Hawaii QUEST Integration
Quarterly Monitoring Report to CMS

Federal Fiscal Year 2021 2nd Quarter
(DY27 Q2)

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: May 27, 2021

Reporting Period: January 2021 – March 2021

Federal Fiscal Quarter:	2nd Quarter 2021
State Fiscal Quarter:	3rd Quarter 2021
Calendar Year:	1st Quarter 2021
Demonstration Year:	27th Year (10/1/20-9/30/21)

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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 is in process to procure new QI contracts effective July 1, 2021. On July 21, 2020, MQD issued a Request for Information (RFI) for community needs, best practices, and resources. MQD received 37 responses from stakeholders and the public. All responses are available on the Med-QUEST website: medquest.hawaii.gov. From those responses, the "HOPE Leadership Team" focused on refining the care coordination/service coordination model for the new QI RFP, to ensure alignment with HOPE goals. This was incorporated into the QI Request for Proposal (RFP) issued in December 2020. Proposals were submitted in February 2021, and contract awardees announced in March 2021. Execution of the contracts as well as Readiness Review activities are planned for April-June 2021.

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.

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.

In this quarter, MQD collected, aggregated, and shared member lists with independent pharmacies willing to participate in the effort to travel into the community to provide 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. Six independent pharmacies participated in this effort on Oahu, and one independent pharmacy participated on the Big Island. Over the course of 2 consecutive 4-week periods, pharmacies went into the homes of these members to vaccinate the member as well as all of the member's care givers. The first 4-week period was to complete the first dose of COVID vaccine, and the second 4-week period was to complete the 2nd final dose. In total, over 90% of the targeted home-community-bound population were fully vaccinated at the end of this effort. In contrast to this effort, on Maui county and Kauai county home-bound vaccinations were administered by each county's Department of Health Office.

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 then 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 started and continued through this 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.

Lastly, the State of Hawaii COVID Re-Opening Strategy progressed throughout this quarter. One example of this progress was Honolulu county moving from Tier 1 (most restrictive status) to Tier 2 during this quarter. Other counties also had progress toward re-opening, and each county had their own standards and Tier levels.

II. Operational Updates

A. Administration

During this Report 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 will be made by MQD in April whether to suspend Medicaid payments to HDC.

Contracts

During this period, MQD awarded Community Care Services contract to Ohana Health Plan on February 8, 2021. This contract provides behavior health services to the SMI and SPMI eligible Medicaid beneficiaries. Also, QUEST integration (QI) Request for Proposal (RFP) issued on December 8, 2020 was awarded on March 15, 2021 to 5 Health Plans: Aloha Care, HMSA, Kaiser, Ohana Health Plan and UnitedHealth Care. QI contract provides all medically necessary services to all the eligible Medicaid beneficiaries. In addition, MQD issued a Dental Third Party Administration RFP on February 26, 2021 with an expected award date of April 28, 2021.

In addition to the new contracts, MQD also continues to meet and work with CMS on approval of the current QI contract Supplemental Changes 15 & 16 including revising the CAP rates for 2020 to include payment of the vaccination fee.

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 second quarter. The Hawaii QUEST Integration (Project Number 11-W00001/9) authorities in the 1115 Attachment K was approved on March 25, 2021. This changed the end date of our Appendix K to be 6 months after the end of the federally declared COVID-19 public health emergency.

HOPE Initiative

MQD staff continues to work on the implementation of the HOPE initiative. As noted above, the next phase of this work focused on including the new HOPE initiatives in the revised MCO contracts and re-procuring the MCO contracts. Some of the HOPE initiatives that were included in the revised RFP addressed improving outcomes in the areas of behavioral health and care coordination. Contracts were awarded to five MCOs, and now the focus of the HOPE initiative is transitioning to contract monitoring and quality improvement. Additionally, MQD also re-procured the CCS contract and included HOPE initiatives in the contract and is now transitioning to contract monitoring and quality improvement activities.

MQD is also working on developing a community-based palliative care benefit and plans to submit an 1115 waiver amendment this summer. Additionally, MQD is also working on a CHIP Health Services Initiative State Plan Amendment focused 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 July 14, 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) are done with system reviews and in the process of analyzing the data and requesting missing verification. Efforts continued to identify and provide any missing documentation. Additionally, MQD is analyzing and providing documentation for any disagreements with the findings, or a Difference Resolutions (DR). A DR is reviewed by the ERC and if upheld the state has 15 days to appeal to CMS.

In light of the demands, time, and requirements of PERM, MQD is proposing a new process to help support the increasing complexity, workloads and demands of the PERM process. One suggested idea is the development of a new PERM/MEQC team whose primary focus is to review findings, provide supporting documentation and dispute error findings as appropriately. The team will be responsible to identify the potential error causes, best practices, and recommendation for future system modifications and changes to Standard Operating Procedures.

MEQC is underway with working with KOLEA Team and Unisys for the sample pull. Several meetings with CMS and the Quality Control Office were conducted to obtain the necessary uninterested for each criteria identified in the Sampling plan and then presented to Unisys. As of March 2021, with the help of CMS, narrowed down the parameters for the Active and Negative Sample universe to Unisys for action.

Hawaii State Plan Amendments

PPDO completed the following SPAs for this quarter:

- **SPA 20-0003 FFS DME in relation to 19-0005** - Approved 03/01/21
  Description: Required to meet CMS requirements as stated 19-0005 companion letter request to Hawaii. This amendment updates Attachment 4.19-B, by creating a new page (2.1) to include updated fee schedule dates and weblinks for EPSDT, home pharmacy, home health agency services and medical supplies.
  Note: 03/09/21 CMS following up on DME Demonstration supporting documentation. Hawaii coordinating response. 03/25/21 CMS checking on DME Demonstration supporting documentation, Hawaii updated plan to send before end of day.

- **SPA 21-0006 Nursing Facility Pass-through Phase out** - Approved 03/25/21
  Description: Amendment required to be in compliance with 42 CFR §438.6(c)(2) as amended in the final rule, "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability"; Final Rule, 81 Fed. Reg. 27498 (May 6, 2016). The pass-through payments as currently structured do not meet the conditions of the final rule. Hawaii will be allowed a transition period for implementation of this amendment.

Policy and Program Directives (PPDs) and Forms

The following PPDs were issued during this quarter.

21-001 1/8/2021 2021 MEDICARE PREMIUMS, DEDUCTIBLES AND CO-INSURANCE AMOUNTS

21-002 2/18/2021 2021 INCREASE IN THE RESOURCE LIMITS FOR THE MEDICARE SAVINGS PROGRAMS: QMB, SLMB AND QI-

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

QI-2104A: CCFFH and EARCH Rates for HCBS (Addendum to QI-2104)
QI-2104: Community Care Foster Family Home and Expanded Adult Residential Care Home Rates for Home and Community Based Services Effective January 1, 2021

QI-2103: Medicaid Eligibility for Freely Associated States Under the Compact of Free Association (COFA) Citizens

QI-2102: Civil Rights Awareness Training Requirements

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 have been able to 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, collection of cost share, oversight of the Self-Direct process, concurrent review of inpatient hospital stays, implementation of new Federal law covering individuals from the Compact of Free Association nations and implementation of a new state law affecting adolescent mental health services. Med-QUEST continues collaboration with the Department of Education for Administrative Medicaid Claiming. Specifically, the focus continuing for this quarter included redrafting of the MOA, continued work on the Random Moment in Time sampling plan for Administrative Claiming and drafting of the school health services SPA with CMS. Efforts continue to engage with other DOE staff whose participation is integral to this work.

C. Availability and Access of Covered Services & Network Adequacy

MQD extended the HCBS level-of-care assessment waiver for an additional six months during this quarter.

MQD's planned issue of memorandum in FFY 2020 Q2 outlining the data requirements around Community Integration Services (CIS) for our homeless population was delayed for additional review and refinement, and is now forecasted to be issued in early FFY 2021 Q3.

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

There were no public forums conducted during this reporting period.

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)

January 2021 – March 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	0
Provider/Provider Staff Behavior/Services	9
Transportation Customer Service	0
Treatment Plan/Diagnosis	0
Fraud and Abuse of Services	0
Billing/Payments	3
Member Rights	9
Medication	0
General Information	3
Forward to Other Departments	4
Total	**28**

Some grievances fit into multiple categories.

Month	# of Member Grievances to HCSB by Month
January 2021	14
February 2021	7
March 2021	7
Total	**28**

Status of Member Grievances Addressed by HCSB					
		Jan 2021	Feb 2021	Mar 2021	**TOTAL**
Received		**14**	**7**	**7**	**28**
Status					
Referred to Subject Matter Expert		7	0	1	8
Health Plan resolved with Members		2	3	3	8
Member withdrew grievance		0	1	2	3
Resolution in Health Plan favor		2	1	0	3
Resolution in Member's favor		2	0	0	2
Still awaiting resolution		0	2	1	3
Return to Health Plan awaiting Resolution Letter		1	0	0	1
Carry-over from previous Quarter		0	0	0	0

2. Grievances to Health Plans

Types of Member Grievances Reported to Health Plans	
	Jan – Mar 2021
	Total
Provider Policy	7
Health Plan Policy	27
Provider/Provider Staff Behavior	146

Health Plan Staff Behavior	32
Appointment Availability	12
Network Adequacy/ Availability	3
Waiting Times (office, transportation)	158
Condition of Office/ Transportation	6
Transportation Customer Service	14
Treatment Plan/Diagnosis	22
Provider Competency	25
Interpreter	0
Fraud and Abuse of Services	1
Billing/Payments	37
Health Plan Information	7
Provider Communication	13
Member Rights	20

Status of Member Grievances Reported to Health Plans	
	Jan – Mar 2021
	Total
Total number filed during the reporting period	382
Status received from Health Plans	
Total number that received timely acknowledgement from health plan	350
Total number not receiving timely acknowledgement from health plan	32
Total number expected to receive timely acknowledgement during next reporting period	16
Total number that received timely decision from health plan	337
Total number not receiving timely decision from health plan	24
Total number expected to receive timely decision during next reporting period	36
Total number currently unresolved during the reporting period	36

B. Member Appeals and State Fair Hearings

1. Appeals to Health Plans

During January – March 2021, there were a total of 284 Appeals submitted with the Health Plans.

Types of Member Appeals to Health Plans		
		Jan – Mar 2021
Service denial		47
Service denial due to not a covered benefit		4
Service denial due to not medically necessary		233
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		
		Jan – Mar 2021
Total number filed during the reporting period		284
Status received from Health Plans		
Total number that received timely acknowledgement from health plan		264
Total number not receiving timely acknowledgement from health plan		20
Total number expected to receive timely acknowledgement during next reporting period		17
Total number that received timely decision from health plan		258

Total number not receiving timely decision from health plan		19
Total number expected to receive timely decision during next reporting period		24
Total number currently unresolved during the reporting period		66
Total number overturned		140

2. Appeals to the State (State Fair Hearings)

For January - March 2021, there was a total of ten (10) Appeals submitted to AAO. Nine (9) were resolved, and we are awaiting one (1) resolution.

Types of Member Appeals to State Administrative Appeals Office (AAO)					
		Jan 2021	Feb 2021	Mar 2021	**TOTAL**
Medical		2	1	0	3
Home and Community Based Services (HCBS)		0	0	1	1
Van Modification		0	0	0	0
Applied Behavioral Analysis (ABA)		0	0	0	0
Durable Medical Equipment		1	1	1	3
Reimbursement		0	2	0	2
Medication		0	0	0	0
Miscellaneous		1	0	0	1

Status of Member Appeals to State Administrative Appeals Office (AAO)					
		Jan 2021	Feb 2021	Mar 2021	**TOTAL**
Submitted		4	4	2	10

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		4	2	0	6
Dismiss as untimely filing		0	0	0	0
Member withdrew hearing request		0	0	0	0
Resolution in DHS' favor		0	1	1	2
Resolution in Member's favor		0	1	0	1
Still awaiting resolution		0	0	1	1

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

A. Beneficiary Choice of Health Plan Exercised

January 2021 – March 2021	Number of Beneficiaries
Chose a health plan when they became eligible	**5427**
Automatically assigned when they became eligible	**6425**
Changed their health plan after being automatically assigned	**2438**
Beneficiaries in the ABD program who changed their health plan within days 61 to 90 after confirmation notice was issued	**18**

During this reporting period, 5,427 individuals chose their health plan since they became eligible in the previous quarter, 2,438 changed their health plan after being automatically assigned. In addition, 18 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

V. 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	386,086	126,998
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	125,516	40,663
Aged	Aged w/Medicare Aged w/o Medicare	97,636	32,924
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	78,830	26,350
Expansion State Adults	Expansion State Adults	384,568	125,574
Newly Eligible Adults	Newly Eligible Adults	84,198	27,139
Optional State Plan Children	Optional State Plan Children	0	0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,931	642
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)	87,112	28,453
Total		**1,245,877**	**408,743**

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan	227,577
Title XXI funded State Plan	28,453
Title XIX funded Expansion	152,713
Enrollment current as of	03/31/2021

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	129,110	129,378	129,529	388,017
EG 2 – Adults	41,189	41,899	42,428	125,516
EG 3 – Aged	32,447	32,392	32,797	97,636
EG 4 – Blind/Disabled	26,255	26,200	26,375	78,830
EG 5 – VIII-Like Adults	0	0	0	0
EG 6 – VIII Group Combined	154,646	155,577	158,543	468,766

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 03/31/21
State Plan Children	125,045	125,787	127,480	386,086
State Plan Adults	39,132	40,540	40,325	125,516
Aged	29,861	30,247	30,390	97,636
Blind or Disabled	24,654	24,866	25,648	78,830
Expansion State Adults	115,321	117,918	122,908	384,568
Newly Eligible Adults	24,940	25,341	27,334	84,198

Optional State Plan Children	**0**	**0**	**0**	**0**
Foster Care Children, 19-20 years old	**619**	**620**	**633**	**1,931**
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.	**4,895**
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).	**653**

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.	**843**

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	Jan 2021	Feb 2021	Mar 2021
Aloha Care	478	481	586
HMSA	752	608	621
Kaiser	347	353	348
Ohana	2507	2486	2387
United Healthcare	2238	2145	2078
Total	**6322**	**6073**	**6020**

VI. Outreach, Innovative Activities, and Beneficiary Support System

On December 27, 2020, the Omnibus Bill was signed into law, which restored Medicaid benefits to citizens from the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau, the nations which are covered under the Compact of Freely Associated States (COFA). During the first quarter of 2021 our branch and community partners were extremely busy conducting outreach to all of our COFA residents who applied and enrolled to a health plan through www.healthcare.gov during open enrollment, to inform them that COFA residents may now apply to Med-QUEST and if determined eligible will be able to select a QUEST Integration health plan and will then need to terminate their coverage at www.healthcare.gov. Hawaii was one of the first states to implement this bill. We created simple messaging in-language and distributed to all of our partners to share with their COFA communities they serve and to continue helping the community apply to Med-QUEST. See messaging below.

Citizens from the Compact of Free Association nations (COFA) - Federated States of Micronesia, Republic of Marshall Islands, Republic of Palau
You may now be eligible for Medicaid. We encourage you to apply to Med-QUEST:

1. online at https://medical.mybenefits.hawaii.gov
2. By phone at 808-524-3370 (Oahu) or 1-800-316-8005 (Neighbor Islands)

Meet with a Kokua from the Med-QUEST Community Partners to complete your application
https://medquest.hawaii.gov/en/resources/community-partners.html

Chuukese:
Ngeni aramasen ekkewe muun Compact of Free Association (COFA) - Federated States of Micronesia, Republic of Marshall Islands, Republic of Palau
Iei ewe Medicaid a pwan suk sefan ngeni kich. Iei popun ach kapasen pesepes ngeni kich sia tongeni amasou ngeni Med-QUEST: Iei anen omw kopwe amasaou ngeni:

1. Won nain ren https://medical.mybenefits.hawaii.gov
2. Kori ekkei fon nampa ren 808-524-3370 (Oahu) 1-800-316-8005 (Neighbor Islands)
3. Churi ika kori emon ekkewe Kokua seni Med-QUEST Community Partners an epwe anisuk ren noum we taropwen amasou. Ika anisuk ne amasou won ei nenien: https://medquest.hawaii.gov/en/resources/community-partners.html

Marshallese:
Armej in lal ko iumin Compact of Free Association (COFA) eo – Federated States of Micronesia, Republic of Marshall Islands, Republic of Palau
Kom maron apply nan Medicaid eo kio. Kim ej rōjañ bwe komin apply ilo Med-QUEST:

1. online ilo https://medical.mybenefits.hawaii.gov
2. Ilo telephone kom naj call e 808-524-3370 (Oahu) ak 1-800-316-8005 (Neighbor Islands)
3. Jibadrōk Kokua ro rej mottan Med-QUEST Community Partners nan aer jipañ kanne application eo am https://medquest.hawaii.gov/en/resources/community-partners.html

Kosraen:
Mwet ke Compact of Free Assciation nations (COFA) – Federated Stae of Micronesia, Republic of Marshall Islands, Republic of Palau
Sulpac na ikacklah kasru ke Medicaid nuh sesr. Kuht lihksreni kwacfe sesr kewa in nwacklah ke Med-Quest:

1. Nwacklah online ke https://medical.mybenefits.hawaii.gov
2. Pangon nampuh se 808-525-3370 (Oahu) kuh 1-800-3005 (Neighbor Islands)
3. Kuh sifana osun nuh sin mwet Kokua ke Med-Quest Community Partners in kasruh nwaklah application lom an https://medquest.hawaii.gov/en/resources/community-partners.html

Pohnpeian:
Ong kumwail akan me wia towe mehlel in Compact of free Association de (COFA) - Federated States of Micronesia, Republic of Marshall Islands, Republic of Palau
En wehwehieng wehi me kumwail kakehr en iang naineki medicaid. Eri se men kangongongeh kin kumwail en nsohnohkihda ong iang alehda de wiahda sapwelmamwail Med-QUEST:

1. Mwail kak ketla online ni website https://medical.mybenefits.hawaii.gov
2. De eker nempehn delepwohn 808-524-3370 (Oahu) de 1-800-316-8005 (Neighbor Islands)
3. De komw kak tueng tohn doadoahk en med-quest en sewesei komwi audehda sapwelmomwi application https://medquest.hawaii.gov/en/resources/community-partners.html

When the Biden Administration announced the signing of the American Rescue Plan, our Branch sent out email communications and scheduled a Statewide virtual Teams call with our community partners to highlight the details of how this plan can further assist our residents with lowering their premium on the Federal Health Insurance Marketplace; helping those who may have been eligible for COBRA in 2020 to current but elected not to sign up for the coverage due to the expense, may now be able to obtain $0 cost COBRA coverage from 4/1/2021 – 9/30/2021.

The COVID-19 pandemic has been challenging for everyone. The one thing we have done better is conducting outreach differently given all of the restrictions with masks, social distancing, etc. by holding virtual talk story sessions/webinars, scheduled drive through education and assistance sessions in parking lots of our community partners, connecting with other grassroot organizations who directly serve those most needy and directly impacted and providing resource information flyers to organizations such as food banks, COVID-19 testing sites, Grab N Go breakfast and lunches through the Department of Education.

During this period, the HCOB team is still seeing a large number of residents being admitted to Hawaii State Hospital and have worked to help these members suspend their Medicaid coverage. This pandemic has put a tremendous stress on our residents who have mental health/behavioral health challenges and our branch worked closely with the Hawaii State Hospital to ensure we were helping to seamlessly suspend and/or unsuspend patients health coverage with Med-QUEST. During this period, we assisted over 70 patients suspend or unsuspend their coverage or submit new application to Med-QUEST.

VII. 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 January - March 2021, there were 391 adverse events from the Health Plan, 14 adverse events from Nursing Facilities, and 9 adverse events from ICF DD/ID for a total of 414 adverse events.

Jan 2021 – Mar 2021	**Health Plan**	**Nursing Facility**	**ICF DD/ID**	**TOTAL**
Fall	135	12	0	**147**
Hospital	62	1	3	**66**
Death	26	0	0	**26**
Emergency Room Visit	108	1	5	**114**
Injury	36	0	1	**37**
Med Error	10	0	0	**10**
Aspiration	14	0	0	**14**
TOTAL	**391**	**14**	**9**	**414**

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

MQD conducts a monthly encounter validation meeting with all participating MCOs to address major issues in encounter data submission or validation. Ongoing engagement supports a continuous data quality improvement initiative aimed at decreasing the number of encounters that fail system edits. MQD has developed an encounter reconciliation process directly with the MCOs that accounts for financial discrepancies between encounters submitted by the MCOs and accepted by MQD. The protocol for this reconciliation process has undergone iterative improvements, and the reconciliation is conducted at least twice per year. Substantial work has also begun to investigate and address the sources of discrepancies between the MCOs' and MQD's systems. MQD During FFY 2021, 2nd Quarter, MQD worked with its contracted actuary, Milliman, to refine the reconciliation process that will also compare encounters submitted by the MCOs to Milliman for rate development to those submitted and accepted by MQD. The revised forms were disseminated to MCOs; the first reconciliations using the new templates is expected in FFY 2021, 3rd Quarter. Triangulation of the reconciliation process to identify discrepancies found in the three systems (MCOs, Milliman, and MQD), and reconciliation of those differences, will enable improvements in data quality to support the use of data in the State Medicaid encounter system for future rate setting.
In addition to encounter data reconciliation, MQD has also worked closely with Milliman to effectively increase the financial consequences to MCOs associated with poor data quality in the State Medicaid encounter system; specifically, risk sharing calculations for high cost newborns and risk sharing for high cost drugs are transitioning to be solely determined based on encounters found within the State Medicaid encounter system. Beyond these measures, MQD has also built new provisions into the managed care re-procurement RFP to enhance oversight into encounter data submissions during the next contract cycle. During FFY 2021, 2nd Quarter, MQD developed additional questions to support the creation of an Encounter Data Financial Summary report template for its MCOs to begin using in FFY 2022. The new report includes additional data collection used to comprehensively evaluate timeliness, completeness, and accuracy of encounter data.

MQD also completed a contract with its EQRO to conduct an external encounter data validation project. The project included a full assessment of the Hawaii encounter pend system, including pend system edits; described in detail the current process by which MCOs prepare files for MQD and the data challenges experienced or incurred as a result; and resulted in a full data quality profile of Hawaii encounter data along with the development of a data quality protocol that may be implemented by MQD to track improvements in quality as processes are refined and improved. The project will inform future efforts to improve encounter data quality.

Beginning with FFY 2021, MQD has had additional funding to implement encounter data validation supports to improve encounter data validation, processing, investigations, and support from AHCCCS. As a result, tremendous planning and implementation of work continued into FFY 2021, 2nd Quarter. MQD now has a weekly meeting with AHCCCS to more routinely discuss issues, identify misalignments between states, and develop solutions in close partnership with AHCCCS. During FFY 2021, 2nd Quarter, MQD and AHCCCS developed a systematic approach to investigating and addressing encounter data quality issues; implemented a pend report that allows for monthly tracking of pends; and recruited 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. Additionally, AHCCCS issued a request for proposals for a documentation consultant. The documentation consultant will support MQD in a much needed policy-validation re-alignment exercise. The scope of work will include a needs assessment, followed by facilitation activities with stakeholders to develop solutions, and action planning to implement the solutions developed. The work order for the new scope of work is expected to begin in the third quarter of FFY 2021.

IX. 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.

X. Performance Metrics & Quality Assurance and Monitoring

A. Quality Activities

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)

PIPs are an organized way for health plans to assess healthcare processes and design interventions to improve member health, functional status, and/or satisfaction. The MQD required the health plans to conduct rapid-cycle PIPs based on plan-specific data that demonstrated a need for improvement.

January:

- Scheduled webinar with the health plans for Module 4 (PDSA) and 5 (PIP Conclusions) training on 02/11/21.
- Provided technical assistance to Kaiser for its Adolescent Well Care Visits PIP on 01/26/21.

February:

- Conducted Module 4 and 5 training webinars on 02/11/21.
- Conducted meeting with the MQD about the next set of rapid-cycle PIP topics on 02/16/21 and sent a summary of the meeting to the MQD on 02/19/21.

March:

- Continue to provide PIP technical assistance to the health plans and the MQD, as requested.

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.

January:

- Received HEDIS MY 2020-2021 Roadmap from all five health plans by 01/29/21.
- Completed survey sample frame validation and provided results report to each health plan by 01/29/21.

February:

- Approval of four health plan's Healthcare Organization Questionnaire (HOQ) submission has been completed as of 02/03/21.
- HSAG provided technical assistance to the MQD as requested.

March:

- Completed source code review for all non-HEDIS measures, including corrective actions, on 03/01/21.
- Finalized approval for all MCO standard and nonstandard supplemental data on 03/31/21.

3. Compliance Monitoring

MQD's EQRO evaluates the health plans' compliance with State and federal requirements for organizational and structural performance.

January:

- Provided technical assistance on CAPs to KFHP on 01/12/21 and 01/20/21 for Standards: Provider Selection, Subcontracts and Delegation, Credentialing and Program Integrity.
- Completed CAPs review of 'Ohana QI and 'Ohana CCS for the Standard Subcontracts and Delegation, and CAPS for UHC CP QI for Program Integrity Standard. Submitted CAP documents to the MQD for review on 01/14/21.
- MQD provided feedback on CAPs on 01/26/21. Email notification sent to 'Ohana on 01/27/21 requesting additional documentation.
- Email notification sent to UHCCP on 01/27/21 closing CAPs.

February:

- Received and reviewed updated CAP and supporting documentation from KFHP on 02/01/21.
- Reviewed additional documents submitted by 'Ohana QI and 'Ohana CCS on 02/05/21 and submitted to the MQD for review on 02/09/21. MQD provided feedback on 02/16/21.
- Email notification sent to 'Ohana QI and 'Ohana CCS on 02/16/21 closing CAPs.
- Completed review of KFHPs CAPs. Submitted CAP documents to the MQD for review on 02/22/21.

March:

- Received feedback from the MQD on KFHPs CAPs on 03/03/21 and sent follow-up email to KFHP regarding open CAP items on 03/03/21.

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.

January:

- MQD received updated CAHPS timeline on 01/04/21.
- Received 2021 sample frame files from the MQD on 01/07/21.
- Submitted CAHPS 2021 survey materials to NCQA for approval prior to volume printing on 01/15/21.

- Received sample frame file for CHIP and updated sample frame files for the QI health plans on 01/20/21.
- Received a deduplication file for UnitedHealthcare Community Plan (UHC CP) QI on 01/27/21.
- Received updated sample frame files for the QI health plans on 01/28/21.
- HEDIS Auditors completed validation of the sample frame files on 01/29/21.
- Sent sample frames to subcontractor, including deduplication file for UHC CP QI on 01/29/21.

February:

- Selected survey samples on 02/05/21.
- Ran survey samples through the U.S. Postal Service's National Change of Address (NCOA) system on 02/11/21.
- Notified MQD that the samples have been selected and address information has been updated on 02/11/21.
- MQD received final copies of survey materials for each population to be surveyed on 02/11/21.
- Printed and produced survey packets on 02/17/21.
- Mailed first questionnaires and cover letters to members on 02/18/21.
- Mailed first postcard reminders to non-respondents on 02/25/21.

March:

- Mailed second questionnaires and cover letters to non-respondents on 03/25/21.
- Sent weekly disposition reports to MQD on 03/12/21, 03/19/21, and 03/26/21.

Weekly Disposition Report
CAHPS 5.1H Child Medicaid Health Plan Survey
Hawaii Med-QUEST
March 12, 2021

	Sample Size	2021 Preliminary Response Rate	2019 Child/ 2020 CHIP Response Rate	Completes			Returns			Ineligible			
				Total	Phone	Mail	Mail 1	Mail 2	Undel.	Total	Not Enr.	Dec.	Lang.
Hawaii Child Medicaid Total—QUEST Integration	**10,725**	**4.09%**	**7.62%**	**439**	**0**	**439**	**439**	**0**	**741**	**0**	**0**	**0**	**0**
AlohaCare	2,145	2.84%	6.20%	61	0	61	61	0	169	0	0	0	0
HMSA	2,145	5.64%	9.09%	121	0	121	121	0	112	0	0	0	0
KFHP	2,145	4.90%	9.84%	105	0	105	105	0	98	0	0	0	0
'Ohana	2,145	3.92%	7.37%	84	0	84	84	0	169	0	0	0	0
UHC CP	2,145	3.17%	5.59%	68	0	68	68	0	193	0	0	0	0
Hawaii Child Medicaid Total—CHIP	**2,145**	**5.73%**	**10.91%**	**123**	**0**	**123**	**123**	**0**	**54**	**0**	**0**	**0**	**0**
Hawaii CHIP	2,145	5.73%	10.91%	123	0	123	123	0	54	0	0	0	0

Weekly Disposition Report
CAHPS 5.1H Child Medicaid Health Plan Survey
Hawaii Med-QUEST
March 19, 2021

	Sample Size	2021 Preliminary Response Rate	2019 Child/ 2020 CHIP Response Rate	Completes			Returns			Ineligible			
				Total	Phone	Mail	Mail 1	Mail 2	Undel.	Total	Not Enr.	Dec.	Lang.
Hawaii Child Medicaid Total—QUEST Integration	**10,725**	**6.99%**	**8.43%**	**750**	**0**	**750**	**750**	**0**	**905**	**0**	**0**	**0**	**0**
AlohaCare	2,145	5.45%	6.95%	117	0	117	117	0	200	0	0	0	0
HMSA	2,145	9.79%	10.02%	210	0	210	210	0	132	0	0	0	0
KFHP	2,145	8.25%	10.86%	177	0	177	177	0	121	0	0	0	0
'Ohana	2,145	6.06%	8.02%	130	0	130	130	0	216	0	0	0	0
UHC CP	2,145	5.41%	6.29%	116	0	116	116	0	236	0	0	0	0
Hawaii Child Medicaid Total—CHIP	**2,145**	**10.44%**	**11.56%**	**224**	**0**	**224**	**224**	**0**	**67**	**0**	**0**	**0**	**0**
Hawaii CHIP	2,145	10.44%	11.56%	224	0	224	224	0	67	0	0	0	0

Weekly Disposition Report
CAHPS 5.1H Child Medicaid Health Plan Survey
Hawaii Med-QUEST
March 26, 2021

	Sample Size	2021 Preliminary Response Rate	2019 Child/ 2020 CHIP Response Rate	Completes			Returns			Ineligible			
				Total	Phone	Mail	Mail 1	Mail 2	Undel.	Total	Not Enr.	Dec.	Lang.
Hawaii Child Medicaid Total—QUEST Integration	**10,725**	**8.42%**	**8.54%**	**903**	**0**	**903**	**903**	**0**	**948**	**0**	**0**	**0**	**0**
AlohaCare	2,145	6.90%	6.99%	148	0	148	148	0	204	0	0	0	0
HMSA	2,145	11.89%	10.12%	255	0	255	255	0	147	0	0	0	0
KFHP	2,145	9.79%	11.05%	210	0	210	210	0	127	0	0	0	0

'Ohana	2,145	7.18%	8.07%	154	0	154	154	0	226	0	0	0	0
UHC CP	2,145	6.34%	6.48%	136	0	136	136	0	244	0	0	0	0
Hawaii Child Medicaid Total—CHIP	**2,145**	**13.05%**	**12.63%**	**280**	**0**	**280**	**280**	**0**	**71**	**0**	**0**	**0**	**0**
Hawaii CHIP	2,145	13.05%	12.63%	280	0	280	280	0	71	0	0	0	0
Note: Preliminary response rates do not reflect the final reconciliation process. All reported response rates are preliminary until the final reconciliation is completed after the close of the survey field.													

5. Provider Survey

Due to COVID-19 and HSAG's findings of other states receiving only 2% Response Rate on this survey, MQD decided to postpone this activity.

January:

- Met with MQD on 01/12/21 to discuss provider survey administration.
- MQD decided on 01/15/21 that the Provider Survey will be postponed allowing providers to prioritize more critical issues during the PHE.

February:

- This activity is currently postponed.

March:

- This activity is currently postponed.

6. Annual Technical Report

January:

- MQD received draft EQR technical report for review and comment on 01/11/21.

February:

- Received approval of the 2020 EQR Technical Report from the MQD on 02/02/21.
- Finalized and submitted the 508-compliant EQR technical report to the MQD on 02/17/21.
- Five hard copies of the report shipped via FedEx to the MQD on 02/17/21.

March:

- Sent notification email to all health plans with the link to the 2020 EQR Technical Report on the MQD website and the final PDF file of the report on 03/05/21.
- MQD received letter from CMS regarding CMS's review of the 2018 and 2019 EQR Technical Reports on 03/12/21. MQD and HSAG discussed and drafted response letter on 03/26/21.

7. Technical Assistance

January:

- Provided technical assistance to the MQD and Health Analytics Office (HAO) as needed.

- Submitted Hospital P4P workplan to HAO for review and feedback on 01/04/21.
- Submitted Hospital P4P Environmental Scan Report Template to HAO for review and feedback on 01/14/21.
- Received feedback on the Hospital P4P workplan and report template from the HAO on 01/21/21.
- Conducted Hospital P4P update meeting with HAO on 01/15/21 and 01/28/21.

February:

- Received request from HAO for HSAG to provide reporting templates/guidelines provided to the health plans for incorporation into the MCO Health Plan Manual on 02/09/21.
- Received request from HAO to re-validate CY2019 P4P rates and payouts on 02/16/21. Completed validation and submitted P4P Excel document to HAO on 02/18/21.
- Conducted Hospital P4P update meeting with HAO on 02/25/21.
- Submitted the Hospital P4P Environmental Scan Report to the HAO on 02/27/21.

March:

- Conducted presentation of the Hospital P4P Environmental Scan results to the MQD and the HAO on 03/01/21.
- Provided PIP and PMV reporting templates to the HAO on 03/07/21 for consideration in the HAO's development of the health plan report manual.
- Conducted Hospital P4P update meeting with HAO on 03/11/21.

XI. Budget Neutrality and Financial Reporting Requirements

The Budget Neutrality Workbook for the quarter ending December 31, 2020 was submitted to CMS by the February 28, 2021 deadline. The Budget Neutrality Summary (worksheet) for the quarter ending March 31, 2021 will be submitted separately by the May 31, 2021 deadline.

XII. Evaluation Activities and Interim Findings

During FFY 2021 2nd Quarter, MQD's Health Analytics Office (HAO) worked closely with a newly recruited team at the University of Hawaii (MQD's external evaluators) to provide training and beginning planning and data collection activities. Data planning activities included the creation of brand new report templates to support a variety of reports that will collect data to support the evaluation project. Specifically, report templates were designed to collect new information on value-based purchasing and alternative payment models; special health care needs populations; LTSS populations; the CIS population; social determinants of health and health disparities; and the advancing primary care initiative. In addition, progress was made in granting access to MQD data.

XIII. 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.

The State of Hawaii believes that pursuant to section 1903(i)(24) of the Social Security Act (the Act), execution of this phased implementation plan brings the State into compliance with federal requirements under section 1940 of the Act within 12 months of our approval of this CAP. In response to a February 25, 2021 call with CMS, MQD sent a letter to CMS on March 25, 2021 requesting closure of this CAP. CMS has acknowledged receipt of the request and the State of Hawaii is awaiting further response from CMS.

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.

On August 3rd, HOKU was available to new Medicaid providers (enrolling for the first time) and our Wave 0 plans/organizations, Kaiser and Hawaii Pacific Health, who have internal administrative staff that enroll the providers for their plan/organization. MQD wanted to work in partnership with Kaiser and Hawaii Pacific Health to minimize the amount of external communication regarding provider application questions and issues. On August 10th, Wave 1 began, which included Group billers. Then on September 14th, Wave 2 began Wave 2 included individual providers (except for MDs), Adult Foster Care providers, Home Care Agencies, Adult Day Health and Case Management Agencies. Wave 3 began on October 26th and included all MDs (physicians). Finally, Wave 4 began on December 14th and included all remaining provider types (hospitals, pharmacies, labs, various agencies, etc.).

Our goal is to ger 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'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.

- **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**
    - MQD added additional MQD and Koan staff to assist with applications. Training is ongoing as staff started off with a specific enrollment type, then are trained on additional enrollment types. Also, there has been training to move staff to a place where they are able to complete applications fully

by themselves. MQD is in the process of working with Koan to add on additional staffing to assist with provider enrollment. The same training plan will be followed.

- **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 March.

Application Status	Number of Applications	Description
In Process	1,500	Number of applications providers are currently working on in HOKU but have not yet submitted.
In Review	1,769	Number of applications providers submitted in HOKU and are awaiting State Review.
Approved	1,581	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 2 (Q2), 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: Apply final updates and submit the EVV evidence packets to CMS/MITRE. 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.

JANUARY

During the month of January 2021, 100% of provider IDs became active and were ready for authorizations and EVV visits. Achieved a 95% completion rate for the provider agency self-paced Sandata administration training allowing provider agencies to begin setting up and configuring the EVV solution. The final sessions of Sandata instructor-led training completed. The EVV vendor Sandata fixed a second Authorization load issue. The AZ and HI EVV Project Teams continued to work the project schedule, participated in focused workstreams that address training, outreach, support, device management, and certification. Meetings

were hosted with the MCOs, Home Health and Home Care provider agencies, Financial Intermediary, and Self-Directed MCO stakeholders to review the EVV status and questions. Aligning with the Open Model approach, Alternate EVV vendor testing with Sandata continued.

FEBRUARY

During the month of February 2021, Med-QUEST performed outreach to all EVV provider agencies that have not loaded visits. Increased outreach activity for provider agencies from monthly meetings to bi-weekly. All MCOs completed the second round of authorization validation between what was sent to the EVV vendor and what is found in production. As a result of the authorization validation efforts, MCOs identified missing authorizations for correction and resubmission. The EVV vendor Sandata fixed a mobile application issue that prevented switching services when capturing visits. The EVV Project Teams continued focused workstream meetings that address training, outreach, support, device management, and certification. Meetings were hosted 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.

MARCH

During the month of March 2021, multiple 1-on-1 provider agency review sessions were held to review EVV visit statuses, so they clearly understand the overall situation when the hard edit is turned on. The majority of authorizations were sent from the state and MCOs to be loaded into the state EVV vendor Sandata. However, an issue persists with the EVV vendor getting the authorizations transferred from a staging environment to the production environment. Established and held 1st weekly Alt EVV Vendor group meeting to review EVV requirements and address/resolve visit upload issues. Met with 1-on-1 with Alt EVV vendors to address issues preventing visit uploads. Attended the second of three DOMO (Business intelligence reporting tool) training sessions with Sandata. All bulk orders for the Self-directed devices from the EVV vendor was delivered. Determined the Hard Edit date needed to move from 4/1/21 to 7/1/21 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

Through this ongoing COVID-19 public health emergency (PHE), MQD continued to address pandemic-related concerns such as planning and collaborating to carry out COVID-19 vaccinations for beneficiaries at most risk for severe illness if infected with COVID-19, and personal protective equipment sourcing and training on proper use for home and community-based (HCB) provider-operated homes.

Planning for operations post-PHE continued, including future telehealth policy planning, and collaborating with our managed care organizations (MCOs) to resume in-person assessments for beneficiaries residing in HCB provider-operated homes. In addition to the ongoing review of quarterly member grievance and appeal reports from our MCOs, an analysis of beneficiary appeals for years 2015 through 2020 identified high-frequency and emerging clinical issues to inform future policy decisions.

Finally, notifications to stakeholders were made concerning recent policy changes such as dental services requiring general anesthesia performed in a hospital setting and Medicaid eligibility for the previously ineligible citizens of the Freely Associated States under the Compact of Free Association (COFA), Inclusion of COFA under Medicaid will result in better access to health care and health outcomes for this population.

MQD Workshops and Other Events

Focus:	Understanding		
For:	**QUEST Integration HCBS Service Coordinators and Case Managers**		
Trainer	MQD Staff	**Location**	Webinar
Length	1.5 hours per session	**Dates**	December 22, 2020 January 5, 2021 January 20, 2021
Attendees	Approximately 50 – 225, varied by session		
Description	Review new Medicaid reporting forms for HCBS enrollment and termination. Review how cost share works for LTSS members		

Focus:	COVID 19 Vaccination Plan		
For:	**Case Managers, Residential Caregivers, MCO Service Coordination Supervisors**		
Speaker	Curtis Toma, MD/QI Quality Staff	**Location**	Webinars
Length	1 hour per session (3 sessions)	**Dates**	January 11, 2021 January 12, 2021 January 13, 2021
Attendees	Approximately 50-350+ based on content and target audience		
Description	COVID 19 Updates, Statewide Vaccination Plan		
Objectives/Outcomes	• Ensure implementation of Statewide Vaccination Plan for high risk individuals that reside in licensed/certified residential settings • Educate on pre-registration process and scheduling logistics • Open discussion for questions to guest speakers/experts		

Focus:	COVID 19 Vaccination Plan		
For:	**Members, Family, and other Stakeholders**		
Speaker	Curtis Toma, MD/AARP/Lt. Gov Josh Green	**Location**	Webinars
Length	1 hour per session (2 sessions)	**Dates**	January 30, 2021 February 12, 2021
Attendees	Approximately 50-350+ based on content and target audience		
Description	COVID 19 Updates, Statewide Vaccination Plan		
Objectives/Outcomes	• Ensure implementation of Statewide Vaccination Plan for high risk individuals that reside in licensed/certified residential settings		

	• Educate on pre-registration process and scheduling logistics • Open discussion for questions to guest speakers/experts

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	Aileen Manuel/NCAPPS team	**Location**	Go to Webinar
Length	1.0 hours (4 sessions)	**Date**	January 21, 2021 February 11, 2021 March 17, 2021 March 29, 2021
Attendees	Approximately 20+		
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 January 2021 – March 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 12/31/2020 is attached. The Budget Neutrality Summary for the quarter ending 03/31/2021 will be submitted by the 05/31/2021 deadline.

Attachment C: Budget Neutrality Workbook
The Budget Neutrality Workbook for the quarter ending 12/31/2020 is attached. The Budget Neutrality Workbook for the quarter ending 03/31/2021 will be submitted by the 05/31/2021 deadline.

B. MQD Contact(s)

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QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jan-21					Feb-21					Mar-21				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
Medicaid	68,954	184,507	45,034	28,830	40,767	69,927	186,763	41969	29018	41,128	70,759	188,817	42512	29121	41,190
Duals	4,069	7,324	2,005	9,274	16,064	4,113	7,474	1891	9239	16,091	4,170	7,703	1953	9248	16,090
Total	**73,023**	**191,831**	**47,039**	**38,104**	**56,831**	**74,040**	**194,237**	**43860**	**38257**	**57,219**	**74,929**	**196,520**	**44465**	**38369**	**57,280**
# Network Providers															
PCPs	857	1,092	222	807	919	877	1102	213	802	868	880	1100	212	794	847
PCPs - (accepting new members)	733	751	193	591	624	748	759	184	589	596	754	756	183	581	582
Specialists	2,811	3,149	458	1,553	1,682	2,822	3154	599	1553	1,685	2,853	3145	565	1551	1,703
Specialists (accepting new members)	1,989	3,149	458	993	1,425	2,016	3154	549	993	1,424	2,047	3145	565	991	1,436
Behavioral Health	882	1,727	194	680	1,066	899	1735	207	680	1,070	914	1725	228	680	1,067
Behavioral Health (accepting new members)	799	1,727	194	627	1,035	817	1735	207	627	1,036	834	1725	228	619	1,030
Hospitals	25	27	13	24	23	25	26	11	24	23	25	26	12	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	50	38	20	38	43	50	46	20	38	43	50	46	21	38	43
Residential Setting (CCFFH, E-ARCH, and ALF)	625	629	136	1,052	1,191	625	630	140	1054	1,192	631	622	148	1054	1,192
HCBS Providers (except residential settings and LTSS facilities)	93	157	69	92	85	98	135	66	92	85	103	135	62	92	84
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	2,052	2,541	251	1,786	1,845	2,120	2,498	282	1786	1,831	2,148	2,489	243	1788	1,846
Total # of providers	**7,395**	**9,360**	**1,363**	**6,032**	**6,854**	**7,516**	**9,326**	**1538**	**6,029**	**6,797**	**7,604**	**9,288**	**1491**	**6,021**	**6,805**
Call Center															
# Member Calls	4,284	10,286	793	5,311	4,087	3,986	9,492	569	4,801	3,589	7,479	10,794	618	5,693	4,065
Avg. time until phone answered	0	0	0	0	0:00:05	0:00:19	0:02:38	0:00:07	0:00:25	0:00:04	0:01:22	0:02:54	0:00:10	0:00:53	0:00:12
Avg. time on phone with member	0	0	0	0	0:08:12	0:06:07	0:07:35	6:26	0:08:25	0:07:26	0:06:28	0:07:43	6:38	0:08:41	0:07:23
% of member calls abandoned (member hung up)	0	0	0	0	0.20%	2.73%	12.82%	1%	2%	0.20%	10.30%	13.92%	1%	4%	0.70%
# Provider Calls	6,581	5,101	98	2,687	2,184	6,315	5,521	85	2,506	2,127	6,968	6,501	97	2,535	2,231
Avg. time until phone answered	0	0	0	0	0:00:02	0:00:12	0:07:16	0:00:03	0:00:15	0:00:03	0:00:26	0:06:41	0:00:09	0:00:10	0:00:08
Avg. time on phone with provider	0	0	0	0	0:07:49	0:06:41	0:08:41	6:07	0:08:58	0:07:40	0:06:51	0:09:20	5:39	0:09:07	0:07:52
% of provider calls abandoned (provider hung up)	0	0	0	0	0.23%	0.63%	29.40%	0%	2%	0.38%	2.90%	27.38%	3%	1%	0.40%
Medical Claims- Electronic															
# Submitted, not able to get into system	1,705	2,267	0	20,577	1,901	1,990	2,902	0	5060	2,287	2,042	2,607	0	2653	3,395
# Received	46,540	160,504	33,061	388,010	74,258	50,743	163,194	34985	63691	77,917	62,626	198,435	38630	55544	95,026
# Paid	41,725	131,800	31,491	335,518	69,280	48,602	146,781	33245	43234	71,317	60,053	155,427	35543	50047	83,841
# In Process	12,976	47,805	578	87,057	2,066	13,185	51,284	677	18361	2,376	10,812	78,430	2003	12446	9,184
# Denied	3,024	12,177	992	42,439	9,156	2,166	12,934	1063	9094	9,814	5,221	15,862	1084	11453	11,346
Avg time for processing claim in days	6	9	1	5.25	9	6	9	1	6	7	7	8	2	6.4	7
% of electronic claims processed in 30 days	1	99%	100	1	99	99%	99%	99.98	99%	100	97%	99%	99.99	100%	100
% of electronic claims processed in 90 days	1	100%	100	1	99	100%	100%	100	100%	100	100%	100%	100	100%	100
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	274	1,185	7	886	864	268	653	3	46	921	120	1,057	6	74	627
# Received	12,530	14,944	13	30,786	5,750	13,574	14,298	13	3437	5,722	17,161	15,919	7	2314	7,810
# Paid	11,239	10,181	3	23,597	4,835	12,604	13,002	4	2138	4,834	17,065	11,569	1	1579	5,855
# In Process	6,118	10,823	0	8,944	364	7,862	10,312	2	1236	451	5,921	12,828	0	917	1,075
# Denied	1,656	1,620	10	6,671	1,517	1,877	1,807	7	735	1,489	2,844	1,834	6	570	1,710
Avg time for processing claim in days	16	20	6	9	6	16	19	0	9.4	6	15	22	12	10.9	5
% of electronic claims processed in 30 days	1	93%	100	1	100	97%	94%	100.00	99%	100	94%	90%	85.71	100%	100
% of electronic claims processed in 90 days	1	99%	100	1	100	99%	100%	100.00	100%	100	100%	99%	100.00	100%	100
Prior Authorization (PA)- Electronic															
# Received	230	2924	900	811	1,187	232	2962	863	548	992	242	3275	813	457	1,266
# In Process	26	569	23	705	0	42	514	11	463	0	37	391	30	403	0
# Approved	195	2438	862	851	1,107	181	2,727	838	552	916	197	3,102	793	488	1,185
# Denied	37	225	15	14	80	66	290	14	22	76	57	296	21	7	81
Avg time for PA in days	1	3	3	4	1	1	4	3	8	1	0	5	3	5	2
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1,501	553	0	770	811	1,469	454	0	819	1,004	1,561	587	0	958	1,391
# In Process	188	36	0	710	0	255	23	0	699	0	185	28	0	897	0
# Approved	1,251	468	0	825	703	1,133	429	0	735	920	1,273	534	0	952	1,378
# Denied	125	67	0	16	108	181	38	0	24	84	228	48	0	26	113
Avg time for PA in days	2	3	0	4	2	1	2	0	3	2	1	2	0	5	2
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	3,106	4,174	597	4465	7,956	3,107	4,532	626	4452	7,642	1,687	5,594	806	4954	8,821
Air (by segment)	540	731	167	200	422	570	785	160	239	317	473	868	167	349	345
Public Transportation Pass (bus pass & handivan coupons)	1,130	829	491	1302	860	911	1,526	477	1299	822	205	744	770	1481	964
# Member Grievances															
# Received	12	8	16	38	18	18	9	19	17	28	96	12	26	33	28
# Resolved	12	12	15	7	15	11	4	20	1	20	75	10	23	3	32
# Outstanding	6	6	11	50	18	13	11	10	66	26	34	13	13	96	22
# Provider Grievances															
# Received	85	1	37	0	0	109	3	113	0	1	144	1	112	0	0
# Resolved	134	2	36	0	1	120	1	110	0	0	149	0	106	0	1
# Outstanding	66	1	1	0	0	55	3	3	0	1	50	4	6	0	0

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Jan-21					Feb-21					Mar-21				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Member Appeals															
# Received	3	64	0	4	10	3	74	0	9	10	5	57	1	4	9
# Resolved	1	52	0	3	15	3	70	0	6	6	5	69	0	8	11
# Outstanding	3	25	0	3	0	3	29	0	6	4	3	17	1	0	2
# Provider Appeals															
# Received	4	6	0	44	40	3	11	0	37	41	-	30	0	44	65
# Resolved	9	9	0	19	35	3	3	0	63	57	4	13	0	40	29
# Outstanding	4	8	0	44	23	4	16	0	18	7	-	33	0	1	43
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	60	76	3	91	53	56	68	4	81	44	62	78	4	80	53
Inpatient Acute Days * (A) - per 1,000	353	238	18	566	386	290	224	18	546	314	331	234	23	612	386
Readmissions within 30 days* (A)	25	133	23	34	25	27	132	14	32	26	36	197	24	25	33
ED Visits * (C) - per 1,000**	349	286	20	576	419	313	261	21	453	384	368	289	22	498	428
# Prescriptions (C) - per 1,000	6,652	8,662	455	10,136	8,587	5,996	8,223	477	9,507	8020	6,715	9,208	478	10,413	9,009
Waitlisted Days * (A) - per 1,000	27	2	0	20	125	33	3	0	57	151	31	4	1	22	146
NF Admits * (A)	40	14	5	8	33	23	17	4	6	20	27	20	6	12	27
# Members in NF (non-Medicare paid days) (C)**	212	323	105	631	659	225	324	104	614	620	248	329	107	601	589
# Members in HCBS **(C)- note: member can be included in more than one category listed below	266	429	242	1876	1,579	256	284	249	1872	1525	338	292	241	1786	1489
# Members in Residential Setting **(C)	147	139	124	514	846	141	140	129	478	858	145	141	106	466	873
# Members in Self-Direction **(C)	79	120	54	657	280	78	118	60	696	253	74	114	62	638	281
# Members receiving other HCBS **(C)	125	228	188	1219	1,299	123	119	189	1176	1272	196	113	179	1148	1208
# Members in At-Risk ** (C)	821	930	158	804	1,242	834	951	166	801	1360	851	963	160	850	1367
# Members in Self-Direction **(C)	319	379	33	348	422	322	377	35	358	435	311	380	34	337	489
# Members receiving other HCBS **(C)	343	735	125	412	820	390	752	131	402	925	398	754	126	466	878
(* 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: 3/31/2021

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	501	83	23	12	68	90	103	880
PCPs - (accepting new members)	**422**	**73**	**20**	**10**	**57**	**78**	**94**	**754**
Specialists*	2097	290	6	0	179	82	199	2853
members)	**1519**	**184**	**4**	**0**	**125**	**60**	**155**	**2047**
Behavioral Health*	567	127	12	3	48	86	71	914
Behavioral Health (accepting new members)	**510**	**119**	**12**	**3**	**45**	**81**	**64**	**834**
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)	522	29	1	0	10	53	16	631
HCBS Providers (except residential settings and LTSS facilities)	46	18	5	3	8	17	6	103
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1432	257	25	14	146	133	141	2148
Totals	**5206**	**809**	**73**	**34**	**469**	**468**	**545**	**7604**

* 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	42471	9331	2335	491	6214	7104	6983	**74929**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	85	112	102	41	91	79	68	85

Note: RFP requirement is 300 members for every PCP

HMSA

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	701	92	14	13	67	103	110	1,100
PCPs - (accepting new members)	**454**	**66**	**12**	**9**	**46**	**77**	**92**	**756**
Specialists*	1,877	318	66	44	184	331	325	3,145
members)	**1,877**	**318**	**66**	**44**	**184**	**329**	**325**	**3,145**
Behavioral Health*	1,074	210	8	7	96	193	137	1,725
Behavioral Health (accepting new members)	**1,074**	**210**	**8**	**7**	**96**	**193**	**137**	**1,725**
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)	493	31	1	0	12	63	22	622
HCBS Providers (except residential settings and LTSS facilities)	57	17	9	7	12	22	11	135
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,644	267	23	13	154	168	220	2,489
Totals	**5,887**	**939**	**123**	**85**	**533**	**886**	**835**	**9,288**

* 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	116249	14746	972	205	13388	29991	20969	**196,520**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	166	160	69	16	200	291	191	179

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)*	156	57						213
PCPs - (accepting new members)	136	47						**183**
Specialists*	464	101						565
members)	464	101						**565**
Behavioral Health*	188	40						228
Behavioral Health (accepting new members)	188	40						**228**
Hospitals	10	2						12
LTSS Facilities (Hosp./NF)	20	1						21
Residential Setting (CCFFH, E-ARCH, and ALF)	134	14						148
HCBS Providers (except residential settings and LTSS facilities)	55	14						69
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	177	58						235
Totals	**1204**	**287**	**0**	**0**	**0**	**0**	**0**	**1491**

* 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	29348	15117						**44465**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	188	265	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	209

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)*	545	51	8	10	71	71	38	794
PCPs - (accepting new members)	405	34	8	10	58	36	30	**581**
Specialists*	1168	108	13	4	113	76	69	1551
members)	706	88	13	4	53	66	61	**991**
Behavioral Health*	474	50	4	0	34	74	44	680
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)	884	41	0	0	18	86	25	1054
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**	**443**	**44**	**22**	**379**	**503**	**346**	**6021**

* 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	23899	3905	401	99	2148	4731	3186	**38369**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	44	77	50	10	30	67	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)*	565	71	12	7	66	87	67	875
PCPs - (accepting new members)	399	34	7	5	60	49	48	**602**
Specialists*	1309	175	66	11	118	220	191	2.090
members)	1062	159	47	11	110	204	175	**1,768**
Behavioral Health*	764	243	62	63	176	236	202	1,746
Behavioral Health (accepting new members)	739	237	62	63	173	233	199	**1,706**
Hospitals	10	2	1	1	3	4	3	24
LTSS Facilities (Hosp./NF)	27	3		1	5	6	1	43
Residential Setting (CCFFH, E-ARCH, and ALF)	983	53	1		23	109	23	1.192
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	1338	251	16	18	141	184	159	2,107
Totals	**5,043**	**810**	**159**	**101**	**540**	**864**	**652**	**8,169**

* 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	37,398	4,935	280	104	3,183	7,307	4,073	**57,280**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	66	70	23	15	48	84	61	65

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls as of: 3/31/2021

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	103	5	4	0	4	5	5	**126**
Network (provider look up, access)	116	15	2	0	2	18	7	**160**
Primary Care Physician Assignment or Change	303	38	8	1	15	33	12	**410**
NEMT (inquiry, scheduling) -*monthly report*	2472	176	51	35	19	169	115	**3037**
Authorization/Notification (prior auth status)	502	40	7	1	11	60	17	**638**
Eligibility (general plan eligiblity, change request)	841	72	4	4	40	86	20	**1067**
Benefits (coverage inquiry)	202	24	6	2	4	54	7	**299**
Enrollment (ID card request, update member information)	41	2	0	0	0	11	2	**56**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	326	14	1	0	11	18	7	**377**
Billing/Payment/Claims	842	34	1	0	16	78	14	**985**
Appeals	6	0	0	0	0	2	0	**8**
Complaints and Grievances	28	6	0	1	1	6	1	**43**
Other	337	48	6	0	19	29	10	**449**
Totals	**6,119**	**474**	**90**	**44**	**142**	**569**	**217**	**7,655**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	5	0	0	0	0	4	0	**9**
Network (provider look up, access)	130	17	0	0	7	18	12	**184**
Primary Care Physician Assignment or Change	1191	156	6	2	138	215	182	**1890**
NEMT (inquiry, scheduling) -*monthly report*	168	68	19	4	53	156	99	**567**
Authorization/Notification (prior auth status)	26	4	0	0	1	13	11	**55**
Eligibility (general plan eligiblity, change request)	274	61	3	0	25	36	33	**432**
Benefits (coverage inquiry)	262	60	3	0	38	43	40	**446**
Enrollment (ID card request, update member information)	829	85	3	2	87	170	106	**1282**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	46	9	1	0	1	19	9	**85**
Billing/Payment/Claims	203	27	0	0	26	18	23	**297**
Appeals	1	3	1	0	1	0	2	**8**
Complaints and Grievances	1	0	0	0	1	0	0	**2**
Other	547	97	4	1	52	109	111	**921**
Totals	**3683**	**587**	**40**	**9**	**430**	**801**	**628**	**6178**

s

KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	4	0						**4**
Network (provider look up, access)	39	9						**48**
Primary Care Physician Assignment or Change	5	2						**7**
NEMT (inquiry, scheduling) -*monthly report*	14	1						**15**
Authorization/Notification (prior auth status)	0	0						**0**
Eligibility (general plan eligiblity, change request)	211	36						**247**
Benefits (coverage inquiry)	141	38						**179**
Enrollment (ID card request, update member information)	31	13						**44**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	18	2						**20**
Appeals	0	0						**0**
Complaints and Grievances	0	0						**0**
Other	124	27						**151**
Totals	**587**	**128**	**0**	**0**	**0**	**0**	**0**	**715**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	258	41	6	2	23	77	21	**428**
Network (provider look up, access)	31	4	0	0	0	13	1	**49**
Primary Care Physician Assignment or Change	85	21	2	0	5	22	9	**144**
NEMT (inquiry, scheduling) -*monthly report*	1869	295	29	4	45	58	18	**2318**
Authorization/Notification (prior auth status)	17	7	7	0	1	18	11	**61**
Eligibility (general plan eligiblity, change request)	53	6	2	0	4	14	5	**84**
Benefits (coverage inquiry)	154	22	4	1	10	20	10	**221**
Enrollment (ID card request, update member information)	244	37	1	0	10	77	17	**386**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	143	20	2	1	4	29	2	**201**
Billing/Payment/Claims	24	8	2	0	3	7	3	**47**

Appeals	16	0	0	0	0	3	2	**21**
Complaints and Grievances	16	1	0	0	0	6	1	**24**
Other	1085	163	26	5	54	267	101	**1701**
Totals	**3,995**	**625**	**81**	**13**	**159**	**611**	**201**	**5,685**

UNITED HEALTHCARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	152	16	0	0	6	14	31	**219**
Network (provider look up, access)	95	21	1	0	5	38	22	**182**
Primary Care Physician Assignment or Change	33	3	0	0	1	5	6	**48**
NEMT (inquiry, scheduling) -*monthly repor*t	73	19	1	0	9	24	11	**137**
Authorization/Notification (prior auth status)	35	14	0	0	9	27	6	**91**
Eligibility (general plan eligiblity, change request)	486	65	4	1	29	83	60	**728**
Benefits (coverage inquiry)	670	88	4	1	43	101	49	**956**
Enrollment (ID card request, update member information)	125	23	0	0	8	24	13	**193**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	146	17	1	0	9	26	13	**212**
Billing/Payment/Claims	10	0	2	0	0	0	1	**13**
Appeals	9	2	0	0	0	2	1	**14**
Complaints and Grievances	4	1	0	0	0	0	2	**7**
Other	1043	158	16	1	70	261	94	**1643**
Totals	**2,881**	**427**	**29**	**3**	**189**	**605**	**309**	**4,443**

Health plan shall highlight changes made for the previous month(s)	
# Members	Description of Information to Include
	Number of members receiving QI benefit package who do not have
Medicaid	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

# 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 (excluldes 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

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	$ 394,369,386	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,549,075,451
EG 2 - Adults	2	$ 169,062,711	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,181,147,007
EG 3 - Aged	3	$ 395,961,900	$ 432,413,782	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,177,401,263
EG 4 – Blind/Disabled	4	$ 480,047,927	$ 583,690,940	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,167,038,280
TOTAL		**$ 1,439,441,923**	**$ 1,637,661,792**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,511,708,323**

Savings Phase-Down

Medicaid Per Capita			26	27	28	29	30	TOTAL
	1	*Savings Phase-Down*						
EG 1 - Children		**Without Waiver**	$ 629,048,812	$ 717,839,231	$ 743,144,011	$ 769,348,398	$ 796,466,688	
		With Waiver	$ 394,369,386	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
Difference			$ 234,679,426	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 176,009,569	$ 236,014,446	$ 244,334,666	$ 252,953,883	$ 261,869,576	
	2	*Savings Phase-Down*						
EG 2 - Adults		**Without Waiver**	$ 389,003,731	$ 493,673,250	$ 524,738,003	$ 557,755,942	$ 592,854,097	
		With Waiver	$ 169,062,711	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
Difference			$ 219,941,020	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 164,955,765	$ 206,452,113	$ 219,443,384	$ 233,250,960	$ 247,929,298	
	3	*Savings Phase-Down*						
EG 3 - Aged		**Without Waiver**	$ 658,268,709	$ 667,386,828	$ 696,978,684	$ 727,880,659	$ 760,156,997	
		With Waiver	$ 395,961,900	$ 432,413,782	$ 460,966,093	$ 481,405,329	$ 502,750,842	
Difference			$ 262,306,809	$ 234,973,046	$ 236,012,591	$ 246,475,330	$ 257,406,155	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 196,730,107	$ 176,229,784	$ 177,009,443	$ 184,856,498	$ 193,054,616	
	4	*Savings Phase-Down*						
EG 4 – Blind/Disabled		**Without Waiver**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 480,047,927	$ 583,690,940	$ 616,353,767	$ 649,908,066	$ 685,289,061	
Difference			$ 275,366,492	$ 298,588,627	$ 313,956,731	$ 331,048,536	$ 349,071,717	
Phase-Down Percentage			25%	25%	25%	25%	25%	
Savings Reduction			$ 206,524,869	$ 223,941,470	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 744,220,310**	**$ 842,637,813**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,347,118,184**

BASE VARIANCE			**$ 248,073,437**	**$ 280,879,271**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,449,039,395**
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								**$ 1,449,039,395**

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)		$ 1,687,515,360	$ 3,606,056,423	$ 5,624,972,577	$ 7,741,566,436	$ 9,960,747,718
Allowed Cumulative Variance (= CTP X CBNL)		$ 33,750,307	$ 54,090,846	$ 56,249,726	$ 38,707,832	$ -
Actual Cumulative Variance (Positive = Overspending)		$ (248,073,437)	$ (528,952,707)	$ (821,037,721)	$ (1,127,486,969)	$ (1,449,039,395)
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	$649,225,517	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL		**$ 649,225,517**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,339,445,444**

HYPOTHETICALS VARIANCE 1			**$ 620,607,577**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,513,164,523**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ -	$ 2,739,036	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon		2,206	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 2,739,036**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 19,024,137**

With-Waiver Total Expenditures

		26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita							
EG 6 - CIS	1	$ -	$ 2,665,522	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL		**$ -**	**$ 2,665,522**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 18,510,746**

HYPOTHETICALS VARIANCE 2			**$ -**	**$ 73,514**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 513,390**

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**	$ -	$ 7,470,112	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon		2,206	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 7,470,112**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 51,883,960**

With-Waiver Total Expenditures

		26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita							
EG 7 – CIS Community Transition Pilot	1	$ -	$ 7,269,606	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL		**$ -**	**$ 7,269,606**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 50,483,852**

HYPOTHETICALS VARIANCE 3			**$ -**	**$ 200,506**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,400,108**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1148 (CMS-10398 #56)**. The time required to complete this information collection is estimated to average **7.5 hours** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Start Date	9/1/1994	9/1/1995	9/1/1996	9/1/1997	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	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	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	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

		26	27	28	29	30
Medicaid Per Capita						
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

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

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

		26	27	28	29	30
Hypothetical 3 Per Capita						
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:	2/9/2021	Reporting DY	27
For the Time Period Through:	12/31/2020	Reporting Quarter	2

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	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	70,981,761	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	70,981,761	70,981,761
1902 R2	0	173,206,589	0	0	0	0	(28,108)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	173,178,481	173,178,481
1902 R2X	0	(8,243,749)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(8,243,749)	(8,243,749)
1902R2	0	121,392	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	121,392	121,392
AFDC	0	148,069,654	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	148,069,654	148,069,654
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(295)	121,279,464	314,952,648	350,714,627	326,518,117	349,156,948	184,750,729	364,919,444	307,865,937	320,856,325	330,120,146	557,686,762	367,673,762	161,062,904	0	0	0	4,057,557,518	4,057,557,518
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,424,989	17,555,107	24,914,002	19,728,957	24,483,589	14,925,306	37,994,811	48,712,106	46,535,285	55,494,164	84,455,174	64,625,579	31,836,506	0	0	0	473,685,575	473,685,575
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(473,188)	(505,165)	(397,775)	(598,936)	(490,186)	(31,916)	0	0	0	(2,497,166)	(2,497,166)
Aged without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(14,668)	(44,822)	(62,495)	(43,976)	(17,253)	0	0	0	0	(183,214)	(183,214)
B/D w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(13,736)	31,794,652	74,760,519	81,089,359	77,504,607	88,201,319	49,105,356	98,847,286	163,362,887	158,584,686	154,651,730	245,425,073	149,275,133	65,960,465	0	0	0	1,438,549,336	1,438,549,336
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(28,991)	81,514,842	211,664,665	248,689,322	257,028,809	282,670,355	148,440,400	290,201,067	285,336,958	310,399,367	340,654,230	473,812,306	334,707,192	157,186,860	0	0	0	3,422,277,382	3,422,277,382
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(324,738)	(333,645)	(370,635)	(399,762)	(294,330)	(17,997)	0	0	0	(1,741,107)	(1,741,107)
Blind/Disabled with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(61,110)	(74,223)	(153,925)	(230,511)	(81,788)	(2,258)	0	0	0	(603,815)	(603,815)
Breast Cervical Cancer Treatment (BCCT)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(2)	4,053	545,332	904,018	750,145	365,104	585,589	277,616	222,869	103,847	107,702	25,702	38,601	0	0	0	3,930,576	3,930,576
CURRENT	0	493,934,086	0	0	0	0	1,661,326	159,616,917	75,521,154	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	730,733,483	730,733,483
CURRENT POP	0	272,778,438	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	272,778,438	272,778,438
Current-Hawaii Quest	0	0	0	0	0	0	0	0	40,064,795	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	40,064,795	40,064,795
Demo Elig Adults	0	0	0	0	0	0	0	0	134,638	1,995	51,709	318,560	127,982,800	129,456,848	154,209,257	177,392,619	201,628,981	238,945,778	244,752,485	227,394,155	43,950,943	55,913	(5,724)	735	0	0	0	0	0	0	0	1,546,271,692	1,546,271,692
Expansion State Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	191,925,290	343,651,347	477,526,936	537,025,591	785,722,101	533,344,073	275,716,918	0	0	0	3,144,912,256	3,144,912,256
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	91,499	83,366	94,158	137,403	73,022	176,324	173,482	703,614	618,274	885,664	1,318,600	2,269,310	1,687,982	785,885	0	0	0	9,098,583	9,098,583
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	33,061	26,332	8,001	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,925,126	7,925,126
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	135,520	683,159	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	818,679	818,679
HealthQuest-Current	0	3,884,748	350,430	12,121,771	10,002,019	7,377,643	10,651,130	9,373,702	64,428,704	230,593,470	268,955,153	392,471,288	(2,325,152)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,007,884,906	1,007,884,906
HealthQuest-Others	0	1,783,163	215,685	5,322,833	3,698,445	2,678,918	3,915,013	3,306,673	21,010,550	63,645,959	99,234,046	93,729,117	(621,643)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	297,918,759	297,918,759
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	56,504	120,767	115,693	58,345	117,005	109,837	8,305	0	0	0	0	0	0	0	0	0	0	0	0	586,456	586,456
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,715	3,960	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11,675	11,675
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	122,839	581,513	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	704,352	704,352
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,331	217,050,612	165,225,916	110,172,746	126,903,825	187,913,635	115,881,444	59,643,184	0	0	0	982,792,693	982,792,693
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,100,418	16,199,737	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	21,300,155	21,300,155
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	76,678	103,084	80,075	257,166	253,182	31	0	0	0	0	0	0	0	0	0	0	0	0	0	770,216	770,216
OTHERS	0	288,512,308	0	0	0	0	786,332	56,430,712	30,507,680	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	376,237,032	376,237,032
Others-Hawaii Quest	0	0	0	0	0	0	0	0	13,142,103	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,142,103	13,142,103
OthersX	0	(15,309,727)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(15,309,727)	(15,309,727)
QUEST ACE	0	0	0	0	0	0	0	0	0	0	0	0	(2,751)	798,681	5,696,094	14,348,747	23,867,636	30,465,656	27,968,205	76,432,838	26,173,447	106,232	0	0	0	0	0	0	0	0	0	205,854,785	205,854,785
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,862,479	17,432,949	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	25,295,428	25,295,428
St Pl Adults-Preg Immig/COFAs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,990	2,628,840	2,628,927	2,873,646	987,921	1,532,329	1,448,764	2,048,646	2,315,023	4,043,498	3,109,986	1,077,062	0	0	0	24,719,632	24,719,632
State Plan Adults	0	0	0	0	0	0	0	0	(10)	218	99	39,158	111,982,730	118,021,622	109,034,691	128,225,118	131,863,143	123,596,289	112,790,909	130,112,852	80,834,554	202,368,440	172,913,238	169,042,108	182,723,816	254,549,511	165,927,023	83,115,353	0	0	0	2,277,140,862	2,277,140,862
State Plan Children	0	0	0	0	0	0	0	(41)	(9,403)	2,008	878	2,541,467	181,803,051	179,672,723	155,392,585	168,853,209	202,959,370	213,968,923	187,874,968	215,942,758	106,595,493	248,572,557	306,184,516	316,589,798	372,171,569	589,063,353	392,681,404	171,796,012	0	0	0	4,012,657,198	4,012,657,198
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	7,500,002	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,500,002	7,500,002
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	17,822,210	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17,822,210	17,822,210
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	15,688,221	22,546,108	18,919,184	16,356,580	24,507,605	34,064,491	48,859,842	12,164,879	5,856,911	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	609,561	0	0	0	0	0	0	0	0	0	0	0	0	609,561	609,561
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	10,056,500	3,403,710	7,500,000	7,500,000	7,500,000	7,500,000	0	38,818,619	39,694,442	82,153,936	85,515,739	66,000,000	0	0	0	0	0	0	0	355,642,946	355,642,946
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	71,468,225	(8,863)	0	0	0	0	0	0	0	0	0	71,459,362	71,459,362
Total	0	1,430,419,192	673,385	19,929,180	15,337,318	10,916,896	18,580,159	228,727,963	244,800,211	294,243,934	368,276,721	514,860,384	444,696,938	454,123,543	464,250,373	785,020,500	1,211,765,023	1,357,369,890	1,307,250,732	1,449,178,427	773,323,644	1,747,098,723	1,886,418,458	1,978,888,489	2,102,497,711	3,183,775,240	2,128,055,723	1,008,167,579	0	0	0	25,428,646,336	25,428,646,336

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
1,115	0	35,490,882	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35,490,882	35,490,882
1902 R2	0	86,769,823	0	0	0	0	(14,054)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	86,755,769	86,755,769
1902 R2X	0	(4,205,136)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(4,205,136)	(4,205,136)
1902R2	0	60,696	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	60,696	60,696
AFDC	0	74,034,827	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	74,034,827	74,034,827
Aged w/Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(199)	81,134,508	211,362,743	229,319,379	165,433,841	179,767,116	95,671,244	189,594,082	162,182,080	173,947,428	181,187,273	302,914,812	210,405,222	95,669,650	0	0	0	2,278,589,179	2,278,589,179
Aged w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,622,988	11,822,762	16,022,396	9,984,628	12,621,590	7,728,650	19,714,969	25,630,796	25,194,791	30,421,066	45,729,072	37,082,262	18,907,985	0	0	0	262,483,955	262,483,955
Aged with Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(249,679)	(273,613)	(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	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(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	133,308,080	85,379,901	39,178,066	0	0	0	799,642,593	799,642,593
B/D w/o Mcare	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(19,525)	54,511,233	141,799,152	161,274,589	130,207,936	145,622,789	76,872,883	150,336,282	149,646,906	167,640,879	186,541,259	255,768,734	191,184,821	93,366,811	0	0	0	1,904,754,749	1,904,754,749
Blind/Disable without Medicare - MFP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(171,495)	(180,813)	(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	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(1)	2,754	361,286	592,247	495,478	241,945	376,275	201,477	152,695	77,771	62,536	15,488	27,629	0	0	0	2,607,580	2,607,580
CURRENT	0	247,684,665	0	0	0	0	904,176	83,526,544	40,668,142	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	372,783,527	372,783,527
CURRENT POP	0	136,389,220	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	136,389,220	136,389,220
Current-Hawaii Quest	0	0	0	0	0	0	0	0	22,572,505	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	22,572,505	22,572,505
Demo Elig Adults	0	0	0	0	0	0	0	0	79,127	1,144	30,236	186,922	75,196,276	74,766,107	87,642,204	114,378,784	135,452,513	154,819,222	123,131,082	116,746,726	22,522,276	29,051	(3,183)	397	0	0	0	0	0	0	0	904,978,884	904,978,884
Expansion State Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	157,575,707	316,564,065	458,125,253	498,122,382	729,873,052	485,811,150	248,145,226	0	0	0	2,894,216,835	2,894,216,835
FosterCare(19-20)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	51,916	53,413	63,415	89,013	36,291	90,804	89,632	365,633	326,044	480,663	723,548	1,231,959	965,803	466,759	0	0	0	5,034,893	5,034,893
HawaiiQuest-1902(R)(2)	0	353,988	53,702	1,242,907	818,930	430,573	808,769	0	0	166	20,369	256,468	0	0	18,679	19,755	5,389	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,029,695	4,029,695
HCCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	76,578	438,797	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	515,375	515,375
HealthQuest-Current	0	1,963,002	175,736	6,063,866	5,004,058	3,692,366	5,386,340	4,903,637	36,087,606	132,768,282	165,985,082	231,578,381	(1,365,848)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	592,242,508	592,242,508
HealthQuest-Others	0	901,053	107,974	2,662,739	1,849,641	1,340,727	1,981,352	1,733,011	11,768,154	36,642,802	60,584,431	55,313,761	(363,962)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	174,521,683	174,521,683
Med Needy Adults	0	0	0	0	0	0	0	0	0	0	0	0	32,497	68,553	68,082	38,985	78,049	64,590	4,238	0	0	0	0	0	0	0	0	0	0	0	0	354,994	354,994
Med Needy Children	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	5,196	2,666	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,862	7,862
MFCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	69,404	368,050	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	437,454	437,454
Newly Eligible Adults	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,331	217,032,614	165,225,680	110,132,233	120,601,192	175,896,520	105,592,782	53,678,867	0	0	0	948,161,219	948,161,219
NH w/o W	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,881,647	10,235,011	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13,116,658	13,116,658
Opt St Pl Children	0	0	0	0	0	0	0	0	0	0	0	0	44,819	59,404	45,487	166,217	170,408	21	0	0	0	0	0	0	0	0	0	0	0	0	0	486,356	486,356
OTHERS	0	144,525,295	0	0	0	0	426,612	29,580,209	16,428,385	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	190,960,501	190,960,501
Others-Hawaii Quest	0	0	0	0	0	0	0	0	7,404,260	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7,404,260	7,404,260
OthersX	0	(7,809,492)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	(7,809,492)	(7,809,492)
QUEST ACE	0	0	0	0	0	0	0	0	0	0	0	0	(1,583)	454,606	3,232,556	9,373,768	16,050,472	19,640,154	13,856,685	39,331,445	13,397,540	55,183	0	0	0	0	0	0	0	0	0	115,390,826	115,390,826
RAACP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,442,944	10,922,768	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	15,365,712	15,365,712
St Pl Adults-Preg Immig/COFAs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	16,829	1,707,938	1,317,977	1,473,988	508,843	795,526	764,288	1,111,786	1,270,634	2,194,658	1,782,556	639,773	0	0	0	13,584,796	13,584,796
State Plan Adults	0	0	0	0	0	0	0	0	(6)	125	52	22,986	65,812,117	68,288,552	61,892,816	82,540,889	88,651,957	80,730,594	56,365,779	66,741,085	41,647,599	104,845,589	90,882,653	91,217,054	100,152,370	137,841,835	94,809,381	49,365,101	0	0	0	1,281,808,528	1,281,808,528
State Plan Children	0	0	0	0	0	0	0	(23)	(5,530)	1,173	507	1,494,521	106,725,591	103,797,242	88,086,005	108,850,847	136,539,237	138,140,612	92,677,457	110,463,464	54,513,113	128,939,223	161,395,719	171,534,913	204,150,083	319,640,269	224,831,482	102,033,839	0	0	0	2,253,809,744	2,253,809,744
Supp. - Private	0	0	0	0	0	0	0	0	0	0	0	4,385,251	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4,385,251	4,385,251
Supp. - State Gov.	0	0	0	0	0	0	0	0	0	0	0	10,614,749	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	10,614,749	10,614,749
UCC-Governmental	0	0	0	0	0	0	0	0	0	0	0	0	9,212,484	13,041,165	10,762,501	10,040,250	16,505,872	22,280,473	24,838,917	6,249,536	3,037,111	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	0	0	0	0	0	0	0	0	0	0	0	0	0	0	307,706	0	0	0	0	0	0	0	0	0	0	0	0	307,706	307,706
UCC-Private	0	0	0	0	0	0	0	0	0	0	0	0	5,787,516	1,958,835	4,237,500	4,959,750	5,051,250	4,697,250	0	20,131,336	20,583,506	42,677,271	45,049,870	35,626,800	0	0	0	0	0	0	0	190,760,884	190,760,884
VIII-Like Group	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	37,060,184	(4,595)	0	0	0	0	0	0	0	0	0	37,055,589	37,055,589
Total	0	716,158,823	337,412	9,969,512	7,672,629	5,463,666	9,493,195	119,743,378	135,002,643	169,413,692	226,620,677	303,853,039	261,079,907	262,434,464	263,479,344	510,938,536	813,433,104	881,694,769	657,883,822	745,135,931	399,268,014	1,068,914,679	1,206,703,201	1,321,117,892	1,407,568,920	2,103,771,288	1,437,361,508	701,448,576	0	0	0	15,745,962,621	15,745,962,621

ADM Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	39,312,729	11,586,429	43,993,148	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	89,286,976	39,705,766	0	0	0	1,079,287,439	1,079,287,439
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	755,748	34,375,214	12,833,291	0	0	0	0	0	0	0	0	0	0	0	0	0	0	47,964,253	47,964,253
Total	0	0	0	0	0	0	0	0	0	0	0	0	7,241,969	42,748,419	40,068,477	45,961,643	56,826,439	59,479,815	54,588,745	85,205,753	62,594,608	82,954,286	118,530,760	105,382,868	97,409,012	139,266,156	89,286,976	39,705,766	0	0	0	1,127,251,692	1,127,251,692

Federal Share

Waiver Name	A	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	Total	Total Less Non-Adds
ADM	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	20,907,343	6,121,891	25,253,918	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	61,050,371	26,598,376	0	0	0	743,988,277	743,988,277
HealthQuest-Current	0	0	0	0	0	0	0	0	0	0	0	0	0	0	377,874	17,784,187	6,534,554	0	0	0	0	0	0	0	0	0	0	0	0	0	0	24,696,615	24,696,615
Total	0	0	0	0	0	0	0	0	0	0	0	0	3,679,980	22,272,827	21,285,217	23,906,078	31,788,472	34,488,282	31,963,518	59,588,869	48,414,408	61,342,106	93,307,850	78,500,894	71,800,158	98,697,486	61,050,371	26,598,376	0	0	0	768,684,892	768,684,892

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)	$1,687,982	$785,885			
EG 1 - Children	1	State Plan Children	$392,681,404	$171,796,012			
EG 2 - Adults	2	State Plan Adults	$165,927,023	$83,115,353			
EG 2 - Adults	2	Breast Cervical Cancer Treatment (BCCT)	$25,702	$38,601			
EG 2 - Adults	2	St Pl Adults-Preg Immig/COFAs	$3,109,986	$1,077,062			
EG 3 - Aged	3	Aged w/Mcare	$367,673,762	$161,062,904			
EG 3 - Aged	3	Aged w/o Mcare	$64,625,579	$31,836,506			
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	$149,275,133	$65,960,465			
EG 4 – Blind/Disabled	4	B/D w/o Mcare	$334,707,192	$157,186,860			
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	$533,344,073	$275,716,918			
EG 5 – Group VIII	1	Newly Eligible Adults	$115,881,444	$59,643,184			
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			$2,128,055,723	$1,008,167,579			

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	-$15,020,590				Cost share
EG 4 – Blind/Disabled	4	-$3,558,280	-$1,359,442				Cost share
Hypothetical 1 Per Capita							
EG 5 – Group VIII	1						
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	$394,369,386	$172,581,897			
EG 2 - Adults	2	$169,062,711	$84,231,016			
EG 3 - Aged	3	$395,961,900	$177,846,904			
EG 4 – Blind/Disabled	4	$480,047,927	$221,767,628			
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$649,225,517	$335,360,102			
Hypothetical 2 Per Capita						
EG 6 - CIS	1					
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1					
TOTAL		**$ 2,088,667,440**	**$ 991,787,548**	**$ -**	**$ -**	**$ -**

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		$230,571,406	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2		$134,172,751	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3		$254,566,878	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4		$361,923,311	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1		$490,630,196	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1		$2,665,522	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		$7,269,606	$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	$394,369,386	$403,153,303	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2	$169,062,711	$218,403,767	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3	$395,961,900	$432,413,782	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4	$480,047,927	$583,690,940	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$649,225,517	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1		$2,665,522	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		$7,269,606	$13,386,875	$14,380,181	$15,447,190
TOTAL		**$ 2,088,667,440**	**$ 2,473,587,218**	**$ 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	621727			
EG 2 - Adults	2	420331	193802			
EG 3 - Aged	3	339459	149160			
EG 4 – Blind/Disabled	4	285411	123109			
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	1411914	695270			
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		963047	1624394	1665004	1706629
EG 2 - Adults	2		320591	527253	540435	553945
EG 3 - Aged	3		183683	336172	339533	342929
EG 4 – Blind/Disabled	4		196185	322487	325712	328969
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1		867990	1602341	1642400	1683460
Hypothetical 2 Per Capita						
EG 6 - CIS	1		2206	3877	3974	4073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		2206	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		2,206	3,877	3,974	4,073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		2,206	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	1,402,824	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**	**$ 3,183,836,560**	**$ 14,307,865,902**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Medicaid Per Capita								
EG 1 - Children	1		$ 394,369,386	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,549,075,451
EG 2 - Adults	2		$ 169,062,711	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,181,147,007
EG 3 - Aged	3		$ 395,961,900	$ 432,413,782	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,177,401,263
EG 4 – Blind/Disabled	4		$ 480,047,927	$ 583,690,940	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,167,038,280
TOTAL			**$ 1,439,441,923**	**$ 1,637,661,792**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,511,708,323**

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	$ 394,369,386	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
		Difference	$ 234,679,426	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 176,009,569	$ 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	$ 169,062,711	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
		Difference	$ 219,941,020	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 164,955,765	$ 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	$ 395,961,900	$ 432,413,782	$ 460,966,093	$ 481,405,329	$ 502,750,842	
		Difference	$ 262,306,809	$ 234,973,046	$ 236,012,591	$ 246,475,330	$ 257,406,155	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 196,730,107	$ 176,229,784	$ 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	$ 480,047,927	$ 583,690,940	$ 616,353,767	$ 649,908,066	$ 685,289,061	
		Difference	$ 275,366,492	$ 298,588,627	$ 313,956,731	$ 331,048,536	$ 349,071,717	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 206,524,869	$ 223,941,470	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 744,220,310**	**$ 842,637,813**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,347,118,184**

BASE VARIANCE			**$ 248,073,437**	**$ 280,879,271**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,449,039,395**
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								**$ 1,449,039,395**

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)			$ 1,687,515,360	$ 3,606,056,423	$ 5,624,972,577	$ 7,741,566,436	$ 9,960,747,718	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,750,307	$ 54,090,846	$ 56,249,726	$ 38,707,832	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (248,073,437)	$ (528,952,707)	$ (821,037,721)	$ (1,127,486,969)	$ (1,449,039,395)	
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		$649,225,517	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 649,225,517**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,339,445,444**

HYPOTHETICALS VARIANCE 1			**$ 620,607,577**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,513,164,523**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ -	$ 2,739,036	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon		2,206	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 2,739,036**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 19,024,137**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ -	$ 2,665,522	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ -**	**$ 2,665,522**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 18,510,746**

HYPOTHETICALS VARIANCE 2			**$ -**	**$ 73,514**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 513,390**

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**	$ -	$ 7,470,112	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon		2,206	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 7,470,112**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 51,883,960**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ -	$ 7,269,606	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ -**	**$ 7,269,606**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 50,483,852**

HYPOTHETICALS VARIANCE 3			**$ -**	**$ 200,506**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,400,108**

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 Pl 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
$ 1,449,039,395