Hawaii QUEST Integration
Quarterly Monitoring Report to CMS

Federal Fiscal Year 2021 1st Quarter
(DY27 Q1)

Hawaii QUEST Integration
Section 1115 Quarterly Report
Submitted: February 26, 2021

Reporting Period: October 2020 – December 2020

Federal Fiscal Quarter:	1st Quarter 2021
State Fiscal Quarter:	2nd Quarter 2021
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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 plans to procure a new QI contract effective July 1, 2021, with a targeted release of the QI Request for Proposal (RFP) in the last quarter of 2020. 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. Ongoing regular meetings have been continuing for the "HOPE Leadership Team" to discuss specific language changes to the QI Request for Proposal (RFP). Recent meetings have focused on refining the care coordination/service coordination model for the new QI RFP, to ensure alignment with HOPE goals.

MQD leadership continued targeted communications with QI health plans (Health Plans) during the Public Health Emergency (PHE). The Task Force that began meeting three times a week in the spring reduced the meeting frequency to two times a week and now in this latest quarter transitioned to meeting once a week, with an enhanced focus on ensuring the Home and Community Based Services (HCBS) residential settings have the Personal Protective Equipment (PPE) needed to prevent the spread of the COVID-19 virus (COVID-19). Ensuring compliance with the FFCRA provisions around continuing Medicaid eligibility and approved services, expanding telehealth access to services, and monitoring provider network adequacy during the PHE were other priorities during the Task Force meetings. The Medicaid Director continued to meet with Health Plan Chief Executive Officers (CEOs) once a week to discuss high-level issues around COVID-19, and MQD continued weekly meetings with Health Plan Chief Financial Officers (CFOs) to discuss financing impacts to Health Plans and to providers as a result of COVID-19.

MQD resources and activities during this reporting period continued to be focused on issues and interventions related to COVID-19. MQD continued to follow flexibilities afforded by CMS through the approved 1135, 1115, and 1915(c) waivers during the PHE. QI Health Plans continued to stock and distribute preventative PPE as needed to HCBS providers. MQD continued to have a stock of PPE "Go-Kits" to deploy to community residential settings when there is a COVID+ or suspected COVID+ case. A Go-kit contains a 14-day supply of PPE for primary and secondary caregivers in COVID-19+ homes – including disposable gloves, surgical masks, face shields, surgical gowns, shoe coverings, and use instructions – and are distributed one per member to the caregivers. This is in recognition of the negative impact that sick caregivers and secondary caregivers would have on provider capacity in the HCBS residential settings. QI Health Plans also developed additional Go-Kits for the HCBS population living in their own home, recognizing the additional need for COVID+ PPE in these settings. Finally, MQD began planning for a limited distribution of portable pulse oximeters to homes where COVID+ cases have been reported. The goal here is to equip the caregivers with an additional tool to monitor critical oxygen levels for high risk COVID+ members. The pulse oximeter will be packaged along with directions for use and additional documentation to ensure proper interpretation and necessary follow-up with outside clinicians. They are expected to be distributed along with the Go-Kits.

In this quarter, MQD began collaborating with Health Plans and State partners on strategizing for the COVID-19 vaccine roll-out. Our focus was 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. Initial planning centered around utilizing smaller independent pharmacies to travel into the community to provide in-home vaccinations, as opposed to asking the fragile HCBS population to come to a vaccination site.

Lastly, 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 the August month 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.

II. Budget Neutrality Monitoring Spreadsheet

The Budget Neutrality Workbook for the quarter ending September 30, 2020 was submitted to CMS by the November 30, 2020 deadline. The Budget Neutrality Summary (worksheet) for the quarter ending December 31, 2020 will be submitted separately by the February 28, 2021 deadline.

III. Events Affecting Healthcare Delivery

A. Approval & Contracting with New Plans

During this reporting period, no new contracts were awarded.

B. Benefits & Benefit Changes

Compliance with Section 1115 Demonstration Special Terms and Conditions

CMS approved several documents during the fourth quarter. The evaluation design for Hawaii's section 1115 demonstration entitled "Hawaii QUEST Integration" (Project Number 11-W00001/9 was approved on October 14, 2020 and posted on our website on October 19, 2020. The evaluation design for Hawaii's Section 1115 demonstration entitled, "Hawaii COVID-19 Public Health Emergency Demonstration" (Project Number 11-W00351/9) was approved on October 28, 2020 and posted on our website on November 2, 2020. MQD is working on implementation for all approved documents both internally and with the MCO's.

HOPE Initiative

MQD staff continues to work on the implementation of the HOPE initiative. One major area of focus was on writing requirements that were included in the MCO RFP. MQD made substantial changes in the areas of behavioral health and care coordination that included clarifying roles and responsibilities, increasing the use of evidence-based practices, improving access to care, and better addressing social risk factors. MQD also made similar changes to the CCS RFP. MQD also continues to work on other HOPE initiatives such as supporting palliative in community-based settings and developing additional strategies to advance primary care. All these efforts required intensive discussions with various teams and the consultants assigned to this task.

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

PPDO continues to be very involved with MQD administration and staff to ensure continued receipt of 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. This has been an extremely coordinated and intense effort between 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 April 22, 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.

Collaboration with the Department of Education (DOE) to increase Medicaid Claiming for School Based Services

Med-QUEST continues collaboration with DOE for Medicaid Claiming issues. The focus continuing for this quarter included coordinating meetings with HCSB office to schedule training for provider enrollments and assistance with specific codes for medically needy services, continued work on the RMT 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. It has been challenging due to COVID-19 issues taking precedence, however, we are doing our best to work around them.

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

During the last quarter of 2020, PERM FY2021 federal team requested updated rules, waivers, and changes made to the system due to the Public Health Emergency (PHE). The PHE resulted in a reduction of the original sample size of 800 to approximately ½ that was subjected to be reviewed. Bi-weekly meeting were established to discuss Hawaii specific issues and clarifications of eligibility, system design, and reporting requirements using the PERM SFTP sites and PERM reporting online tool. Training and access were conducted during this quarter. In addition to bi-weekly meetings, the PERM team meets monthly with all state calls. Re-education and re-establishing PERM requirements/procedures with the Eligibility Branch was a challenge to onboard procedures virtually with the use of MS/TEAMS as request for additional information and findings began on a weekly basis.

PPDO collaborated with Hawaii Quality Control Office (QC) on a regular basis as the deadline to provide a proposal was drawing near, and CMS was clear that MEQC will commence as planned during the PHE. PPDO coordinated meetings and act as liaison with the other offices within MQD. QC was able to submit the proposal by the due date and received final approval from CMS on 12/31/20.

Hawaii Administrative Rules

PPDO continues work amending the Hawaii Administrative Rules as well as the Medicaid State Plan to ensure compliance with new federal and state regulations and guidelines.

No Hawaii Administrative Rules were amended, however, during this period. However, as summarized in the first paragraph of this section, several waiver documents were approved during this quarter.

Policy and Program Directives (PPDs) and Forms

The following PPDs were issued during this quarter.

- 20-005: 12/5/2020"Death Payments Program" was issued 09/21/20. This PPD clarifies eligibility requirements for an unclaimed body under the provisions of Hawaii Administrative Rules (HAR) Chapter 17-1745-4.
- 20-006: 12/7/2020 2021 SSA RSDI SSI and VA COST OF LIVING INCREASE
- 20-007: 12/7/2020 2021 SPOUSAL IMPOVERISHMENT STANDARD AND THE HOME EQUITY LIMIT FOR LTC INDIVIDUALS
- 20-008: 12/15/20 DEATH PAYMENTS PROGRAM AUTHORIZED VENDOR LIST FOR UNCLAIMED BODIES

In addition, fillable forms (DHS 1123, DHS 1128 DHS 1133, DHS 1135, DHS 1136, DHS 1137, DHS 1148 DHS 1151, 1161 and DHS 1163) were made available for MQD and provider use online. DHS 1139 (interim) was updated to use with the new HOKU provider enrollment system issued. PPDO also assisted with BPMO P&P regarding the Forms Management Program.

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

- QI-2042: Medicaid Fee-For-Service Federally Qualified Health Center (FQHC) & Rural Health Clinic (RHC) Prospective Payment System (PPS) Rates - Effective January 1, 2021 through December 31, 2021
- QI-2041: Medicaid Fee-For-Service Rates - Effective January 1, 2021 (Addendum to QI-2022)
- QI-2040: Medicaid Fee-For-Service Hospice Nursing Facility Rates for Hospice Hilo dba Hawaii Care Choices and St. Francis Hospice - Effective January 1, 2021
- QI-2039: Dental Services Requiring General Anesthesia Performed in a Hospital Setting
- QI-2038: Orally Administered Drugs to Terminate a Pregnancy During the Public Health Emergency
- QI-2037A: COVID-19 Pandemic Action Plan for QI Health Plans - Part V (Addendum)
- QI-2037: COVID-19 Pandemic Action Plan for QI Health Plans - Part V
- QI-2036: Telehealth Guidance During the Public Health Emergency related to EPSDT Visits
- QI-2035: Suspension to Provider (Paul A. Kaiwi, Jr.)
- QI-2033: COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured

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 continued work on reviewing options for alignment with the Dual Special Needs Plan population, overseeing the MCO's development of a joint telehealth plan for all Medicaid providers and members to utilize, which was approved on December 29, 2020, addressing 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 COFA individuals and implementation of a new state law affecting adolescent mental health services.

C. Enrollment and Disenrollment

The Customer Service Branch (CSB), Eligibility Branch (EB), and Health Care Outreach Branch (HCOB) remain committed to assist community members complete their Medicaid application and pre-enroll in a QI health plan. Since federal fiscal year 2020, Med-QUEST continued to enhance technology and completed the installation of Voice over Internet Protocol (VoIP) in two EB offices, Kauai and Kailua-Kona. VoIP increased the amount of staff available to answer calls from the public, whether working in-office or remotely, and complete the application intake process by phone. A pre-selection of QI plan completes the application and ensures immediate enrollment when applicant is deemed eligible for Medicaid. HCOB manages community activity and ensures navigators follow the same process as Med-QUEST staff with assisting the public.

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

1. Enrollment Summary

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

MAGI Excepted	Oahu	Kauai	Hawaii	Maui	Molokai	Lanai	Total
AlohaCare	57	7	3	13	2	1	83
HMSA	174	12	29	37	2	0	337
Kaiser	40	0	0	26	0	0	320
Ohana Health Plan	37	3	5	3	0	0	114
UnitedHealthcare Community Plan	329	7	15	15	2	0	416
Total	637	29	52	94	6	1	819
Beneficiaries w/APC Choice	1.10%	0.05%	0.09%	0.16%	0.01%	0.00%	1.41%
MAGI	Oahu	Kauai	Hawaii	Maui	Molokai	Lanai	Total
AlohaCare	466	85	199	100	33	6	889
HMSA	1632	167	509	218	10	1	3426
Kaiser	535	3	0	280	0	0	3355
Ohana Health Plan	46	1	15	8	0	0	888
UnitedHealthcare Community Plan	129	3	36	15	0	0	253
Total	2808	259	759	621	43	7	4497
Beneficiaries w/APC Choice	0.91%	0.08%	0.25%	0.20%	0.01%	0.00%	1.46%

[Member Choice of Health Plan Exercised, appears in section XII.A.]

2. Disenrollment Summary

	# of Beneficiaries	Reason
Beneficiaries that requested plan-to-plan change with cause	7	**7 Continuity of Care** ○ 3 beneficiaries primary care physician not participating with QI plan ○ 1 Pregnant woman in third trimester ○ 3 clients in behavioral health therapy.
Beneficiaries that requested plan-to-plan change from health plan	26	**Loss / Gain** AlohaCare 4 / 4 HMSA 0 / 9 Kaiser 8 / 6 Ohana Health Plan 8 / 0 UnitedHealthcare Community Plan 6 / 7 26 / 26

		Reason PCP Continuity 14 LTC Placement 0 Behavioral Therapy 2 Specialist* 2 TPL** 4 Seek service outside Kaiser network 2 Family Continuity 2 26 *Cardiologist **Obstetrician
Beneficiaries that changed health plan after being auto-assigned	4,646	[redacted]

D. Quality of Care

See EQRO information in section XIV. (Quality Assurance and Monitoring Activity).

E. Access that is Relevant to the Demonstration

MQD worked to expand the availability of telehealth during the PHE. MQD issued additional clarifying guidance for the delivery of Applied Behavioral Analysis (ABA) services via telehealth. Additional codes were considered as deliverable via telehealth, and factors for consideration were outlined for providers when allowing ABA services via telehealth. This guidance can be found in memo QI-2028 issued on July 21, 2020.

MQD issued memorandum in FFY 2020 Q2 outlining the data requirements around Community Integration Services (CIS) for our homeless population. In the current quarter MQD has taken additional steps to further define CIS policy around housing assessments, housing support/crisis plans, service authorizations, billing and payment, credentialing and contracting, program integrity and documentation, and member disenrollment. Near the end of September, MQD shared with community partners and MCOs a draft of this subsequent memo that will cover criteria, processes, and codes for these services. Specific feedback on this draft was received and is being integrated into a forth coming final draft.

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.

F. 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 has gathered additional information and submitted it to MQD's Attorney Generals on the case, but there has been no significant movement with the case.

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. The trial occurred during this reporting period and the judge's ruling is expected to be announced in the 2nd quarter of FFY 2021.

A case is scheduled to go to court in the 2nd quarter of FFY 2021 that has to do with inappropriate billing of dialysis services.

G. Public Forums

There were no public forums conducted during this reporting period.

IV. Grievances, Appeals & State Fair Hearing

A. Grievance Events that Affect Health Care Delivery

See section IV.B. (Member Grievances and Appeals Filed During the Reporting Period by Type), below.

B. Member Grievances and Appeals Filed During the Reporting Period by Type

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

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

October 2020 – December 2020 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	1
Provider/Provider Staff Behavior/Services	1
Transportation Customer Service	0
Treatment Plan/Diagnosis	2
Fraud and Abuse of Services	2
Billing/Payments	1
Member Rights	7
Medication	1
General Information	6
Forward to Other Departments	5
Total	**26**

Some grievances fit into multiple categories.

Month	**# of Member Grievances to HCSB by Month**
October 2020	10
November 2020	12
December 2020	04
Total	**26**

Status of Member Grievances Addressed by HCSB					
		Oct 2020	Nov 2020	Dec 2020	**TOTAL**
Received		10	12	4	26
Status					
Referred to Subject Matter Expert		7	11	3	20
Health Plan resolved with Members		1	0	0	1
Member withdrew grievance		0	0	0	0
Resolution in Health Plan favor		1	1	0	2
Resolution in Member's favor		1	0	0	1
Still awaiting resolution		0	0	1	1
Return to Health Plan awaiting Resolution Letter		0	0	0	0

Carry-over from previous Quarter		0	0	0	0

2. Grievances to Health Plans

Types of Member Grievances Reported to Health Plans				
		Oct – Dec 2020		
		QI	**CCS**	**Total**
Provider Policy		7	0	7
Health Plan Policy		28	0	28
Provider/Provider Staff Behavior		105	0	105
Health Plan Staff Behavior		49	1	50
Appointment Availability		5	0	5
Network Adequacy/ Availability		0	0	0
Waiting Times (office, transportation)		79	0	79
Condition of Office/ Transportation		5	0	5
Transportation Customer Service		19	0	19
Treatment Plan/Diagnosis		35	0	35
Provider Competency		24	0	24
Interpreter		0	0	0
Fraud and Abuse of Services		3	2	5
Billing/Payments		36	0	36
Health Plan Information		11	0	11
Provider Communication		4	5	9
Member Rights		12	7	19

Status of Member Grievances Reported to Health Plans				
		Oct – Dec 2020		
		QI	**CCS**	**Total**
Total number filed during the reporting period		326	12	338
Status received from Health Plans				

Total number that received timely acknowledgement from health plan		310	12	322
Total number not receiving timely acknowledgement from health plan		16	0	16
Total number expected to receive timely acknowledgement during next reporting period		10	0	10
Total number that received timely decision from health plan		319	11	330
Total number not receiving timely decision from health plan		22	1	23
Total number expected to receive timely decision during next reporting period		9	0	9
Total number currently unresolved during the reporting period		12	1	13

3. Appeals to Health Plans

During October – December 2020, there were a total of 311 Appeals submitted with the Health Plans.

Types of Member Appeals to Health Plans		
		Oct – Dec 2020
Service denial		45
Service denial due to not a covered benefit		5
Service denial due to not medically necessary		256
Service reduction, suspension or termination		2
Payment denial		5
Timeliness of service		0
Prior authorization timeliness		0
Other		5

Status of Member Appeals to Health Plans		
		Oct – Dec 2020
Total number filed during the reporting period		311
Status received from Health Plans		
Total number that received timely acknowledgement from health plan		297
Total number not receiving timely acknowledgement from health plan		5
Total number expected to receive timely acknowledgement during next reporting period		9
Total number that received timely decision from health plan		294
Total number not receiving timely decision from health plan		2
Total number expected to receive timely decision during next reporting period		17
Total number currently unresolved during the reporting period		17
Total number overturned		172

4. Appeals to the State (State Fair Hearings)

For October 2020 - December 2020, there was a total of 12 Appeals submitted to AAO. Nine (9) were resolved, and we are awaiting three (3) resolution.

Types of Member Appeals to State Administrative Appeals Office (AAO)					
		Oct 2020	Nov 2020	Dec 2020	**TOTAL**
Medical		3	1	2	6
Home and Community Based Services (HCBS)		1	0	0	1
Van Modification		0	0	0	0
Applied Behavioral Analysis (ABA)		0	0	0	0
Durable Medical Equipment		1	1	0	2

Reimbursement		0	0	0	0
Medication		1	0	0	1
Miscellaneous		0	1	1	2

Status of Member Appeals to State Administrative Appeals Office (AAO)					
		Oct 2020	Nov 2020	Dec 2020	**TOTAL**
Submitted		6	3	3	12
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	2	8
Dismiss as untimely filing		0	0	0	0
Member withdrew hearing request		0	0	0	0
Resolution in DHS' favor		1	0	0	1
Resolution in Member's favor		0	0	0	0
Still awaiting resolution		1	1	1	3

V. Adverse Incidents

A. 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 October 2020 - December 2020, there were 419 adverse events from the Health Plan, 9 adverse events from Nursing Facilities, and 6 adverse events from ICF DD/ID for a total of 434 adverse events.

Oct 2020 – Dec 2020	Health Plan	Nursing Facility	ICF DD/ID	TOTAL
Fall	151	8	0	159
Hospital	80	0	0	80
Death	28	0	1	29
Emergency Room Visit	95	0	5	100
Injury	59	1	0	60
Med Error	6	0	0	6
TOTAL	419	9	6	434

VI. 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 is currently working with its contracted actuary, Milliman, to refine a reconciliation process that will also compare encounters submitted by the MCOs to Milliman for rate development to those submitted and accepted by MQD. This process has been conducted on an ad hoc basis in the past but will be folded into an ongoing reconciliation process conducted annually. 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 for high cost newborns is based on encounters found within the State Medicaid encounter system. Beginning in 2019, risk sharing for high cost drugs will also be 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.

MQD has also made substantial progress in a contract with its EQRO to conduct an external encounter data validation project. The project includes a full assessment of the Hawaii encounter pend system, including pend system edits; describes in detail the current process by which MCOs prepare files for MQD and the data challenges experienced or incurred as a result; and result 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 is expected to be completed by the second quarter of FFY 2021, and will inform future efforts to improve encounter data quality.

Beginning with FFY 2021, MQD has 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 new work began during FFY 2021 1st Quarter.

1) 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.

2) AHCCCS has begun recruitment and contracting efforts to 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 be released in the second quarter of FFY 2021.

VII. Action Plans for Addressing Issues Identified In:

A. Policy

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 April 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. Additionally, Phase 1 of the Asset Verification System (AVS) for eligibility determinations was implemented in December, with work continuing on Phase 2, scheduled for implementation in mid-February 2021.

B. Administration

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 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 will automate 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, scheduled for implementation on February 22, 2021, will introduce 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.

C. Budget

See section IX. (Financial and Budget Neutrality Development and Issues), below.

VIII. Expenditure Containment Initiatives

No new containment initiatives for this reporting period.

IX. Financial and Budget Neutrality Development and Issues

There were no significant issues.

X. Monthly Enrollment Reports for Demonstration Participants

A. Enrollment Counts

		Member Months	Unduplicated Members
Medicaid Eligibility Groups	**FPL Level and/or other qualifying Criteria**	**Oct 2020 – Dec 2020**	**Oct 2020 – Dec 2020**
Mandatory State Plan Groups			
State Plan Children	State Plan Children	378,312	124,651
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrant/Compact of Free Association (COFA)	119,997	38,452
Aged	Aged w/Medicare Aged w/o Medicare	90,498	30,315
Blind or Disabled (B/D)	B/D w/Medicare B/D w/o Medicare Breast and Cervical Cancer Treatment Program (BCCTP)	75,168	24,796
Expansion State Adults	Expansion State Adults	356,147	115,873
Newly Eligible Adults	Newly Eligible Adults	77,615	24,974
Optional State Plan Children	Optional State Plan Children	0	0
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	1,872	615
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)	87,589	29,098
Total		**1,187,198**	**389,234**

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	219,289
Title XXI funded State Plan	29,098
Title XIX funded Expansion	140,847
Enrollment current as of	12/31/2020

B. Member Month Reporting

For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 12/31/20
EG 1 – Children	125,664	126,407	128,113	380,184
EG 2 – Adults	39,132	40,540	40,325	119,997
EG 3 – Aged	29,861	30,247	30,390	90,498
EG 4 – Blind/Disabled	24,654	24,866	25,648	75,168
EG 5 – VIII-Like Adults	0	0	0	0
EG 6 – VIII Group Combined	140,261	143,259	150,242	433,762

For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending 12/31/20
State Plan Children	125,045	125,787	127,480	378,312
State Plan Adults	39,132	40,540	40,325	119,997
Aged	29,861	30,247	30,390	90,498
Blind or Disabled	24,654	24,866	25,648	75,168
Expansion State Adults	115,321	117,918	122,908	356,147
Newly Eligible Adults	24,940	25,341	27,334	77,615
Optional State Plan Children	0	0	0	0

Foster Care Children, 19-20 years old	**619**	**620**	**633**	**1,872**
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.	**4,789**
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).	**738**
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.	**822**

D. Enrollment of Individuals Eligible for Long Term Services and Supports (LTSS)

Long Term Services and Supports (LTSS) enrollment reported by the health plans is as follows.

Health Plan	Oct 2020	Nov 2020	Dec 2020
Aloha Care	524	504	497
HMSA	698	691	690
Kaiser	310	322	345
Ohana	2678	2514	2499
United Healthcare	2058	2110	2160
Total	**6268**	**6141**	**6191**

Plan-to-plan change requests and results, specifically for LTSS members, are not tracked. The QI program includes LTSS services amongst its benefits.

XI. Outreach and Innovative Activities

The Health Care Outreach Branch (HCOB), together with our Community Partners have been assisting residents to apply for Medicaid through our online system. Many of the Hawaii Unions terminated health coverage for employees at the end of October, November and December, so we were able help those who reached out to us apply to Medicaid. If they were denied due to their income exceeded the Medicaid threshold, we were able to help them apply and enroll for coverage through the Federal Health Insurance Marketplace.

HCOB worked with community partners to ensure a smooth transition of health coverage for justice involved populations, by working closely with the Department of Public Safety to help unsuspend coverage or reapply those who were being released, due to the COVID-19 situation. During this period the HCOB team was able to suspend/unsuspend, submit applications and supplemental forms for over 35 incarcerated. 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 42 patients.

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). On 12/28/2020, Med-QUEST administrators met to discuss the modifications we needed to make to our eligibility system and put in place a manual system for determining applications for this population, and began outreach to our community partners statewide, to inform them of the changes and how to proceed with applying COFA citizens in our state to Medicaid.

XII. Number of Participants who Chose an MCO and Number of Participants who Changed MCO After Auto-Assignment

A. Member Choice of Health Plan Exercised

October 2020 – December 2020	Number of Members
Individuals who chose a health plan when they became eligible	**3,268**
Individuals who were auto-assigned when they became eligible	**11,538**
Individuals who changed their health plan after being auto-assigned	**4,646**
Individuals who changed their health plan outside of allowable choice period (i.e., plan-to-plan change)	**26**
Individuals in the ABD program that changed their health plan within days 61 to 90 after confirmation notice was issued	**23**

During this reporting period, 3,268 individuals chose their health plan since they became eligible in the previous quarter, 4,646 changed their health plan after being auto-assigned. In addition, 23 individuals in the aged, blind, and disabled (ABD) program changed their health plan during days 61 to 90 after a confirmation notice was issued.

XIII. Demonstration Evaluation and Interim Findings

During FFY 2021 1st Quarter, MQD's Health Analytics Office (HAO) received approval from CMS on its submitted evaluation design to support the PHE 1115 Demonstration ("Hawaii COVID-19 Public Health Emergency Demonstration" - 11-W-00351/9). Additionally, upon receiving final approval of the 1115 Demonstration Evaluation Design (2019-2024), the University of Hawaii team (MQD's external evaluators) began efforts to recruit a team of graduate students to support the evaluation project. MQD extended its contract with the University of Hawaii, and signed a business associate agreement, so the team may begin to have access to MQD data as early as the second quarter of FFY 2021. Early planning efforts related to evaluation have begun; in the second quarter of FFY 2021,

the UH evaluation team is expected to support MQD in implementing several data collection efforts to support the evaluation of the program.

XIV. Quality Assurance and Monitoring Activity

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)

October:

- Received 2nd Module 4 intervention progress updates from Kaiser (FUH PIP) on 10/23/20.
- Reviewed and provided feedback on the 2nd Module 4 intervention progress updates from Ohana Quest (WCV PIP) on 10/23/20, AlohaCare (both PIPs) on 10/26/20, and UHC (AWC PIP) on 11/2/20.

November:

- Reviewed and provided feedback on the 2nd Module 4 intervention progress update from Kaiser (FUH PIP) on 11/12/20.
- Received 2nd Module 4 intervention progress updates from UHC (FUH PIP), HMSA (both PIPs) and Kaiser (AWC PIP) on 11/30/20.
- Provided technical assistance via teleconference on 11/24/20 to Ohana upon request in preparation for its 2nd Module 4 intervention progress updates for Ohana Quest (FUH PIP) and Ohana CCS (both PIPs). Ohana was granted an extension for the 2nd check-in submissions from 11/30/20 to 12/07/20.

December:

- Reviewed and provided feedback on 2nd Module 4 intervention progress updates from UHC (FUH PIP), HMSA (both PIPs), Kaiser (AWC PIP), Ohana Quest (FUH PIP) and Ohana CCS (both PIPs) by 12/18/20.

2. Healthcare Effectiveness Data and Information Set (HEDIS)

October:

- HSAG forwarded the HEDIS MY 2020 Roadmap to QI health plans upon release from NCQA on 10/01/20.
- HSAG submitted the Audit Introductory Packet to the Quest Integration (QI) health plans on 10/09/20.
- HSAG submitted the Medical Record Review (MRRV) Introductory packet to the QI health plans on 10/14/20.
- HSAG held technical assistance webinar with MQD and QI health plans to review reportable measures and required rates on 10/14/20.

November:

- HSAG sent the Survey Sample Frame Validation Process Packet to the QI health plans on 11/10/20.
- HSAG conducted Technical Assistance call to review MY 2020 audit scope and MQD reporting requirements on 11/10/20.

- HSAG scheduled HEDIS virtual audits with four health plans by 11/30/20. One plan is pending confirmation date.
- HSAG provided technical assistance to the MQD and the health plans as requested.

December:
- HSAG received survey sample frame source code on 12/01/20.
- Confirmed the MY 2020-2021 measure list and none of the measures are non-certified hybrid measures, needing source code review.
- HSAG provided technical assistance to the MQD and the health plans as requested.

3. Compliance Monitoring

October:
- Conducted a technical assistance call with UHCCP regarding completion of the corrective action plan (CAP) template on 10/22/20.
- Received completed CAPs from the health plans by 10/29/20.

November:
- Completed initial review of health plan CAPs and submitted them to the MQD for review and approval on 11/13/20.
- Received MQD feedback and approval on the health plan CAPs on 11/23/20.
- Provided feedback to the health plans regarding CAPs on 11/23/20.
- HMSA provided evidence of implementation of CAPs. HMSAs CAPs were closed on 11/23/20.

December:
- Received CAP update and supporting documents from AlohaCare on 12/01/20.
- Provided CAP feedback to AlohaCare on 12/22/20. AlohaCare submitted additional documentation of CAP completion on 12/23/20. HSAG and the MQD reviewed documentation supporting CAP implementation and closed CAP on 12/28/20. Notification email sent to AlohaCare on 12/29/20.
- Received CAP update and supporting documentation from ‘Ohana QI and ‘Ohana CCS on 12/22/20.
- Received CAP update and supporting documentation from UHC CP QI on 12/23/20

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

October:
- Attended NCQA HEDIS/CAHPS 2020 survey vendor training on 10/07/20.

November:
- Sent draft notification email of deduplication requirements (e.g., NCQA notification, data preparation) and timeframes for QI health plans to the MQD for review on 11/04/20.
- Received approval from the MQD on the deduplication request notification email on 11/06/20.
- Sent survey notification letter with data submission and administrative requirements to the MQD, including supplemental questions, text for English language cover letters and postcards, and sample frame creation instructions to the MQD on 11/06/20.
- Notified QI health plans of deduplication requirements (e.g., NCQA notification, data preparation) and timeframes on 11/13/20.
- Received source code from the MQD on 11/20/20, and the test sample frame files (CHIP and one child health plan) generated by the MQD for review on 11/24/20.

- Received request for deduplicated sample from 'Ohana QI on 11/23/20.

December:
- Received deduplicated sample request from UnitedHealthcare Community Plan QI on 12/02/20.
- Received final approval from the MQD on supplemental questions to include in the 2021 surveys, language block, CHIP cover letters text, and completed administrative forms on 12/02/20.
- Reviewed test sample frame files for CHIP and UnitedHealthcare Community Plan QI and provided feedback to MQD on 12/08/20

5. Provider Survey

October:
- Discussed the survey administration with the MQD and received confirmation to postpone the survey administration until 2021 on 10/09/20.
- Informed MQD that there would be no cost to postponing the survey administration on 10/13/20.

November:
- This activity is postponed until 2021.

December:
- None at this time.

6. Annual Technical Report

October:
- Continued compiling/analyzing data and incorporating HSAG's findings, conclusions, and recommendations into the draft EQR technical report sections.

November:
- Continued compiling/analyzing data and incorporating HSAG's findings, conclusions, and recommendations into the draft EQR technical report sections.

December:
- Submitted draft report for editorial review and analytic validation on 12/14/20.

7. Technical Assistance

October:
- Provided technical assistance to the MQD and Health Analytics Office (HAO) as needed.
- Participated in the EQR workgroup meeting with the MQD on 10/01/20 and provided a document outlining the discussion and additional assistance HSAG could provide on 10/02/20.
- Submitted the draft PLD file layout for review and feedback from HAO on 10/09/20.
- Conducted a meeting with HAO to discuss the MQDs Hospital P4P program on 10/13/20 and provided a cost estimate and scope of work to HAO on 10/27/20.
- Received feedback from HAO on the PLD file layout on 10/19/20 and 10/23/20.

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

- Received approval from HAO and MQD regarding the Hospital P4P technical assistance scope of work and budget on 11/10/20

December:

- Provided technical assistance to the MQD and Health Analytics Office (HAO) as needed.
- Conducted Hospital P4P kick-off meeting with HAO on 12/01/20.
- Participated in EQR workgroup meeting with the MQD on 12/10/20.
- Conducted Hospital P4P workplan meeting with HAO on 12/16/20.

XV. Quality Strategy Impacting the Demonstration

The Division awaits approval of the Quality Strategy that was submitted to CMS in October 2020. Clinical Standards Office staff has started work with our Health Analytics Office to develop more detailed data sets for reporting. The data sets will provide clinical staff with information to assist in making clinical decisions regarding utilization and better analyzing quality of care and health outcomes.

XVI. Other

Status of Current QUEST Integration and Other Contracts

During this period, MQD submitted QI RFP supplemental change #16 while waiting for CMS's final approval for supplemental change #15. MQD sent the executed Health Plan contracts to CMS for supplemental change #15 and responded to CMS's OACT questions regarding the rates and pre-prints for supplemental change #16.

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.

In the 3rd quarter of 2020, the last two waves were given access to HOKU. Wave 3 began on October 26th and was for all MDs (physicians). Wave 4 began on December 14th and was for all remaining provider types, which included hospitals, pharmacies, labs, various agencies, etc. MQD has seen in increase in the number of applications of submitted by existing providers, registering in HOKU. 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). One the system is updated; the information is passed on to MQD and Koan staff. Lastly, MQD prioritized EVV providers to ensure that they are active and can proceed with the EVV project.

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

Application Status	Number of Applications	Description
In Process	1,041	Number of applications providers are currently working on in HOKU but have not yet submitted.
In Review	1,495	Number of applications providers submitted in HOKU and are awaiting State Review.
Approved	522	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 1 (Q1), MQD continued to collaborate with Arizona Health Care Cost Containment System (AHCCCS) towards implementation.

During this quarter, MQD successfully performed the soft launch of EVV with the MCOs and provider agencies in early October. MQD implemented a state-wide mandatory EVV use date of December 30th, 2020. MCO self-directed departments began the training the self-directed members in December. As EVV implementation started in October, stakeholder communications were increased through multiple methods.

MQD's future EVV workplans 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.

OCTOBER

During the month of October 2020, HI went live with a soft launch of EVV statewide. All MQD members and the majority of EVV providers and authorizations were loaded into the state vendor Sandata. The first of many instructor-led webinar training sessions commenced. This allowed provider agencies to begin setting up and configuring the EVV solution. EVV visits were also starting to be recorded. The CMS Operational Readiness Review meeting was held. Hosted a third virtual EVV town hall meeting open to the public. 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.

NOVEMBER

During the month of November 2020, additional instructor-led webinar training sessions continued. All but one MCO completed the claims validation testing with the EVV vendor. The remaining MCO has manual EVV claims validation process implemented until testing is complete. Authorization upload issues were discovered by the EVV vendor that were assessed and resolved. 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. Finalized and approved the EVV training schedule. Met with the provider agencies to review the training schedule, authorization cutover and 3rd party EVV vendor requirements.

DECEMBER

During the month of December, additional instructor-led webinar training sessions continued. Additional authorization upload issues were discovered by the EVV vendor that were assessed and resolved. Met one-on-one with many provider agencies to address EVV questions and perform mini-training sessions. Hosted the eighth EVV town hall meeting open to the public. Implemented the statewide mandatory use of EVV on the 30th of December 2020.

EVV Townhall Meetings Held

Who	Date	Time
Public-QI-All/DDD-All	9/30/2020	2-3 PM
DDD-All	10/20/2020	3-4 PM
DDD-Consumer Direct (Acumen)	10/27/2020	5-6 PM
DDD-Consumer Direct (Acumen)	11/2/2020	9-10 AM
DDD-Agency	11/5/2020	2-3 PM
DDD-Consumer Direct (Acumen)	11/7/2020	9-10 AM
DDD-Agency	11/12/2020	2-3 PM
QI-Self Direct	11/17/2020	1-2 PM
QI-Agency	12/22/2020	2-3 PM

Clinical Care Guidelines

The pandemic and access to services continues to be at the forefront of work. The Division issued guidance to providers regarding EPSDT services that allows increased access to visits to be conducted using a telehealth modality if an in-person visit is not possible due to a family member having COVID or the family is not comfortable going to the provider's office. Components that cannot be done due to the telehealth visit, those components need to be completed as soon as possible or as soon after the end of the PHE.

The Division worked with all health plans to develop a Pay for Performance measure to develop a plan to increase utilization of telehealth to access care. While use of telehealth has increased it was still felt that providers and recipients needed more information about the option to utilize telehealth modalities to increase access to services during and after the pandemic. The plan includes a timeline for implementing the plan, developing education materials for providers and recipients, and surveys to determine a baseline and to measure the increase in utilization.

MQD Workshops and Other Events

Focus:	COVID 19 Updates for Medicaid Providers
For:	Case Managers and Residential Caregivers and MCO Service Coordination Supervisors

Speaker	Curtis Toma, MD/ QI Quality Staff	**Location**	Webinars
Length	1 hour per session (10 sessions)	**Dates**	March 23,2020 May, 2020 June 8, 2020 July 9, 2020 July 27,2020 August 6, 2020 August 13,2020 September 24, 2020 October 6, 2020 October 28, 2020
Attendees	Approximately 50-350+ based on content and target audience		
Description	COVID 19 Updates, Infection Control Trainings, Case Reporting, PPE and Flu Shot Distribution and Other Pertinent Discussion		
Objectives/Outcomes	• Ensure safe practices, supports and timely coordination to keep COVID infections in community residences low and eliminate COVID spread. • Facilitate access to PPE, testing, hospitals and nursing home for caregivers and members • Engage, MCOS, home-caregivers and case managers to develop timely distribution mechanisms for PPE, Flu shots and other medical equipment statewide. • Provide updates on State COVID practices, stats and protocol changes. • Thank caregivers, vendors and MCOs for teamwork and implementation of effective COVID controls statewide.		

Focus:	**HOKU Provider Enrollment Training**		
For:	**Medicaid Providers**		
Speaker	Kelli Komatsu	**Location**	Go to Webinar
Length	1.5 hours	**Date**	Every Tuesday and Thursday
Attendees	Approximately 155		
Description	On August 3, 2020, the Med-QUEST Division launched a new web-based provider enrollment system called HOKU. Training is provided to inform and assist providers in navigating the new system. Providers learn how to enroll, update, and make changes to their information online. This will reduce paper processing and will save time for both providers and State of Hawaii staff.		

Focus:	**Dementia and Person Cantered Communication Practices in Foster Homes**
For:	**Community Care Foster Family Home Caregivers (CCFFH) / EARCH Home HCBS Medicaid Providers**

Trainer	Kevin Kawamoto, UH	**Location**	Webinar
Length	1.5 hours per session	**Dates**	October 6, 2020- 1 session
Attendees	Approximately 382		
Description	Person Centered Approaches to care giving persons with dementia living in community-based residences – foster home/EARCHs		
Objectives/Outcomes	• Tips to make residents feel welcome in their home • Identifying barriers to good communication with residents • Practicing effective 'person-centered' communication • Understanding that communication is verbal, non-verbal, and environmental		

Focus:	**HOKU Provider Enrollment Training**		
For:	**Medicaid Residential Providers with the United Home Care Association of Hawaii**		
Speaker	Aileen Manuel	**Location**	Go to Webinar
Length	1.5 hours	**Date**	October 7, 2020
Attendees	Approximately 155		
Description	On August 3, 2020, the Med-QUEST Division launched a new web-based provider enrollment system called HOKU. Training is provided to inform and assist providers in navigating the new system. Providers learn how to enroll, update, and make changes to their information online. This will reduce paper processing and will save time for both providers and State of Hawaii staff.		

Focus:	**Diabetes Training for Caregivers**		
For:	**CCFFH/EARCH Caregivers HCBS Medicaid Providers**		
Trainer	Grace Shonhardt, MSN, APRN-Rx, CDE	**Location**	Webinar
Length	2 hours per session	**Dates**	October 24, 2020- 1 session
Attendees	Approximately 391		
Description	Help caregivers manage residents with **diabetes** and problem solve issues in their homes to improve compliance with diet, medications and exercise.		
Objectives/Outcomes	• Understand the risk factors and pathology of diabetes • Identify the symptoms of high blood glucose and how diabetes is diagnosed • Understand what to cook for diabetics, portion size; impact of carbohydrates, exercise and obesity • Overview of diabetes medicines, diabetes monitoring and testing.		

Focus:	**1915(c) I/DD Waiver Renewal Information Sessions**

For:	General public, waiver participants, families, caregivers, providers, and DDD program staff.		
Speaker	Grace Schonhardt	**Location**	Go to Webinar
Length	1.0 hours	**Date**	October 29, 2020 November 10, 2020 November 19, 2020 November 23, 2020
Attendees	Approximately 200+		
Description	The state seeks public comments to the changes to the 1915(c) I/DD Waiver. Multiple information sessions held statewide on the changes. Public comment period starts on December 1, 2020 to January 10, 2021.		

Focus:	Electronic Visit Verification (EVV) Townhall Trainings		
For:	**Med QUEST Members and Caregivers who will be using the EVV system**		
Trainer	MQD EVV Team	**Location**	Webinar
Length	1.5 hours per session	**Dates**	September 30, 2020 October 20, 2020 November 17,2020 December 22, 2020
Attendees	Approximately 50 – 325, varied by session		
Description	Provide an EVV overview for members and caregivers. Review the implementation timeline. Separate trainings were offered to Members who receive services through an agency, members who receive Self Direct services, I/DD Waiver Members who receive agency services and I/DD Waiver Members who receive Self Direct services.		
Objectives/Outcomes	• What is EVV. Why Hawaii Medicaid is implementing EVV • What provider types and Medicaid services are required to participate in EVV. • How EVV works. • How the QI health plan and the I/DD Waiver program will assist Members to participate and learn how to use the system		

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		

A. Attachments

Attachment A: QUEST Integration Dashboard for October 2020 – December 2020
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 9/30/2020 is attached. The Budget Neutrality Summary for the quarter ending 12/31/2020 will be submitted by the 2/28/2021 deadline.

Attachment C: Budget Neutrality Workbook
The Budget Neutrality Workbook for the quarter ending 09/30/2020 is attached. The Budget Neutrality Workbook for the quarter ending 12/31/2020 will be submitted by the 2/28/2021 deadline.

B. MQD Contact(s)

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

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Oct-20					Nov-20					Dec-20				
	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED	AlohaCare	HMSA	Kaiser	Ohana	UNITED
# Members															
Medicaid	66,602	172,900	39025	29190	###### ##	67,585	176,131	40941	29535	###### ####	68,632	179,332	42933	29771	###### ###
Duals	4,039	6,792	1722	9526	###### ##	4,071	6,966	1781	9515	###### ####	4,123	7,154	1899	9521	###### ###
Total	**70,641**	**179,692**	**40747**	**38716**	**55,452**	**71,656**	**183,097**	**42722**	**39050**	**56,379**	**72,755**	**186,486**	**44832**	**39292**	**56,774**
# Network Providers															
PCPs	822	1,065	226	811	913	836	1,081	221	814	915	834	1,093	222	809	920
PCPs - (accepting new members)	697	858	210	594	622	711	874	205	595	620	710	747	206	**590**	624
Specialists	2,748	3,084	438	1553	1,656	2,779	3,126	438	1553	1,663	2,792	3,141	458	1553	1,671
Specialists (accepting new members)	1,932	3,084	438	994	1,400	1,958	3,126	438	993	1,404	1,969	3,141	458	**993**	1,413
Behavioral Health	848	1,694	129	672	1,058	858	1,712	129	676	1,061	866	1,717	196	677	1,067
Behavioral Health (accepting new members)	763	1,694	129	627	1,025	773	1,712	129	627	1,028	782	1,717	196	**627**	1,034
Hospitals	25	27	13	24	23	25	27	13	24	23	25	27	13	24	23
LTSS Facilities (Hosp w/ NF unit/NF)	47	37	21	38	34	48	38	24	38	33	45	38	20	38	35
Residential Setting (CCFFH, E-ARCH, and ALF)	617	618	140	1053	1,191	620	625	148	1052	1,191	624	628	136	1052	1,191
HCBS Providers (except residential settings and LTSS facilities)	83	154	67	91	56	81	155	65	91	56	88	157	67	92	58
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA)	1,939	2,472	116	1782	1,822	1,954	2,508	119	1783	1,835	1,972	2,531	256	1784	1,841
Total # of providers	**7,129**	**9,151**	**1150**	**6,024**	**6,753**	**7,201**	**9,272**	**1157**	**6,031**	**6,777**	**7,246**	**9,332**	**1368**	**6,029**	**6,806**
Call Center															
# Member Calls	4,443	8,957	627	5,399	4,516	3,611	8,311	1,375	4,869	3,727	3,917	9,014	713	5,056	3,850
Avg. time until phone answered	0:00:08	0:00:22	0:00:08	0:00:20	0:00:27	0:00:07	0:00:23	0:00:09	0:00:24	0:00:07	0:00:06	0:00:22	0:00:07	0:00:31	0:00:07
Avg. time on phone with member	0:06:30	0:07:28	8:52	0:09:13	0:07:35	0:06:38	0:07:18	6:51	0:08:55	0:07:54	0:06:45	0:07:18	6:29	0:08:33	0:08:17
% of member calls abandoned (member hung up)	0.52%	2.23%	1%	1%	1.80%	0.69%	2.59%	0%	2%	0.40%	0.28%	2.33%	0%	3%	0.50%
# Provider Calls	6,821	5,335	85	2,708	2,300	5,942	4,584	116	2,285	1,902	6,516	4,974	83	2,376	2,015
Avg. time until phone answered	0:00:16	0:00:28	0:00:07	0:00:11	0:00:01	0:00:18	0:00:31	0:00:04	0:00:22	0:01:01	0:00:10	0:00:20	0:00:05	0:00:18	0:00:11
Avg. time on phone with provider	0:06:40	0:08:28	4:41	0:08:55	0:07:34	0:06:31	0:07:55	5:06	0:08:53	0:07:15	0:06:26	0:08:19	4:55	0:08:40	0:07:23
% of provider calls abandoned (provider hung up)	1.07%	2.21%	0%	1%	0.04%	1.50%	2.23%	0%	2%	0.50%	0.63%	1.65%	0%	2%	0.89%
Medical Claims- Electronic															
# Submitted, not able to get into system	2,762	3,238	0	3238	3,882	2,348	2,660	0	2660	4,081	1,843	2,456	0	12848	3,408
# Received	52,785	164,544	33809	198353	83,984	48,147	153,209	33067	186276	80,629	54,780	162,427	35632	242471	83,694
# Paid	44,118	171,403	32385	203788	77,459	50,067	137,499	30028	167527	73,221	46,923	161,709	33174	209970	78,424
# In Process	9,513	40,222	510	40732	1,792	6,699	44,843	2100	46943	4,475	11,183	31,553	1420	54158	1,671
# Denied	2,907	14,801	914	15715	11,123	3,453	11,089	939	12028	8,363	3,386	14,008	1038	26522	9,531
Avg time for processing claim in days	5	8	2	5.6	6	7	9	1	5.8	6	5	9	2	5	6
% of electronic claims processed in 30 days	99%	99%	99.99	100%	99.8	97%	99%	99.99	100%	100.0	98%	99%	99.97	100%	100.0
% of electronic claims processed in 90 days	100%	100%	100	100%	100.0	100%	100%	100	100%	100.0	100%	100%	100	100%	100.0
(month to date)															
Medical Claims- Paper															
# Submitted, not able to get into system	451	979	12	991	758	289	777	6	783	972	306	934	8	552	796
# Received	14,899	15,625	7	15632	6,729	13,486	15,642	6	15648	6,647	14,423	14,605	11	19273	6,906
# Paid	12,573	15,045	1	15046	5,722	12,942	13,530	0	13530	5,229	12,314	14,360	7	14846	6,042
# In Process	7,383	8,831	3	8834	199	3,894	8,923	3	8926	749	5,404	7,099	1	5550	209
# Denied	1,615	2,456	3	2459	1,483	1,823	2,020	3	2023	1,387	1,854	2,069	3	4187	1,603
Avg time for processing claim in days	10	17	3	8.5	6	14	17	21	10	6	12	17	13	8	6
% of electronic claims processed in 30 days	97%	95%	100.00	99%	99.7	93%	95%	100.00	100%	99.9	95%	93%	80.00	100%	99.9
% of electronic claims processed in 90 days	100%	100%	100.00	99%	100.0	100%	100%	100.00	100%	100.0	100%	99%	100.00	100%	100.0
Prior Authorization (PA)- Electronic															
# Received	266	2624	904	330	2,138	184	2300	937	269	1,097	213	2632	830	515	1,130
# In Process	49	443	35	285	133	45	260	47	237	0	34	192	62	357	0
# Approved	204	2,512	838	1,157	1,811	135	2,272	873	524	1,004	176	2534	739	385	1,044
# Denied	44	215	31	16	194	38	211	17	16	93	45	255	29	11	86
Avg time for PA in days	1	4	3	29	2	1	4	3	32	1	1	3	3	4	1
(month to date)															
Prior Authorization (PA)- Paper and Telephone															
# Received	1,627	584	0	1,026	128	1,515	488	0	1,007	705	1,771	530	0	1,460	804
# In Process	320	27	0	922	8	437	45	0	916	0	293	18	0	1,330	0
# Approved	1,246	523	0	1,025	114	1,231	415	0	1,005	606	1,402	507	0	1,409	699
# Denied	201	74	0	37	6	115	55	0	15	99	196	50	0	12	105
Avg time for PA in days	2	2	0	3	3	1	2	0	3	2	1	2	0	2	1
(month-to-date)															
# Non-Emergency Transports															
Ground (# of round trips)	3,169	4,050	600	5094	7,538	3,013	3,807	569	4626	6,974	3,422	4,544	614	5038	7,401
Air (by segment)	397	569	134	190	284	425	619	182	231	286	513	644	111	236	293
Public Transportation Pass (bus pass & handivan coupons)	1,168	950	318	1454	820	1,101	1,156	251	1367	934	838	1,156	528	1425	930
# Member Grievances															
# Received	25	6	16	36	22	31	16	10	21	33	22	13	15	20	20
# Resolved	19	15	20	7	27	33	7	12	3	20	28	16	13	2	37
# Outstanding	14	4	10	29	17	12	13	8	18	32	6	10	10	17	15
# Provider Grievances															
# Received	61	2	302	0	0	70	2	39	0	1	105	0	52	0	0

QUEST Integration Dashboard Report Health Plan Comparison Monthly Trend Analysis

	Oct-20					Nov-20					Dec-20				
	AlohaCare	**HMSA**	**Kaiser**	**Ohana**	**UNITED**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**UNITED**	**AlohaCare**	**HMSA**	**Kaiser**	**Ohana**	**UNITED**
# Resolved	274	3	282	0	0	273	0	38	0	0	291	2	50	0	0
# Outstanding	506	2	20	0	0	301	4	1	0	0	115	2	2	0	1
# Member Appeals															
# Received	3	93	0	6	19	4	54	0	9	11	2	57	0	4	11
# Resolved	3	95	0	7	18	4	60	1	6	9	2	58	0	8	15
# Outstanding	1	20	0	3	7	1	14	0	6	9	1	13	0	2	5
# Provider Appeals															
# Received	12	19	0	27	71	3	11	0	21	39	2	12	0	44	53
# Resolved	59	16	0	31	65	46	22	0	19	40	41	10	0	37	48
# Outstanding	91	20	0	10	14	48	9	0	12	13	9	11	0	17	18
Utilization - based on Auth (A) or Claims (C)															
Inpatient Acute Admits * (A) - per 1,000	60	81	4	87	56	59	78	3	83	58	58	74	3	88	58
Inpatient Acute Days * (A) - per 1,000	305	242	19	694	420	316	230	20	493	425	312	231	17	589	393
Readmissions within 30 days* (A)	25	167	32	46	28	40	152	9	44	32	32	155	12	43	34
ED Visits * (C) - per 1,000**	352	278	20	565	436	360	282	18	531	440	348	272	20	510	434
# Prescriptions (C) - per 1,000	7007	8,908	492	10,552	8,653	6,470	8,435	451	10,113	8,347	6,737	6,921	474	10, 441	8,073
Waitlisted Days * (A) - per 1,000	25	2	3	48	125	32	3	1	40	111	24	3	1	6	127
NF Admits * (A)	43	15	8	9	41	28	7	4	9	25	35	12	6	12	38
# Members in NF (non-Medicare paid days) (C)**	252	301	87	679	681	229	300	92	654	649	240	297	105	608	669
# Members in HCBS **(C)- note: member can be included in more than one category listed below	272	397	223	1999	1377	275	391	230	1860	1,461	257	393	240	1891	1,491
# Members in Residential Setting **(C)	159	128	135	540	876	154	125	133	530	866	151	130	123	502	834
# Members in Self-Direction **(C)	87	117	45	761	259	87	118	46	666	247	88	122	51	711	241
# Members receiving other HCBS **(C)	115	229	178	1238	1118	124	228	184	1194	1,214	112	227	189	1180	1,250
# Members in At-Risk ** (C)	812	841	147	852	1407	815	858	147	821	1,407	826	887	151	789	1,409
# Members in Self-Direction **(C)	346	367	31	413	516	351	373	30	372	487	351	371	33	372	472
# Members receiving other HCBS **(C)	314	738	116	447	891	291	752	117	403	920	348	758	118	406	937
(* 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: 12/31/2020

ALOHA CARE

# Network Providers by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs	468	84	23	12	68	88	91	834
PCPs - (accepting new members)	**393**	**74**	**20**	**10**	**57**	**76**	**80**	**710**
Specialists*	2035	283	25	0	177	78	194	2792
members)	**1448**	**183**	**12**	**0**	**121**	**65**	**150**	**1969**
Behavioral Health*	539	116	12	3	48	82	66	866
Behavioral Health (accepting new members)	**479**	**108**	**12**	**3**	**45**	**76**	**59**	**782**
Hospitals	12	2	1	1	3	1	5	25
LTSS Facilities (Hosp./NF)	24	3	0	1	7	6	4	45
Residential Setting (CCFFH, E-ARCH, and ALF)	517	30	1	0	10	51	15	624
HCBS Providers (except residential settings and LTSS facilities)	43	13	4	3	7	13	5	88
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1268	246	27	14	140	134	143	1972
Totals	**4906**	**777**	**93**	**34**	**460**	**453**	**523**	**7246**

* 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	41243	9190	2282	480	5954	6898	6708	**72755**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	88	109	99	40	88	78	74	87

Note: RFP requirement is 300 members for every PCP

HMSA

	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
PCPs - (Traditional)*	689	93	15	14	65	107	110	1,093
PCPs - (accepting new members)	**443**	**66**	**13**	**9**	**45**	**81**	**90**	**747**
Specialists*	1,874	315	70	43	184	326	329	3,141
members)	**1,874**	**315**	**70**	**43**	**184**	**326**	**329**	**3,141**
Behavioral Health*	1,071	210	9	8	95	190	134	1,717
Behavioral Health (accepting new members)	**1,071**	**210**	**9**	**8**	**95**	**190**	**134**	**1,717**
Hospitals	14	2	1	1	3	1	5	27
LTSS Facilities (Hosp./NF)	26	2	1	0	3	5	1	38
Residential Setting (CCFFH, E-ARCH, and ALF)	498	31	1	0	12	64	22	628
HCBS Providers (except residential settings and LTSS facilities)	77	17	8	6	13	25	11	157
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1,625	280	33	21	162	179	231	2,531
Totals	**5,874**	**950**	**138**	**93**	**537**	**897**	**843**	**9,332**

* 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	109817	13876	947	193	12612	28955	20086	**186,486**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	159	149	63	14	194	271	183	171

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)*	159	63						222
PCPs - (accootino new members)	**152**	**54**						**206**
Specialists*	373	85						458
members)	**373**	**85**						**458**
Behavioral Health*	158	38						196
Behavioral Health (accepting new members)	**158**	**38**						**196**
Hospitals	11	2						13
LTSS Facilities (Hosp./NF)	19	1						20
Residential Setting (CCFFH, E-ARCH, and ALF)	124	12						136
HCBS Providers (except residential settings and LTSS facilities)	51	16						67
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	191	65						256
Totals	**1086**	**282**	**0**	**0**	**0**	**0**	**0**	**1368**

* 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	30317	14515						**44832**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	191	230	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	202

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)*	552	52	9	10	73	69	44	809
PCPs - (accepting new members)	**410**	**35**	**9**	**10**	**59**	**34**	**33**	**590**
Specialists*	1170	108	13	4	113	76	69	1553
members)	**708**	**88**	**13**	**4**	**53**	**66**	**61**	**993**
Behavioral Health*	471	50	4	0	34	74	44	677
Behavioral Health (accepting new members)	**448**	**34**	**3**	**0**	**34**	**68**	**40**	**627**
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)	883	41	0	0	18	85	25	1052
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	1124	180	15	6	131	172	156	1784
Totals	**4285**	**444**	**45**	**22**	**381**	**500**	**352**	**6029**

* 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	24573	4014	416	102	2184	4810	3193	**39292**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	45	77	46	10	30	70	73	49

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)*	579	71	11	6	62	78	58	865
PCPs - (accepting new members)	**419**	**27**	**6**	**4**	**55**	**44**	**36**	**591**
Specialists*	1.281	171	66	9	114	217	189	2.047
members)	**1,045**	**157**	**49**	**9**	**106**	**200**	**175**	**1,741**
Behavioral Health*	765	245	61	63	171	237	202	1,744
Behavioral Health (accepting new members)	**740**	**241**	**61**	**63**	**168**	**235**	**199**	**1,707**
Hospitals	10	3	1	1	3	4	3	25
LTSS Facilities (Hosp./NF)	25	2			3	4	1	35
Residential Setting (CCFFH, E-ARCH, and ALF)	982	53	1		23	109	23	1.191
HCBS Providers (except residential settings and LTSS facilities)	45	9	2		7	18	4	85
Ancillary & Other (All provider types not listed above; incl Phcy, Lab, Therapists, Hospice, HHA	1.327	252	16	16	147	184	165	2.107
Totals	**5.014**	**806**	**158**	**95**	**530**	**851**	**645**	**8.099**

* 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	37.120	4.949	275	104	3.128	7.176	4.022	**56.774**

# Members per PCP by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	
Members per PCP	64	70	25	17	50	92	69	66

Note: RFP requirement is 300 members for every PCP

QUEST Integration Health Plan Summary of Call Center Calls as of: 12/31/2020

ALOHA CARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	66	5	0	2	6	9	5	**93**
Network (provider look up, access)	76	22	1	0	3	19	2	**123**
Primary Care Physician Assignment or Change	239	32	2	1	16	47	16	**353**
NEMT (inquiry, scheduling) -*monthly report*	466	49	19	4	16	62	30	**646**
Authorization/Notification (prior auth status)	713	64	8	2	23	60	32	**902**
Eligibility (general plan eligiblity, change request)	771	122	3	4	41	151	27	**1119**
Benefits (coverage inquiry)	146	21	0	0	15	34	5	**221**
Enrollment (ID card request, update member information)	49	3	0	0	2	11	1	**66**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	381	18	0	0	6	29	8	**442**
Billing/Payment/Claims	517	32	3	1	16	45	13	**627**
Appeals	11	3	0	0	0	1	0	**15**
Complaints and Grievances	7	2	0	0	1	1	1	**12**
Other	250	39	4	1	19	24	7	**344**
Totals	**3,692**	**412**	**40**	**15**	**164**	**493**	**147**	**4,963**

HMSA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	6	2	0	0	1	1	1	**11**
Network (provider look up, access)	122	15	1	0	8	14	25	**185**
Primary Care Physician Assignment or Change	1414	181	7	1	129	231	212	**2175**
NEMT (inquiry, scheduling) -*monthly report*	220	65	26	4	48	220	158	**741**
Authorization/Notification (prior auth status)	28	4	0	0	2	7	5	**46**
Eligibility (general plan eligiblity, change request)	492	66	1		36	84	75	**754**
Benefits (coverage inquiry)	320	70	2	1	40	59	57	**549**
Enrollment (ID card request, update member information)	656	86	1	0	70	133	107	**1053**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	63	9	0	0	9	14	12	**107**
Billing/Payment/Claims	164	24	0	1	12	34	27	**262**
Appeals	10	3	0	0	0	0	2	**15**
Complaints and Grievances	3	0	0	0	0	0	0	**3**
Other	478	85	4	2	58	114	90	**831**
Totals	**3976**	**610**	**42**	**9**	**413**	**911**	**771**	**6732**

KAISER

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	2	0						**2**
Network (provider look up, access)	23	10						**33**
Primary Care Physician Assignment or Change	4	1						**5**
NEMT (inquiry, scheduling) -*monthly report*	14	1						**15**
Authorization/Notification (prior auth status)	0	0						**0**
Eligibility (general plan eligiblity, change request)	262	58						**320**
Benefits (coverage inquiry)	152	27						**179**
Enrollment (ID card request, update member information)	31	15						**46**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	0	0						**0**
Billing/Payment/Claims	19	3						**22**
Appeals	0	0						**0**
Complaints and Grievances	0	0						**0**
Other	144	30						**174**
Totals	**651**	**145**	**0**	**0**	**0**	**0**	**0**	**796**

OHANA

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	248	36	5	0	11	69	23	**392**
Network (provider look up, access)	45	3	0	0	2	11	2	**63**
Primary Care Physician Assignment or Change	84	30	1	0	4	20	10	**149**
NEMT (inquiry, scheduling) -*monthly repor*t	1281	279	26	14	4	22	10	**1636**
Authorization/Notification (prior auth status)	11	7	13	2	1	11	3	**48**
Eligibility (general plan eligiblity, change request)	47	21	0	0	5	7	8	**88**
Benefits (coverage inquiry)	207	31	1	0	12	51	21	**323**
Enrollment (ID card request, update member information)	202	28	6	0	16	52	25	**329**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	112	12	2	0	5	25	5	**161**
Billing/Payment/Claims	10	6	0	0	0	6	2	**24**
Appeals	10	3	0	0	1	7	1	**22**
Complaints and Grievances	10	1	0	0	2	3	4	**20**
Other	1078	231	31	6	58	259	113	**1776**
Totals	**3,345**	**688**	**85**	**22**	**121**	**543**	**227**	**5,031**

UNITED HEALTHCARE

Summary of Calls by Island	Oahu	Maui	Molokai	Lanai	Kauai	East Hawaii	West Hawaii	Totals
Pharmacy - (claim, coverage, access)	131	17	0	0	14	28	11	**201**
Network (provider look up, access)	107	19	0	0	7	22	12	**167**
Primary Care Physician Assignment or Change	444	85	2	0	38	67	52	**688**
NEMT (inquiry, scheduling) -*monthly repor*t	62	9	1	0	3	29	19	**123**
Authorization/Notification (prior auth status)	24	4	1	0	1	10	16	**56**
Eligibility (general plan eligiblity, change request)	449	62	2	1	36	89	60	**699**
Benefits (coverage inquiry)	560	68	4	2	27	110	43	**814**
Enrollment (ID card request, update member information)	97	20	1	1	3	15	10	**147**
Service Coordination Inquiry or request (contact FSC, assessment, service plan)	92	14	2	0	4	28	10	**150**
Billing/Payment/Claims	10	2	0	0	0	3	2	**17**
Appeals	13	4	1	0	1	0	0	**19**
Complaints and Grievances	0	2	0	0	0	0	0	**2**
Other	585	60	10	0	32	149	51	**887**
Totals	**2,574**	**366**	**24**	**4**	**166**	**550**	**286**	**3,970**

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	$ 387,647,479	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,537,499,701
EG 2 - Adults	2	$ 170,110,930	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,180,808,461
EG 3 - Aged	3	$ 389,426,029	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,180,931,855
EG 4 – Blind/Disabled	4	$ 485,333,800	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,174,477,492
TOTAL		**$ 1,432,518,238**	**$ 1,647,483,576**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,514,606,422**

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	$ 387,647,479	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
		Difference	$ 241,401,333	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 181,050,999	$ 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	$ 170,110,930	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
		Difference	$ 218,892,801	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 164,169,600	$ 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	$ 389,426,029	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
		Difference	$ 268,842,680	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 201,632,010	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ 193,054,616	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 485,333,800	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
		Difference	$ 270,080,618	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 202,560,464	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 749,413,074**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,344,944,610**

BASE VARIANCE			**$ 249,804,358**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,448,314,870**
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								**$ 1,448,314,870**

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)	$ 1,682,322,596	$ 3,608,229,997	$ 5,627,146,152	$ 7,743,740,010	$ 9,962,921,292	
Allowed Cumulative Variance (= CTP X CBNL)	$ 33,646,452	$ 54,123,450	$ 56,271,462	$ 38,718,700	$ -	
Actual Cumulative Variance (Positive = Overspending)	$ (249,804,358)	$ (528,228,183)	$ (820,313,196)	$ (1,126,762,444)	$ (1,448,314,870)	
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	$889.37	$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	$655,908,916	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL		**$ 655,908,916**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,346,128,843**

HYPOTHETICALS VARIANCE 1			**$ 613,924,178**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,506,481,124**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ -	$ 3,913,204	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon		3,152	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 3,913,204**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 20,198,305**

With-Waiver Total Expenditures

		26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita							
EG 6 - CIS	1	$ -	$ 3,807,889	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL		**$ -**	**$ 3,807,889**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 19,653,113**

HYPOTHETICALS VARIANCE 2			**$ -**	**$ 105,315**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 545,192**

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**	$ -	$ 10,672,394	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon		3,152	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 10,672,394**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 55,086,243**

With-Waiver Total Expenditures

		26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita							
EG 7 – CIS Community Transition Pilot	1	$ -	$ 10,385,151	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL		**$ -**	**$ 10,385,151**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 53,599,397**

HYPOTHETICALS VARIANCE 3			**$ -**	**$ 287,244**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,486,846**

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:	1/27/2021	Reporting DY	27
For the Time Period Through:	9/30/2020	Reporting Quarter	1

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 R 2	0	173,206,589	0	0	0	0	(28,108)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	173,178,481	173,178,481
1902 R 2X	0	(8,243,749)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	332,285,621	556,431,345	366,508,753	64,039,696	0	0	0	3,960,279,359	3,960,279,359
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	55,786,925	84,337,947	65,278,477	12,051,993	0	0	0	454,729,494	454,729,494
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)	(474,228)	0	0	0	0	(2,449,292)	(2,449,292)
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	155,598,645	244,914,264	148,812,690	25,827,781	0	0	0	1,398,390,315	1,398,390,315
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	342,048,447	473,294,409	340,963,909	61,962,769	0	0	0	3,334,186,328	3,334,186,328
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)	(285,331)	0	0	0	0	(1,714,111)	(1,714,111)
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)	(80,659)	0	0	0	0	(600,428)	(600,428)
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	107,788	54,335	15,411	0	0	0	3,936,105	3,936,105
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	244,752,500	227,394,155	43,950,943	55,913	(5,724)	735	0	0	0	0	0	0	0	1,546,271,707	1,546,271,707
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	546,471,295	785,972,863	538,884,573	102,364,785	0	0	0	2,986,797,089	2,986,797,089
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	1,685,766	301,633	0	0	0	8,612,115	8,612,115
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	129,039,016	188,021,506	117,024,343	21,506,059	0	0	0	948,041,529	948,041,529
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	3,099,812	430,430	0	0	0	24,062,826	24,062,826
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	182,900,835	252,985,641	166,956,783	31,863,396	0	0	0	2,225,531,814	2,225,531,814
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	106,595,650	248,572,791	306,184,516	316,589,798	372,772,425	583,608,263	385,961,713	65,598,485	0	0	0	3,894,886,137	3,894,886,137
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	1,307,250,747	1,449,178,427	773,323,801	1,747,098,957	1,886,418,458	1,978,888,489	2,119,655,849	3,174,713,649	2,134,373,683	385,962,438	0	0	0	24,820,856,108	24,820,856,108

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 R 2	0	86,769,823	0	0	0	0	(14,054)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	86,755,769	86,755,769
1902 R 2X	0	(4,205,136)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	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	182,375,956	302,237,727	209,767,918	38,212,487	0	0	0	2,221,006,310	2,221,006,310
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	30,581,769	45,665,494	37,490,007	7,191,424	0	0	0	251,272,264	251,272,264
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)	(268,101)	0	0	0	0	(1,334,492)	(1,334,492)
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	85,381,721	133,031,444	85,129,219	15,411,437	0	0	0	775,868,431	775,868,431
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	187,306,580	255,487,844	195,096,504	36,973,186	0	0	0	1,852,757,238	1,852,757,238
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)	(160,969)	0	0	0	0	(933,205)	(933,205)
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)	(45,312)	0	0	0	0	(327,585)	(327,585)
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	62,593	35,460	9,196	0	0	0	2,609,176	2,609,176
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	123,131,091	116,746,726	22,522,276	29,051	(3,183)	397	0	0	0	0	0	0	0	904,978,893	904,978,893
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	506,885,661	730,096,646	490,747,450	92,128,307	0	0	0	2,752,123,089	2,752,123,089
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	964,491	179,985	0	0	0	4,746,807	4,746,807
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	122,629,623	176,007,124	106,610,430	19,355,453	0	0	0	916,994,488	916,994,488
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	1,776,531	256,838	0	0	0	13,195,836	13,195,836
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	100,249,540	136,997,743	95,571,934	19,012,889	0	0	0	1,251,471,947	1,251,471,947
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	54,513,194	128,939,345	161,395,719	171,534,913	204,479,908	316,700,343	221,174,434	39,142,615	0	0	0	2,184,651,574	2,184,651,574
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	657,883,831	745,135,931	399,268,095	1,068,914,801	1,206,703,201	1,321,117,892	1,421,422,117	2,099,023,336	1,443,880,604	267,873,817	0	0	0	15,328,012,415	15,328,012,415

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	24,104,754	0	0	0	1,063,686,427	1,063,686,427
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	24,104,754	0	0	0	1,111,650,680	1,111,650,680

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	16,364,026	0	0	0	733,753,927	733,753,927
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	16,364,026	0	0	0	758,450,542	758,450,542

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)	$1,685,766	$301,633			
EG 1 - Children	1	State Plan Children	$385,961,713	$65,598,485			
EG 2 - Adults	2	State Plan Adults	$166,956,783	$31,863,396			
EG 2 - Adults	2	Breast Cervical Cancer Treatment (BCCT)	$54,335	$15,411			
EG 2 - Adults	2	St Pl Adults-Preg Immig/COFAs	$3,099,812	$430,430			
EG 3 - Aged	3	Aged w/Mcare	$366,508,753	$64,039,696			
EG 3 - Aged	3	Aged w/o Mcare	$65,278,477	$12,051,993			
EG 3 - Aged	3	Aged with Medicare - MFP	($474,228)				
EG 3 - Aged	3	Aged without Medicare - MFP	($17,253)				
EG 4 – Blind/Disabled	4	B/D w/Mcare	$148,812,690	$25,827,781			
EG 4 – Blind/Disabled	4	B/D w/o Mcare	$340,963,909	$61,962,769			
EG 4 – Blind/Disabled	4	Blind/Disable without Medicare - MFP	($285,331)				
EG 4 – Blind/Disabled	4	Blind/Disabled with Medicare - MFP	($80,659)				
Hypothetical 1 Per Capita							
EG 5 – Group VIII	1	VIII-Like Group					
EG 5 – Group VIII	1	Expansion State Adults	$538,884,573	$102,364,785			
EG 5 – Group VIII	1	Newly Eligible Adults	$117,024,343	$21,506,059			
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			$2,134,373,683	$385,962,438			

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	-$41,869,720					Cost share
EG 4 – Blind/Disabled	4	-$4,076,809					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	$387,647,479	$65,900,118			
EG 2 - Adults	2	$170,110,930	$32,309,237			
EG 3 - Aged	3	$389,426,029	$76,091,689			
EG 4 – Blind/Disabled	4	$485,333,800	$87,790,550			
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$655,908,916	$123,870,844			
Hypothetical 2 Per Capita						
EG 6 - CIS	1					
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1					
TOTAL		**$ 2,088,427,154**	**$ 385,962,438**	**$ -**	**$ -**	**$ -**

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		$337,253,185	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2		$186,094,530	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3		$365,302,965	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4		$496,741,303	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1		$702,119,454	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1		$3,807,889	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		$10,385,151	$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	$387,647,479	$403,153,303	$417,364,457	$432,076,554	$447,307,253
EG 2 - Adults	2	$170,110,930	$218,403,767	$232,146,824	$246,754,662	$262,281,700
EG 3 - Aged	3	$389,426,029	$441,394,654	$460,966,093	$481,405,329	$502,750,842
EG 4 – Blind/Disabled	4	$485,333,800	$584,531,853	$616,353,767	$649,908,066	$685,289,061
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	$655,908,916	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987
Hypothetical 2 Per Capita						
EG 6 - CIS	1		$3,807,889	$4,908,521	$5,272,733	$5,663,970
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		$10,385,151	$13,386,875	$14,380,181	$15,447,190
TOTAL		**$ 2,088,427,154**	**$ 2,487,666,914**	**$ 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	242327			
EG 2 - Adults	2	420331	74104			
EG 3 - Aged	3	339459	58899			
EG 4 – Blind/Disabled	4	285411	48569			
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1	1411914	261768			
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		1342447	1624394	1665004	1706629
EG 2 - Adults	2		440289	527253	540435	553945
EG 3 - Aged	3		273944	336172	339533	342929
EG 4 – Blind/Disabled	4		270725	322487	325712	328969
Hypothetical 1 Per Capita						
EG 5 – Group VIII	1		1301492	1602341	1642400	1683460
Hypothetical 2 Per Capita						
EG 6 - CIS	1		3152	3877	3974	4073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		3152	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		3,152	3,877	3,974	4,073
Hypothetical 3 Per Capita						
EG 7 – CIS Community Transition Pilot	1		3,152	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		$ 387,647,479	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	$5,537,499,701
EG 2 - Adults	2		$ 170,110,930	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	$3,180,808,461
EG 3 - Aged	3		$ 389,426,029	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	$6,180,931,855
EG 4 – Blind/Disabled	4		$ 485,333,800	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	$7,174,477,482
TOTAL			**$ 1,432,518,238**	**$ 1,647,483,576**	**$ 1,726,831,141**	**$ 1,810,144,611**	**$ 1,897,628,856**	**$ 8,514,606,422**

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	$ 387,647,479	$ 403,153,303	$ 417,364,457	$ 432,076,554	$ 447,307,253	
		Difference	$ 241,401,333	$ 314,685,928	$ 325,779,554	$ 337,271,844	$ 349,159,435	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 181,050,999	$ 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	$ 170,110,930	$ 218,403,767	$ 232,146,824	$ 246,754,662	$ 262,281,700	
		Difference	$ 218,892,801	$ 275,269,483	$ 292,591,179	$ 311,001,280	$ 330,572,397	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 164,169,600	$ 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	$ 389,426,029	$ 441,394,654	$ 460,966,093	$ 481,405,329	$ 502,750,842	
		Difference	$ 268,842,680	$ 225,992,174	$ 236,012,591	$ 246,475,330	$ 257,406,155	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 201,632,010	$ 169,494,130	$ 177,009,443	$ 184,856,498	$ 193,054,616	
		Savings Phase-Down						
EG 4 – Blind/Disabled	4	**Without Waiver**	$ 755,414,418	$ 882,279,567	$ 930,310,498	$ 980,956,602	$ 1,034,360,778	
		With Waiver	$ 485,333,800	$ 584,531,853	$ 616,353,767	$ 649,908,066	$ 685,289,061	
		Difference	$ 270,080,618	$ 297,747,714	$ 313,956,731	$ 331,048,536	$ 349,071,717	
		Phase-Down Percentage	25%	25%	25%	25%	25%	
		Savings Reduction	$ 202,560,464	$ 223,310,785	$ 235,467,548	$ 248,286,402	$ 261,803,788	
Total Reduction			**$ 749,413,074**	**$ 835,271,474**	**$ 876,255,041**	**$ 919,347,743**	**$ 964,657,278**	**$ 4,344,944,610**

BASE VARIANCE			**$ 249,804,358**	**$ 278,423,825**	**$ 292,085,014**	**$ 306,449,248**	**$ 321,552,426**	**$ 1,448,314,870**
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								**$ 1,448,314,870**

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)			$ 1,682,322,596	$ 3,608,229,997	$ 5,627,146,152	$ 7,743,740,010	$ 9,962,921,292	
Allowed Cumulative Variance (= CTP X CBNL)			$ 33,646,452	$ 54,123,450	$ 56,271,462	$ 38,718,700	$ -	
Actual Cumulative Variance (Positive = Overspending)			$ (249,804,358)	$ (528,228,183)	$ (820,313,196)	$ (1,126,762,444)	$ (1,448,314,870)	
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		$655,908,916	$825,990,298	$887,278,778	$953,114,864	$1,023,835,987	
TOTAL			**$ 655,908,916**	**$ 825,990,298**	**$ 887,278,778**	**$ 953,114,864**	**$ 1,023,835,987**	**$ 4,346,128,843**

HYPOTHETICALS VARIANCE 1			**$ 613,924,178**	**$ 647,444,782**	**$ 695,481,615**	**$ 747,097,616**	**$ 802,532,932**	**$ 3,506,481,124**

HYPOTHETICALS TEST 2

Without-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1	**Total**	$ -	$ 3,913,204	$ 5,044,869	$ 5,419,304	$ 5,820,928	
		PMPM	$1,184.76	$1,241.63	$1,301.23	$1,363.69	$1,429.15	
		Mem-Mon		3,152	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 3,913,204**	**$ 5,044,869**	**$ 5,419,304**	**$ 5,820,928**	**$ 20,198,305**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 2 Per Capita								
EG 6 - CIS	1		$ -	$ 3,807,889	$ 4,908,521	$ 5,272,733	$ 5,663,970	
TOTAL			**$ -**	**$ 3,807,889**	**$ 4,908,521**	**$ 5,272,733**	**$ 5,663,970**	**$ 19,653,113**

HYPOTHETICALS VARIANCE 2			**$ -**	**$ 105,315**	**$ 136,348**	**$ 146,571**	**$ 156,958**	**$ 545,192**

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**	$ -	$ 10,672,394	$ 13,758,736	$ 14,779,902	$ 15,875,210	
		PMPM	$3,231.17	$3,386.27	$3,548.81	$3,719.15	$3,897.67	
		Mem-Mon		3,152	3,877	3,974	4,073	
TOTAL			**$ -**	**$ 10,672,394**	**$ 13,758,736**	**$ 14,779,902**	**$ 15,875,210**	**$ 55,086,243**

With-Waiver Total Expenditures

			26	27	28	29	30	TOTAL
Hypothetical 3 Per Capita								
EG 7 – CIS Community Transition Pilot	1		$ -	$ 10,385,151	$ 13,386,875	$ 14,380,181	$ 15,447,190	
TOTAL			**$ -**	**$ 10,385,151**	**$ 13,386,875**	**$ 14,380,181**	**$ 15,447,190**	**$ 53,599,397**

HYPOTHETICALS VARIANCE 3			**$ -**	**$ 287,244**	**$ 371,861**	**$ 399,721**	**$ 428,020**	**$ 1,486,846**

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
$ 1,448,314,870