



QUEST Integration
§1115 Waiver Extension Application

State of Hawai‘i, Department of Human Services,
Med-QUEST Division

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- A. Summaries of EQRO Reports, Quality Assurance Monitoring, and Other Information and Documentation Regarding Quality of and Access to Care
- B. Interim Demonstration Evaluation Report
- C. Hawai'i Med-QUEST Division Quality Strategy
- D. QUEST Integration Special Terms & Conditions (2013-2018)
- E. Documentation of 2017 Post-Award Forum
- F. UCC Pool Evaluation
- G. Budget Neutrality Charts
- H. E-mail Notice
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Introduction

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

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

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

MQD’s vision is that the people of Hawai‘i embrace health and wellness. MQD’s mission is to empower Hawai‘i residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha. The vision and mission will guide the work developed through HOPE. The following guiding principles describe the overarching framework that will be used to develop a transformative healthcare system that focuses on healthy families and healthy communities:

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

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

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

Hawai‘i QUEST Waiver History & the Current Demonstration

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

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

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

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

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

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

MQD’s objectives for the demonstration were:

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

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

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

Eligibility and Alignment with the Affordable Care Act

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

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

Table 1: Enrollment Growth CY2008 - CY2018

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018 (est)
Average Monthly Enrollment	211,2015	235,206	260,457	272,218	287,902	292,423	307,303	325,151	346,357	353,032	361,113
Percent Growth Year over Year		11.4%	10.7%	4.5%	5.8%	1.6%	5.1%	5.8%	6.5%	1.9%	2.3%

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

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

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

Program Integration

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

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

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

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

UCC Pool

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

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

Additional Benefits & Efforts

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

Supportive Housing

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

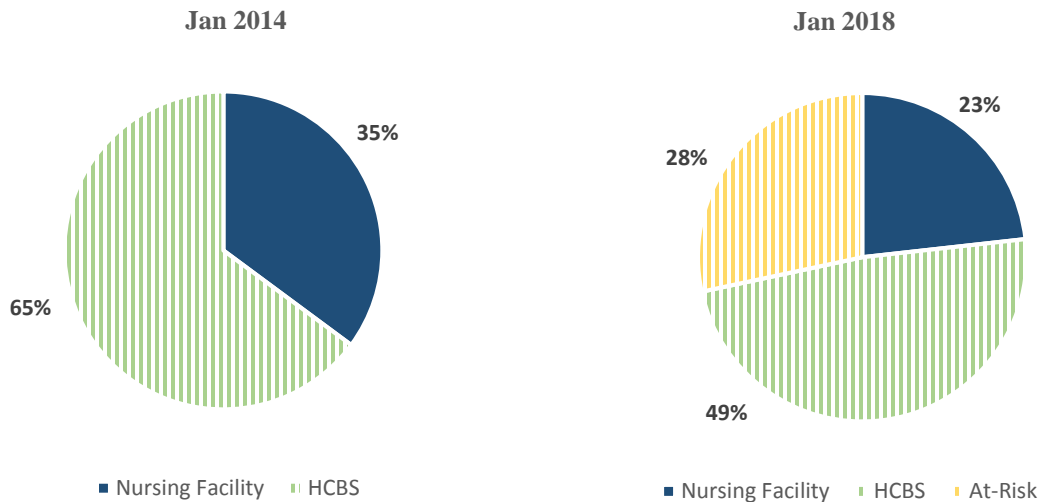
The At-Risk Population

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

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

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

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



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

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

Pay for Performance

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

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

Table 2: P4P Results CY2014-CY2016

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

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

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

QUEST Integration Initiatives

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

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

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

The HOPE Initiative

MQD's strategic focus under the QUEST Integration demonstration extension will be the Hawai'i 'Ohana Nui Project Expansion (HOPE) initiative. The goal of the HOPE initiative is to achieve the Triple Aim of better health, better care, and sustainable costs for our community. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being through decreased onset of preventable illnesses, improved early detection and optimal management of conditions, and a continued sustainable growth rate in health care spending by reducing unnecessary care and shifting care to appropriate settings.

The HOPE initiative is focused on four key strategies. The first strategy is focused on investing in primary care, health promotion, and prevention early in one's life and over one's life. The second strategy is focused on people with the highest, most complex health and social needs because they use a majority of health care resources, and there is potential for a strong return on investment. The third strategy reflects the need to pay for care differently. The focus is to move away from rewarding volume toward accountability for overall cost and quality that is essential for supporting the integrated delivery system reforms identified in the first two strategies. The fourth strategy reflects MQD's commitment to invest in community care, support community initiatives, and develop initiatives that link integrated health systems with community resources in order to improve population health.

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

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

Demonstration Objectives, Waiver Hypotheses, and Extension Evaluation

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

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

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

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

Demonstration Objectives	Evaluation Hypotheses	Potential Approaches
<p>Improve health outcomes for Medicaid beneficiaries covered under the demonstration</p>	<p>Increasing utilization for primary care, preventive services, and health promotion will reduce prevalence of risk factors for chronic illnesses and lower the total cost of care for targeted beneficiaries.</p>	<p>Measure intervention impacts on trends in utilization, targeted HEDIS and state-defined health care quality and outcome measures, and total cost of care per beneficiary.</p> <p>Data will be drawn from a variety of sources including:</p> <ul style="list-style-type: none"> • Administrative data (i.e., claims; encounters, enrollment in Hawaii Prepaid Medical Management Information System (HPMMIS), health plan reports, etc.); • Electronic Health Records; • Member and provider feedback (External Quality Review Organization (EQRO)-conducted surveys, grievances, Ombudsman reports); and • Inter-agency data from other divisions within the Department of Human Services and potentially other agencies such as the Department of Health, Department of Education, and Department of Labor and Industrial Relations.
	<p>Improving care coordination (e.g., by establishing team-based care and greater integration of behavioral and physical health) will improve health outcomes and lower the total cost of care for high-needs, high-cost individuals.</p>	
<p>Maintain a managed care delivery system that leads to more appropriate utilization of the health care system and a slower rate of expenditure growth.</p>	<p>Implementing alternative payment methodologies (APM) at the provider level and value-based purchasing (VBP) reimbursement methodologies at the MCO level will increase appropriate utilization of the health care system, which in turn will reduce preventable healthcare costs.</p>	
<p>Support strategies and interventions targeting the social determinants of health.</p>	<p>Providing community integration services and similar initiatives for vulnerable and at-risk adults and families will result in better health outcomes and lower hospital utilization.</p>	

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

Demonstration Eligibility

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

Table 3: Mandatory State Plan Groups

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

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

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

Table 4: Optional State Plan Groups

Optional State Plan Groups		
Eligibility Group Name	Authority	Qualifying Criteria
Optional Coverage of Families and Children and the Aged, Blind, or Disabled	§1902(a)(10)(ii) §1905(a) 42 C.F.R. § 435.210	ABD individuals who do not receive cash assistance but meet income and resource requirements
	42 C.F.R. § 435.211	Individuals eligible for assistance but for being in a medical institution
	§1902(a)(10)(ii)(VII)	Individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care
	§1902(a)(10)(ii)(XI) 42 C.F.R. § 435.121 42 C.F.R. § 435.230	ABD individuals in domiciliary facilities or other group living arrangements
	§1902(a)(10)(ii)(X) §1902(m)	Aged or disabled individuals with income up to and including 100% FPL
Optional targeted low- income children	§1902(a)(10)(A)(ii)(XIV) Title XXI 42 C.F.R. § 435.229	Up to and including 308% FPL including for children for whom the State is claiming Title XXI funding
Certain Women Needing Treatment for Breast or Cervical Cancer	§1902(a)(10)(A) §1920	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non- Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. § 435.301(b)(1) 42 C.F.R. §435.308	Up to and including 300% FPL, if spend down to medically needy income standard for household size
Medically Needy Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. §§435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology
Foster Children	§1902(a)(10)(A)(ii)(VIII) 42 C.F.R. §435.227	Children with non IV-E adoption assistance

Foster Children (19-20 years old)	§1902(a)(10)(A)(ii)(VIII) 42 C.F.R. §435.227	Receiving foster care maintenance payments or under adoption assistance
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Table 5: Expansion Populations

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

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

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

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

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

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

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

Current Demonstration Benefits and Features to Continue Under the Extension

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

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

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

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

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

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

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

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

Health Plan Enrollment

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

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

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

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

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

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

Long-Term Services and Supports

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

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

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

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

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

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

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

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

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

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

Behavioral Health Services

Under the extension, MQD intends to provide behavioral services the same way it provides them under the current QI program. The QUEST Integration demonstration will continue to offer a full array of standard state plan behavioral health services through managed care. It will also continue to offer additional, specialized state plan and waiver behavioral health services as described in an earlier section.

MQD provides standard behavioral health services to all beneficiaries and specialized behavioral health services to beneficiaries with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD). All beneficiaries have access to standard behavioral health services through QI health plans. The standard behavioral health services include inpatient psychiatric hospitalization, emergency department services, ambulatory services that includes crisis management and residential services, medications, medication management, diagnostic services, psychiatric and psychological evaluation and management, medically necessary substance use disorder (SUD) treatment, and methadone management.

Beneficiaries with SMI, SPMI, or SEBD may be in need of specialized behavioral health services. For children (individuals <21), the SEBD services are provided through the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD); for adults (individuals >21) the SMI/SPMI services are provided through the MQD's behavioral health program Community Care Services (CCS). The available specialized services include:

- For children: multidimensional treatment foster care, family therapy, functional family therapy, parent skills training, intensive home and community based intervention, community-based residential programs, and hospital-based residential programs, and
- For adults: intensive case management, partial hospitalization or intensive outpatient hospitalization, psychosocial rehabilitation/clubhouse, therapeutic living supports or specialized residential treatment centers, supportive housing, representative payee, supportive employment, peer specialist and behavioral health outpatient services.

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

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

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

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

Community Integration Services

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

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

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

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

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

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

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

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

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

Other Features that Will Continue

Medically Needy Non-ABD Individuals

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

Medically Needy ABD Individuals

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

Self-Direction Opportunities

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

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

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

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

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

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

Additional Hospice Payment for Nursing Facility Residents

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

Cost-Sharing

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

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

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

Proposed Waiver and Expenditure Authorities

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

Table 6: Waiver Authorities

Current Waiver Authority	Status under Extension
<p>Medically Needy (Section 1902(a)(10)(C); Section 1902(a)(17))</p> <p>To enable the state to limit medically needy spend-down eligibility in the case of those individuals who are not aged, blind, or disabled to those individuals whose gross incomes, before any spend-down calculation, are at or below 300 percent of the federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, for whom there is no gross income limit.</p>	Continue
<p>Amount, Duration, and Scope (Section 1902(a)(10)(B))</p> <p>To enable the state to offer demonstration benefits that may not be available to all categorically eligible or other individuals.</p>	Continue
<p>Retroactive Eligibility (Section 1902(a)(34))</p> <p>To enable the state to limit retroactive eligibility to a ten (10) day period prior to application, or up to three months for individuals requesting long-term care services.</p>	Continue
<p>Freedom of Choice (Section 1902(a)(23)(A))</p> <p>To enable Hawai'i to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932.</p>	Continue
<p>Annual Redeterminations (Section 1902(a)(17) and Section 1902(a)(19))</p> <p>To the extent necessary to enable the state to extend the eligibility span of enrollees who will need a redetermination between October 1, 2013, and December 31, 2013, to a reasonable date in 2014.</p>	Discontinue
<p>Title XIX Requirements Not Applicable to Demonstration Expansion Populations</p> <p>Cost Sharing Section 1902(a)(14) insofar as it incorporates 1916 and 1916A</p>	Continue

<p>To enable the state to charge cost sharing up to 5 percent of annual family income.</p> <p>To enable the state to charge an enrollment fee to Medically Needy Aged, Blind and Disabled QUEST Integration health plan enrollees (Demonstration Population 3) whose spend-down liability is estimated to exceed the QUEST Integration health plan capitation rate, in the amount equal to the estimated spend-down amount or where applicable, the amount of patient income applied to the cost of long-term care.</p>	
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Table 7: Expenditure Authorities

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

<p>a. <u>Demonstration Population 1</u>. Parents and caretaker relatives who are living with an 18-year-old who would be a dependent child but for the fact that the 18-year-old has reached the age of 18, if such parents would be eligible if the child was under 18 years of age.</p> <p>b. <u>Demonstration Population 2</u>. Aged, blind, and disabled individuals in the 42 C.F.R. § 435.217 like group who are receiving home- and community- based services, with income up to and including 100 percent of the federal poverty limit using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.</p> <p>c. <u>Demonstration Population 3</u>. Aged, blind, and disabled medically needy individuals receiving home-and community-based services, who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income.</p> <p>d. <u>Demonstration Population 4</u>. Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance, who would not otherwise be eligible under the state plan, with the same income limit that is applied for Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement under the state plan</p> <p>e. <u>Demonstration Population 5</u>. Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance) when placed from age 16 to 18 years of age, or would otherwise be eligible under a different eligibility group but for income, and were enrolled in the State plan or waiver while receiving assistance payments</p> <p>f. <u>Demonstration Population 6</u>. Individuals who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not</p>	<p>Discontinue for Demonstration Populations 6 through 7.</p>
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<p>impose an asset limit on this population. Authority for this demonstration population expires December 31, 2013.</p> <p>g. <u>Demonstration Population 7</u>. Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Medicare part A or enrolled for benefits under Medicare part B and are not a mandatory state plan population and whose income (as determined using modified adjusted gross income) does not exceed 133 percent of the FPL, determined using modified adjusted gross income. Authority for this demonstration population expires December 31, 2013.</p>	
<p>Hospital Uncompensated Care Costs. Expenditures for actual uncompensated care costs incurred by certain hospital providers and nursing facility providers for inpatient and outpatient hospital services and long-term care services provided to the uninsured as well as Medicaid managed care and fee-for-service shortfalls, subject to the restrictions placed on hospital and nursing facility uncompensated care costs, as defined in the STCs and the CMS approved Certified Public Expenditures/Government-Owned Hospital Uncompensated Care Cost Protocol. This expenditure authority is effective through June 30, 2016.</p>	Discontinue
<p>Home and Community-Based Services (HCBS) and Personal Care Services. Expenditures to provide HCBS not included in the Medicaid state plan and furnished to QUEST Integration enrollees, as follows:</p> <p>a. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement;</p> <p>b. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, i.e., the “at risk” population. The state may maintain a waiting list, through a health plan, for home and community-based services (including personal care services). No waiting list is permissible for other services for QUEST Integration enrollees.</p> <p>The state may impose an hour or budget limit on home and community based services provided to individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the “at risk” population), as</p>	Continue

<p>long as such limits are sufficient to meet the assessed needs of the individual.</p>	
<p>PLACEHOLDER</p> <p>Community Integration Services</p> <p>Community Integration Services would be an expenditure authority that would read: <i>Community Integration Services (CIS), described in the Special Terms and Conditions, are available for individuals 18 years or older who meet certain needs-based criteria.</i></p>	<p>Continue</p>
<p>Additional Benefits: Expenditures to provide the following additional benefits.</p> <p>a. Specialized Behavioral Health Services: The services listed below are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).</p> <ul style="list-style-type: none"> i. Supportive Housing. ii. Supportive Employment. iii. Financial management services. <p>b. Cognitive Rehabilitation Services: Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical, occupational or speech therapist. Services must be medically necessary and prior approved.</p> <p>c. Habilitation Services. Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.</p>	<p>Continue</p>

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

Quality and Monitoring

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financing

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

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

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

Table 8: Estimated Spending During the Demonstration

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

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

Table 9: Projected Average Enrollment Growth

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

Compliance with Special Terms and Conditions

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

Public Notice

Post Award Forums for the Current Demonstration

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

QUEST Integration Extension Public Input Process

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

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

Public Comment Periods

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

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

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

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

- March 2, 2018 from 8:00 am to 12:00 pm
Hawai‘i Department of Human Services
1390 Miller Street, Conference Room 1 & 2
Honolulu, Hawai‘i
- March 6, 2018 from 8:00 am to 12:00 pm via teleconference at:
 - Oahu Kakuhihewa Videoconference Center
Kakuhihewa State Office Building
601 Kamokila Boulevard, Room 167B
Kapolei, Hawai‘i
 - Hawai‘i Hilo Videoconference Center
Hilo State Office Building
75 Aupuni Street, Basement
Hilo, Hawai‘i

Kauai Lihue Videoconference Center
Lihue State Office Building
3060 Eiwa Street, Basement
Lihue, Hawai'i

Maui Wailuku Videoconference Center
Wailuku Judiciary Building
2145 Main Street, First Floor
Wailuku, Hawai'i

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

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

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

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

Summary of Public Comments Received

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

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

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

- 1. Investments in Primary Care, Health Promotion, and Prevention.** The vast majority of commenters expressed strong support for the QUEST waiver extension and the integration of the HOPE vision into the demonstration. In particular, the stakeholders appreciated the emphasis on primary care, behavioral health integration, strategies for addressing the social determinants of health (SDOH), and restoration of the Medicaid dental benefit and the oral health initiative. Several commenters noted that strategies for integrating behavioral health and addressing the social determinants of health are already underway, both within provider groups but also Medicaid Managed Care Organizations (MCOs) in the state.
- 2. Focus on People with the Highest, Most Complex Health and Social Needs.** Most commenters pointed out that investments in primary care, health promotion, and prevention are critically important in the context of addressing the needs of high cost/high need utilizers of care. Many pointed out on the need for improved real-time availability and transparency of data, especially on the part of Medicaid MCOs, along with the need for a common platform for data sharing. One commenter suggested that the state consider how the use of advanced care planning tools can be used in the context of caring for individuals with high cost/high utilizers of care.
- 3. Movement Toward Payment Transformation and Integrated Delivery Systems.** Overall, commenters indicated support for a move toward value-based purchasing (VBP). They recommended alignment across VBP strategies and MCOs in order to ensure consistency. Commenters support the increased emphasis on performance and outcomes measures (as opposed to process measures) and the use of data to track improved costs and health outcomes, including consideration of incentives to facilitate the transition. They recommended leveraging the HEDIS measure set in order to have a standard that will allow comparisons across health plans. One commenter asked the state how they might measure compliance while transitioning toward VBP. Several comments related to the need for risk adjustment and careful consideration for patient attribution as it relates to payment reform efforts, especially in the context of working with low-income populations. One commenter pointed out that assuming risk for specific populations “is a goal of Medicaid MCOs, not low-income communities.”
- 4. Investments in Community Care, Community-Based Initiatives, and Links Between Integrated Health Systems and Community Resources.** Commenters were very supportive of community-based health reform initiatives, especially if those that are locally-created and implemented. Some commenters emphasized the need for community-based initiatives to be “standardized” or aligned across all Medicaid MCOs. FQHCs and other providers commented that community investment strategies be incorporated into the state's thinking. One commenter pointed out the need for a

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

Other Related Efforts:

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

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

Miscellaneous Comments:

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

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

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

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

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

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

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

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

MQD Response to Public Comments

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

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

Tribal Consultation

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

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

More detail and documentation can be found in Attachment K.

The Post-Award Public Input Process

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

Demonstration Administration

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