance.

Budget Neutrality Reporting Start DY	**26**
Budget Neutrality Reporting End DY	**30**

Actuals + Projected

Without-Waiver Total Expenditures

			26	27	28	29	30	Total
Medicaid Per Capita								
EG 1 - Children	1	**Total**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		PMPM	$448.48	$452.96	$457.49	$462.07	$466.69	
		Mem-Mon	1,402,624	1,584,774	1,624,394	1,665,004	1,706,629	
EG 2 - Adults	2	**Total**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		PMPM	$925.47	$959.72	$995.23	$1,032.05	$1,070.24	
		Mem-Mon	420,331	514,393	527,253	540,435	553,945	
EG 3 - Aged	3	**Total**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		PMPM	$1,939.17	$2,005.11	$2,073.28	$2,143.77	$2,216.66	
		Mem-Mon	339,459	332,843	336,172	339,533	342,929	
EG 4 – Blind/Disabled	4	**Total**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		PMPM	$2,646.76	$2,763.22	$2,884.80	$3,011.73	$3,144.25	
		Mem-Mon	285,411	319,294	322,487	325,712	328,969	
TOTAL			**$ 2,431,735,669**	**$ 2,761,178,875**	**$ 2,895,171,196**	**$ 3,035,941,601**	**$ 3,183,838,560**	**$ 14,307,865,902**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 397,553,231	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,559,343,894
EG 2 - Adults	2		$ 168,737,450	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,182,305,177
EG 3 - Aged	3		$ 398,923,394	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,193,860,672
EG 4 – Blind/Disabled	4		$ 479,051,292	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,171,315,967
TOTAL			**$ 1,444,265,366**	**$ 1,647,483,576**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,526,353,551**

Savings Phase-Down

Medicaid Per Capita			26	27	28	29	30	TOTAL
		Savings Phase-Down						
EG 1 - Children	1	**Without Waiver**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		With Waiver	$ 397,553,231	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 231,495,581	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 173,621,685	$ 236,014,446	$ 244,334,666	$ 252,953,883	$ 261,869,576	
		Savings Phase-Down						
EG 2 - Adults	2	**Without Waiver**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		With Waiver	$ 168,737,450	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 220,266,281	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 165,199,710	$ 206,452,113	$ 219,443,384	$ 233,250,960	$ 247,929,298	
		Savings Phase-Down						
EG 3 - Aged	3	**Without Waiver**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		With Waiver	$ 398,923,394	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 259,345,315	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 194,508,987	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ 193,054,616	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 479,051,292	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 276,363,127	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 207,272,345	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 740,602,727**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,336,134,264**

			26	27	28	29	30	Total
BASE VARIANCE			**$ 246,867,576**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,445,378,088**
Excess Spending from Hypotheticals								$ -
1115A Dual Demonstration Savings (state preliminary estimate)								$ -
1115A Dual Demonstration Savings (OACT certified)								$ -
Carry-Forward Savings From Prior Period								
NET VARIANCE								**$ 1,445,378,088**

Cumulative Target Limit

			26	27	28	29	30	
Cumulative Target Percentage (CTP)			2.0%	1.5%	1.0%	0.5%		
Cumulative Budget Neutrality Limit (CBNL)			$ 1,691,132,942	$ 3,617,040,343	$ 5,635,956,498	$ 7,752,550,357	$ 9,971,731,639	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,822,659	$ 54,255,605	$ 56,359,565	$ 38,762,752	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (246,867,576)	$ (525,291,401)	$ (817,376,414)	$ (1,123,825,662)	$ (1,445,378,088)	
Is a Corrective Action Plan needed?								

HYPOTHETICALS TEST 1

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1	**Total**	$ 1,269,833,094	$ 1,473,435,080	$ 1,582,760,393	$ 1,700,212,480	$ 1,826,368,919	
		PMPM	$899.37	$942.54	$987.78	$1,035.20	$1,084.89	
		Mem-Mon	1,411,914	1,563,260	1,602,341	1,642,400	1,683,460	
TOTAL			**$1,269,833,094**	**$1,473,435,080**	**$1,582,760,393**	**$1,700,212,480**	**$1,826,368,919**	**$7,852,609,967**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 1 Per Capita								
EG 5 – Group VIII	1		$648,239,510	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 648,239,510**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,338,459,437**
HYPOTHETICALS VARIANCE 1			**$ 621,593,584**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,514,150,530**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ -	$ 1,565,282	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon		1,261	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 1,565,282**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 17,850,382**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ -	$ 1,523,155	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ -**	**$ 1,523,155**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 17,368,379**
HYPOTHETICALS VARIANCE 2			**$ -**	**$ 42,126**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 482,003**

HYPOTHETICALS TEST 3

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1	**Total**	$ -	$ 4,268,958	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon		1,261	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 4,268,958**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 48,682,806**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ -	$ 4,154,060	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ -**	**$ 4,154,060**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 47,368,306**
HYPOTHETICALS VARIANCE 3			**$ -**	**$ 114,897**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,314,500**

Yes No

Yes
No

Per Capita or Aggregate

Per Capita
Aggregate

Phase-Down

No Phase-Down
Savings Phase-Down

Actuals and Projected

Actuals Only
Actuals + Projected

MAP_ADM

MAP+ADM Waivers
MAP Waivers Only

Waiver List

MAP WAIVERS

Not Applicable
1,115
1902 R 2
1902 R 2X
1902R2
AFDC
Aged w/Mcare
Aged w/o Mcare
Aged with Medicare - MFP
Aged without Medicare - MFP
B/D w/Mcare
B/D w/o Mcare
Blind/Disable without Medicare - MFP
Blind/Disabled with Medicare - MFP
Breast Cervical Cancer Treatment (BCCT)
CURRENT
CURRENT POP
Current-Hawaii Quest
Demo Elig Adults
EG 6 - CIS
EG 7 – CIS Community Transition Pilot
Expansion State Adults
FosterCare(19-20)
HawaiiQuest-1902(R)(2)
HCCP
HealthQuest-Current
HealthQuest-Others
Med Needy Adults
Med Needy Children
MFCP
Newly Eligible Adults
NH w/o W
Opt St Pl Children
Others
Others-Hawaii Quest
OthersX
QUEST ACE
RAACP
St PI Adults-Preg Immig/COFAs
State Plan Adults
State Plan Children
Supp. - Private
Supp. - State Gov.
UCC-Governmental
UCC-GOVT LTC
UCC-Private
VIII-Like Group

ADM WAIVERS

Demonstration Reporting Start DY	26
Demonstration Reporting End DY	30

Reporting Net Variance

$ 1,445,378,088