DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

OCT 2 6 2015

Judy Mohr Peterson
Med-QUEST Division Administrator
State of Hawaii, Department of Human Services
601 Kamokila Blvd, Room 518
PO Box 700190
Kapolei, HI 96709-0190

Dear Ms. Mohr Peterson:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to Hawaii's section 1115 demonstration, entitled, "QUEST Integration" (Project Number 11-W-00001/9). The technical corrections ensure that the Special Terms and Conditions (STCs) accurately reflect CMS's approval of the demonstration.

To reflect upon the agreed terms between the state and CMS, CMS has incorporated the technical changes that the state requested into the latest version of the STCs. A copy of the updated STCs and the expenditure authorities is enclosed. The waivers for this demonstration are unchanged by this amendment, and remain in force; a copy of the waiver list is also enclosed.

Your CMS project officer, Ms. Heather Ross, is available to address any questions you may have related to this correspondence. Ms. Ross can be reached at 410-786-3666 or heather.ross@cms.hhs.gov.

Official communications regarding official matters should be sent simultaneously to Ms. Ross and Ms. Henrietta Sam-Louie, Acting Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Sam-Louie can be reached at (415) 744-3552, or at Henrietta.Sam-Louie@cms.hhs.gov.

Sincerely,

Angela D. Garner
Director
Division of Systems Reforms Demonstrations

Enclosure

cc: Henrietta Sam-Louie, Acting Associate Regional Administrator,
Region IX, San Francisco Regional Office

DEPT OF HUMAN SVCS
MED-QUEST DIV
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CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00001/9**

TITLE: **QUEST Integration Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Hawaii's QUEST Integration section 1115(a) Medicaid demonstration extension (hereinafter "demonstration"). The parties to this agreement are the Hawaii Department of Human Services (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These amended STCs are effective from October 1, 2013 through December 31, 2018. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description, Objectives, and Historical Context
III. General Program Requirements
IV. Eligibility for the Demonstration
V. Enrollment
VI. Benefits
VII. Managed Care Plan Selection Processes
VIII. Cost Sharing
IX. Delivery System: Managed Care
X. Uncompensated Care
XI. General Reporting Requirements
XII. General Financial Reporting Requirements for Defined Authorized Expenditures
XIII. Monitoring Budget Neutrality for the Demonstration
XIV. Evaluation of the Demonstration
XV. Schedule of State Deliverables during the Demonstration Extension Period.

In the event of a conflict between any provision of these STCs and any provision of an attachment to these STCs, the STCs shall control.

II. PROGRAM DESCRIPTION, OBJECTIVES, AND HISTORICAL CONTEXT

QUEST Integration is a continuation and expansion of the state's ongoing demonstration, which is funded through Title XIX, Title XXI and the state. QUEST Integration uses capitated

managed care as a delivery system unless otherwise noted below. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria to beneficiaries eligible under the state plan and to the demonstration populations described in paragraph 18. During the period between approval and implementation of the QUEST Integration managed care contract the state will continue operations under its QUEST and QExA programs. Further details regarding implementation and transition activities are found in STC 31 of this document.

In December 2012, the state submitted its request to extend the QUEST demonstration under section 1115(a) of the Social Security Act for 5 years under the name QUEST Integration. This extension of the demonstration includes the following program changes:

- Consolidates the 4 programs within the demonstration into a single "QUEST Integration" program;
- Transitions the low-income childless adults and former foster care children from demonstration expansion populations to state plan populations;
- Adds additional new demonstration expansion populations, including a population of former adoptive and kinship guardianship children;
- Increases the retroactive eligibility period to 10 days for the non-long term services and supports population;
- Provides additional benefits, including cognitive rehabilitation, habilitation, and certain specialized behavioral health services;
- Removes the QUEST-ACE enrollment-related benchmarks from the UCC pool; and
- Requires additional evaluation on UCC costs after January 1, 2014.

This renewal integrates the demonstration's eligibility groups and benefits within the context of the Affordable Care Act (ACA). From a benefit perspective, Hawaii will provide all beneficiaries with access to the same benefits based on clinical criteria and medical necessity through capitated-managed care or through managed-fee-for-service delivery systems in certain circumstances.

Beneficiaries enrolled in the states' Home and Community-Based Services for People with Developmental Disabilities Section 1915(c) waiver will receive capitated primary and acute care services through the authority of QUEST Integration. All other services for this group will continue to be provided under section 1915(c) authority.

The state's goals in this extension of the demonstration are to:

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

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

The state of Hawaii implemented QUEST on August 1, 1994. QUEST is a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The state combined its Medicaid program with its then General Assistance Program and its innovative state Health Insurance Program and offered benefits to citizens up to 300 percent of the federal poverty level (FPL). This program virtually closed the coverage gap in the state.

The QUEST program covered adults with incomes at or below 100 percent of the federal poverty level (FPL) and uninsured children with family incomes at or below 200 percent FPL. In addition, the QUEST-Net program provided a full Medicaid benefit for children with family incomes above 200, but not exceeding 300 percent FPL and a limited benefit package for adults with incomes at or below 300 percent FPL.

In 2007, the QUEST demonstration was renewed under the new name QUEST Expanded.

In February 2010, CMS approved an amendment to implement the Hawaii Premium Plus program to encourage employment growth and employer sponsored health insurance in the State.

In July 2010, CMS approved an amendment to eliminate the unemployment insurance eligibility requirement for the Hawaii Premium Plus program.

In August 2010, CMS approved an amendment to add pneumonia vaccines as a covered immunization.

On April 5, 2012, CMS approved an amendment which reduced the QUEST-Net and QUEST-ACE eligibility for adults with income above 133 percent of the FPL and eliminated the grandfathered group in QUEST-Net with income between 200 and 300 percent of the FPL. This amendment was permitted because Hawaii filed a budget deficit certification, in accordance with CMS' February 25, 2011, State Medicaid Director's Letter.

In the 2011 amendment, Hawaii also requested to increase the benefits provided to QUEST-Net and QUEST-ACE under the demonstration; eliminate the QUEST enrollment limit for childless adults;; terminate the Hawaii Premium Plus program; and allow uncompensated cost of care payments (UCC) to be paid to government-owned nursing facilities.

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

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

   In addition, CMS reserves the right to amend and make necessary technical changes to the STCs without requiring the state to submit an amendment to the demonstration under STC 6. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs. These changes shall be effective upon written acceptance by the state.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as

necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.

b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state will not be required to submit Title XIX or Title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, waiting list, sources of non-federal share of funding, budget and/or allotment neutrality, and other comparable program elements that are not specifically described in the these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a. An explanation of the public process used by the state, consistent with the requirements of paragraph 14, to reach a decision regarding the requested amendment;

   b. A data analysis workbook which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming Title XIX and/or Title XXI state plan amendment, if necessary and

e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

a. Compliance with Transparency Requirements at 42 CFR §431.412: As part of the demonstration extension request, the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and public notice requirements outlined in paragraph 14 as well as include the following supporting documentation:

i. Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The state must provide summaries of the External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring and quality improvement activities; home and community based services discovery, remediation, and system improvement activities, and any other documentation that validates the quality of care provided or corrective action taken under the demonstration.

v. Compliance with the Budget Neutrality Cap: The state must provide a financial data workbook (as set forth in the current STCs) demonstrating

the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current President's budget and historical trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If Title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

vi. Draft report with Evaluation Status and Findings: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Demonstration of Public Notice 42 CFR §431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR §431.408 including the post-award public input process described in 42 CFR §431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out and transition plan. The state must submit its notification letter and a draft phase-out and transition plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out and transition plan to CMS, the state must publish on its website the draft phase-out and transition plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out and transition plan.

The state must obtain CMS approval of the phase-out and transition plan prior to the implementation of the phase-out and transition activities. Implementation of phase-out and transition activities must be no sooner than 14 days after CMS approval of the phase-out and transition plan.

b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out and transition plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c) Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling beneficiaries.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; home and community-based services;

compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 C.F.R. §431.408, and the tribal consultation requirements contained in the state's approved State plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 6, are proposed by the state.

    In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

    In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal or renewal of this demonstration (42 C.F.R. §431.408(b)(3)).

    The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

15. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

16. **Additional Federal Funds Participation (FFP) Requirement.** Premiums collected by the state for premiums paid by beneficiaries shall not be used as a source of state match for FFP.

17. **Home and Community-Based Services (HCBS) Requirement.** The state will adhere to a continuous quality improvement process as applied to the following HCBS assurances: Level of Care; Service Plans, Qualified Providers, Health and Welfare, Administrative Authority, and Financial Accountability.

IV. ELIGIBILITY FOR THE DEMONSTRATION

18. **Eligibility Groups Affected by the Demonstration.** Mandatory and optional State Plan groups derive their eligibility through the Medicaid and CHIP State plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid and CHIP State Plan, except as expressly waived under authority granted by this demonstration or as described in these STCs. Any Medicaid and CHIP State Plan Amendments to the eligibility

standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard, will apply to this demonstration.

The beneficiary eligibility groups described below who are made eligible for QUEST Integration by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid and/or CHIP laws, regulations, and policies unless otherwise specified in the not applicable expenditure authorities for this demonstration.

QUEST Integration Medicaid and CHIP State Plan Mandatory and Optional groups

Medicaid Mandatory State Plan Group(s) (Categorical Eligibility)	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Infants under age 1	Subject to the Title XIX state plan.	Title XIX	State Plan Children
Children 1-18	Subject to the Title XIX state plan.	Title XIX	State Plan Children
Parents and caretaker relatives under age 21	Subject to the Title XIX state plan.	Title XIX	State Plan Children
Section 1925 Transitional Medicaid under age 21	Subject to the Title XIX state plan.	Title XIX	State Plan Children
Former Foster Care Children under age 21. Authority to include this group in the demonstration begins January 1, 2014.	Subject to Title XIX state plan.	Title XIX	State Plan Children
Pregnant women	Subject to the Title XIX state plan.	Title XIX	State Plan Adults
Parents and caretaker relatives age 21 and older	Subject to the Title XIX state plan.	Title XIX	State Plan Adults
Section 1925 Transitional Medicaid age 21 and older	Subject to the Title XIX state plan.	Title XIX	State Plan Adults
Former Foster Care Children age 21 to 25. Authority to include this group	Subject to Title XIX state plan.	Title XIX	State Plan Adults

in the demonstration begins January 1, 2014.			
SSI Aged	Subject to the Title XIX state plan.	Title XIX	Aged
SSI Blind or Disabled	Subject to the Title XIX state plan.	Title XIX	Blind or Disabled
Affordable Care Act Low-Income Adult Group eligible for Expansion State FMAP. Authority to include this group in the demonstration begins January 1, 2014.	Subject to the Title XIX state plan.	Title XIX	Expansion State Adults
Affordable Care Act Low-Income Adult Group eligible for Newly Eligible FMAP. Authority to include this group in the demonstration begins January 1, 2014.	Subject to Title XIX state plan.	Title XIX	Newly Eligible Adults
Medicaid State Plan Groups	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
Children through the CHIP Medicaid expansion	Subject to Title XIX state plan.	Title XXI	Opt. State Plan Children[1]
Optional Medicaid State Plan Groups	**Federal Poverty Level and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group Reporting**
Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance	Subject to Title XIX state plan.	Title XIX	Foster Care Children, 19-20 years old

[1] Reported under Title XXI Allotment Neutrality if allotment is available.

agreement			
Medically Needy Non-ABD Pregnant Women	Subject to Title XIX state plan.	Title XIX	Medically Needy Adults
Medically Needy Non-ABD Children	Subject to Title XIX state plan.	Title XIX	Opt. State Plan Children
Breast and Cervical Cancer Treatment Program	Subject to Title XIX state plan.	Title XIX	Blind or Disabled
Aged Adults	Subject to Title XIX state plan.	Title XIX	Aged
Disabled Adults	Subject to Title XIX state plan.	Title XIX	Blind or Disabled
Medically Needy Non-ABD Children and Pregnant Women	Subject to Title XIX state plan.	Title XIX	Aged
Medically Needy Non-ABD Children and PW	Subject to Title XIX state plan.	Title XIX	Blind or Disabled

QUEST Integration Demonstration Expansion Population Groups

Demonstration Eligibles	Federal Poverty Level and/or Other Qualifying Criteria	Funding Stream	Expenditure and Eligibility Group Reporting
Parents or caretaker relatives of certain 18-year-olds	Parents and caretaker relatives who are living with an 18-year-old who would be a dependent child but for the fact that the 18-year-old has reached the age of 18, if such parents would be eligible if the child was under 18 years of age.[2]	Title XIX	Demo Elig Adults

[2] For the period from October 1, 2013 to December 31, 2013, this demonstration expansion population shall not include the parents and caretakers of full time students who are 18 years of age, if these parents and caretakers are covered under the state plan during that time period.

Aged individuals in the 42 C.F.R. § 435.217 like group receiving home- and community- based services	Income up to and including 100% FPL using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.	Title XIX	Aged
Blind or disabled individuals in the 42 C.F.R. § 435.217 like group receiving home-and community-based services	Income up to and including 100% FPL using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.	Title XIX	Blind or Disabled
Aged medically needy individuals receiving home-and community-based services	Individuals who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income and spousal impoverishment eligibility rules.	Title XIX	Aged
Blind or disabled	Individuals who would	Title XIX	Blind or disabled

medically needy individuals receiving home-and community-based services	otherwise be eligible under the state plan or another Quest Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the Quest Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income and spousal impoverishment eligibility rules.		
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	Individuals who are not otherwise eligible under the state plan, with the same income limit that is applied for Foster Children (19-20 years old) who are receiving foster care maintenance payments or who under an adoption assistance agreement under the state plan or Kinship guardian assistance agreement.	Title XIX	Demo Elig Children
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance, age 21 to 25.	Individuals who have aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance) when placed from age 16 to age 18 years of age, would be eligible under a different eligibility group but for income, and were enrolled in the state plan or	Title XIX	Demo Elig Adults

	waiver while receiving assistance payments.		
Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance, under age 21.	Individuals who have aged out of adoption assistance program or kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance) when placed from age 16 to age 18 years of age, would be eligible under a different eligibility group but for income, and were enrolled in the state plan or waiver while receiving assistance payments.	Title XIX	Demo Elig Children
Former Foster Children. Authority for this demonstration expansion group expires December 31, 2013.	Individuals who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not impose an asset limit on this population.	Title XIX	Demo Elig. Adults
Low-income childless adults. Authority for this demonstration expansion group expires December 31, 2013.	Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Medicare part A or enrolled for benefits under Medicare part B and are not a mandatory state plan population and whose income (as determined using modified adjusted gross income) does not exceed 133 percent of the FPL.	Title XIX	VIII-Like Adults

19. **Post-Eligibility Treatment of Income and Resources.** All individuals receiving nursing facility long-term care services must be subject to the post-eligibility treatment of income rules set forth in section 1924 and 42 CFR section 435.733. The application of patient income to the cost of care shall be made to the facility. Individuals receiving HCBS must be

subject to the post-eligibility treatment of income rules set forth in section 1924 and 42 CFR section 435.735 if they are medically needy, with or without spend-down, or individuals who would be eligible for Medicaid if institutionalized as set forth in 42 CFR section 435.217.

20. **Financial Responsibility/Deeming.** The state must determine eligibility using the income of household members whose income may be taken into account under the Medicaid financial responsibility and deeming rules, including institutional deeming for aged, blind, and disabled individuals.

21. **Retroactive Eligibility.** The state will limit retroactive eligibility for all individuals eligible under the state plan or demonstration to a 10-day period prior to the date of application with the exception of individuals requesting long-term care services in which case up to three months of retroactive eligibility will be allowed.

22. **Quality Review of Eligibility.** On March 4, 2010 CMS approved the state's MEQC plan to reflect programmatic changes as a result of the section 1115 demonstration program implementation integrating a major portion of the FFS population into Managed Care. The state shall remain relieved of any liability from disallowance for errors that exceed the 3 percent tolerance. CMS permits the state to continue with its effort to implement administrative renewal and MEQC reviews shall take that policy into account.

V. ENROLLMENT

23. **Spend-Down for Medically Needy Individuals.**

    a) **Pregnant Women and Children Medically Needy State Plan Groups** are eligible upon determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to subparagraph (d). Individuals in this group whose gross income exceeds 300 percent FPL are not eligible.

    b) **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is not expected to exceed the health plans' monthly capitation payment** will be enrolled in a QUEST Integration health plan upon the determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to subparagraph (d).

    c) **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is expected to exceed the health plans' monthly capitation payment** will be eligible under the demonstration subject to subparagraph (d) and an enrollment fee equal to the medically needy spend-down amount or, where applicable, the amount of patient income applied to the cost of long-term care. This group will receive all services through QUEST Integration health plans.

    d) **Medically needy individuals who are expected to incur expenses sufficient to satisfy their spend-down obligation for a retroactive period only** will not be enrolled in a QUEST Integration health plan. They will receive services on a fee-for-service basis. (This category might include, for example, persons who become medically needy for a

short-term retroactive period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically and thus will not meet their spend-down obligations every month.)

VI. BENEFITS

24. **QUEST Integration Benefits.** Benefits provided under authority of this demonstration are delivered through mandatory managed care (except as specified in subparagraph (g)), and are as follows, for all populations under the demonstration (except as otherwise provided in this paragraph):

a) **Full Medicaid State Plan.** Individuals eligible under the demonstration will receive comprehensive benefits including all services as defined in the Medicaid state plan.

b) **Alternative Benefit Plan:** The Affordable Care Act (ACA) New Adult Group will receive benefits provided through the state's approved alternative benefit plan (ABP) SPA. The VIII-like group will receive benefits that are identical to the benefits that will be included in the state's Medicaid State Plan.

c) **Additional Benefits.** Under the demonstration, the state will provide benefits in addition to Medicaid state plan and alternative benefit plan benefits based on medical necessity and clinical criteria. These additional benefits include home and community based services (HCBS), specialized behavioral health benefits, cognitive rehabilitation benefits, and habilitation benefits, as described below.

i. **HCBS:** QUEST Integration health plans will provide access to a comprehensive HCBS benefit package for individuals who meet institutional level of care and are able to choose to receive care at home or in the community and an expanded sub-set of HCBS services for individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "At Risk" population, re-named from "Personal Care-Level I/Chore" population) in order to prevent a decline in health status and maintain individuals safely in their homes and communities. The service definitions and provider types are found in Attachment C of these STCs. The amount, duration, and scope of all covered long-term care services may vary to reflect the needs of the individual in accordance with the prescribed Care Coordination Plan. The HCBS benefits that will be provided through managed care health plans include the following:

Service	Available for individuals who are assessed to be risk of deteriorating to institutional level of care	Available for individuals who meet institutional level of care ("1147 certified")
Adult day care	X*	X
Adult day health	X*	X
Assisted living facility		X

Community care foster family homes		X
Counseling and training		X
Environmental accessibility adaptations		X
Home delivered meals	X*	X
Home maintenance		X
Moving assistance		X
Non-medical transportation		X
Personal assistance	X	X
Personal emergency response system	X*	X
Residential care		X
Respite care		X
Skilled nursing	X	X
Specialized case management		X
Specialized medical equipment and supplies		X

* Denotes new services for the "At Risk" population under QUEST Integration.

ii. **Specialized Behavioral Health Services**: The services listed below (and further described in attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
    1. Supportive Housing.
    2. Supportive Employment.
    3. Financial management services.

iii. **Cognitive Rehabilitation Services:** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical, occupational or speech therapist. Services must be medically necessary and prior approved.

iv. **Habilitation Services.** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.

c) **Cost of Room and Board Excluded from Capitation Rate Calculations.** For purposes of determining capitation rates, the cost of room and board is not included in non-institutional care costs.

d) **Community Participation.** The state, either directly or through its MCO contracts, will ensure that participants' engagement and community participation is supported and facilitated to the fullest extent desired by each participant.

e) **HCBS Standards.** The state will assure compliance with CMS standards for HCBS settings as articulated in current section 1915(c) and 1915(i) policy and as modified by subsequent regulatory changes.

f) **Managed Care Plan Change.** Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

g) **Benefits Provided to the ID/DD Population.** Medicaid eligibles with developmental disabilities will receive the full Medicaid state plan benefit package through QUEST Integration managed care plans. Case management, section 1915(c) HCBS, and ICF/ID benefits for this group will remain carved out of the capitated benefit package. All QUEST Integration health plans will be required to coordinate the state plan benefits received by the DD/MR population with the HCBS that are provided on a fee-for-service basis from the Department of Health's (DOH) Developmental Disabilities Division.

h) **Behavioral Health Benefits.** All QUEST Integration plans will provide a full array of standard behavioral health benefits (including substance abuse treatment) to members who may need such services. The state will also provide specialized behavioral health services to beneficiaries with SMI, SPMI, or requiring SEBD. The Behavioral Health Protocol addresses the following: :

(i) Services provided by the DOH Child and Adolescent Mental Health Division (CAMHD) to children with serious emotional behavioral disorders (SEBD).
(ii) Services provided to adults with SMI or SPMI by the DOH Adult Mental Health Division (AMHD), the Med-QUEST division's Community Care Services (CCS) behavioral health program, or the contracted plans.
(iii) Reimbursement
(iv) A memorandum of agreement (MOA) that reflects the current interagency agreement for behavioral health services provided by the DOH to demonstration eligibles.
(v) The process and protocol used for referral between MCOs and the DOH or CCS, as well as the DOH or CCS and MCOs.

Any revisions to the QUEST Integration delivery system for Behavioral Health Services as defined in this sub-paragraph shall require a revision to Attachment E.

i) **Functional Level of Care (LOC) Assessment.** Access to both institutional and HCBS long-term care services will be based on a functional LOC assessment to be performed by the contracted care plans or those with delegated authority. Individuals who meet the institutional level of care (NF, hospital) may access institutional care and/or HCBS through the contracted managed care plans. The contracted plans will be responsible for performing a functional assessment for each enrollee who is identified as having special health needs. The state's delegated contractor will review the assessments and make a determination as to whether the beneficiary meets an institutional (hospital or nursing facility) level of care. LOC assessments will be performed at least every twelve months (annual renewal) or more frequently, when there has been a significant change in the member's condition or circumstances.

j) **Access to Long-Term Care Services.** A key objective of the QUEST Integration demonstration is that beneficiaries meeting an institutional level of care shall have a choice of institutional services or HCBS. The HCBS provided must be person-centered and sufficient to meet the needs identified in the functional assessment, taking into account family and other supports available to the beneficiary. In order to move toward the objective of providing beneficiaries with a choice of services, the state must require the following from the contracted health plans:

   i. If the individual has previously received services under a Section 1915(c) waiver and continues to meet an institutional level of care, the individual must continue to receive HCBS appropriate to his or her needs. The services need not be identical to the ones previously received under the Section 1915(c) waiver, but any change must be based upon the functional assessment and person-centered plan.
   ii. For all other beneficiaries, if the estimated costs of providing necessary HCBS to the beneficiary are less than the estimated costs of providing necessary care in an institution (hospital or nursing facility), the plan must provide the HCBS to an individual who so chooses, subject to the limitations described in paragraph (c). Health plans will be required to document good-faith efforts to establish a cost-effective, person-centered plan of care in the community using industry best practices and guidelines. If the estimated costs of providing necessary HCBS to the beneficiary exceed the estimated costs of providing necessary care in an institution (hospital or nursing facility), a plan may refuse to offer HCBS if the state or its independent oversight contractor so approves. In reviewing such a request, the state must take into account the plan's aggregate HCBS costs as compared to the aggregate costs that it would have paid for institutional care.
   iii. A plan is not required to provide HCBS if the individual chooses institutional services, if he or she cannot be safely served in the community, if there are not adequate or appropriate providers for the services, or if there is an exceptional increase in the demand for HCBS. An exceptional increase in demand is defined as an increase beyond annual thresholds to be established by the state. In the case of an exceptional increase, the state shall be responsible for monitoring any wait for services as set forth below and reporting its findings

to CMS. Plans will offer a sub-set of HCBS services (described in subparagraph (b)(i)) to "At Risk" individuals in order to prevent a decline in health status and maintain individuals safely in their homes and communities. Based on individual assessed needs, "At Risk" individuals may be subjected to an hourly or budget limitation on HCBS services that must be sufficient to meet the individual's assessed needs. This limit would be adjusted with changes in assessed need.

iv. Individuals certified as institutional LOC may be limited to a maximum of 90 days per benefit period for HCBS services furnished on a 24-hour basis.

v. The plans may have a waiting list for HCBS services for both the institutional level of care and the "At Risk" population. Waiting list policies shall be based on objective criteria and applied consistently in all geographic areas served, and are subject to the approval by the state.

vi. The state will be responsible for monthly monitoring of any HCBS wait list by requiring health plans to submit the following information relevant to the waiting list:

1. The names of the members on the waiting list;
2. The date the member's name was placed on the waiting list;
3. The specific service(s) needed by the member; and
4. Progress notes on the status of providing needed care to the member.

vii. The state shall meet with the health plans on a quarterly basis to discuss any issues associated with management of the waiting list. The purpose of these meetings will be to discuss the health plan's progress towards meeting annual thresholds and any challenges with meeting the needs of specific members on the waiting list. In addition, members who are on the waiting list may opt to change to another health plan if it appears that HCBS are available in the other plan.

viii. The state shall adopt policies that ensure authorized LTSS continue to be provided in the same amount, duration and scope while a modification, reduction or termination is on appeal. The state shall know and monitor MCO service authorization processes and intervene if those processes regularly result in participant appeals of service authorization reductions or expirations.

VII. MANAGED CARE PLAN SELECTION PROCESSES

25. **QUEST Integration.** Eligible individuals will be enrolled in a managed care plan upon initial eligibility. Eligible individuals will choose among participating health plans offered to provide the full range of primary, acute, and home and community based services. Eligible individuals must be provided with information on the available health plans by the state. The state must ask each applicant to select a health plan upon determination of eligibility. If an eligible individual does not make a selection at the time of the approval of eligibility, the individual is automatically assigned to a plan that operates on the island of residence and will have 15 days from the date of auto assignment to select a different health plan from the list provided. The state shall send a notice of enrollment upon auto assigning the individual. The state may place an enrollment limit on health plans in order to assure adequate capacity

and sufficient enrollment in all participating health plans, as long as at least two health plans operating on an island do not have an enrollment limit.

26. **Enrollment and Disenrollment Processes.**

    a) **Enrollment process.** The state must maintain a managed care enrollment and disenrollment process that complies with 42 CFR Part 438, except that disenrollment without cause from a MCO will be more limited in cases where the enrollee was not auto-assigned to the MCO. If the enrollee was not auto-assigned to the MCO, the state must maintain a process by which the enrollee may change MCOs only if both MCOs agree to the change. The state must track and report to CMS these requests on an annual basis; along with MCO choice rates and MCO change rates that occur during the annual open enrollment period.

    b) **Disenrollment With and Without Cause**. The provisions of 42 CFR section 438.56(c), relating to disenrollment with and without cause, must apply to individuals enrolled in QUEST Integration health plans, except that the without cause change period after enrollment in a plan will be 60 days, rather than 90 days. The state shall accommodate and grant all reasonable plan change requests from aged, blind and disabled beneficiaries that occur days 61-90. The state shall track the number of plan change requests from aged, blind and disabled beneficiaries that occur during that timeframe and include this data in quarterly reports described in STC 63.

    Individuals who have been enrolled in a plan within the last 6 months will be reassigned to the prior plan unless the beneficiary exercises his/her option to disenroll for cause.

27. **Member Services**. Following the selection of a health plan, the plan will call the individual or send the individual a survey to identify special health needs (such as the need for long-term services and supports). If the individual is sent a survey and does not respond, the health plan shall be required to call the individual.

28. **Service Coordination Model.** After a beneficiary selects a health plan and completes the function described in paragraph 27, the health plan will assign a licensed or qualified professional as the beneficiaries' service coordinator. The following are required to ensure QUEST Integration program integrity.

    a) **Service Coordinator Responsibilities.**

        i. Assuring that the health plan promptly conducts a face-to-face health and functionality assessment (HFA) for each individual who is identified as having special health needs as described in paragraph 27. Members who are identified as having special health needs will receive a face-to-face HFA within 15 days of the documentation of special health needs through paragraph 27;
        ii. Referring any member appearing to meet a nursing facility level of care to the state's Contractor for a functional eligibility review;

iii. Providing options counseling regarding institutional placement and HCBS alternatives;
iv. Coordinating services with other providers such as physician specialists, Medicare fee-for-service and/or Medicare Advantage health plans and their providers, mental health providers and DD/ID case managers;
v. Facilitating and arranging access to services;
vi. Seeking to resolve any concerns about care delivery or providers;
vii. Leading a team of decision-makers to develop a care plan for those members meeting functional eligibility. The care planning team may include the primary care provider (who may be a specialist); the beneficiary, family members, and significant others (when appropriate); legal guardians, an Ombudsman if so requested by the beneficiary; and other medical care providers relevant to the beneficiary needs; and
viii. For those members meeting functional eligibility, leading the care planning team in the development of a case-specific, person-centered, cost-effective plan of care in the community, using industry best practices and guidelines established in subparagraph (b) below.

b) **Written Comprehensive Care Plans.** For each enrollee who meets the functional Level of Care (LOC) or "At Risk" assessment for long-term care, the MCOs will develop and implement a person-centered written care plan that analyzes and describes the medical, social, HCBS, and/or long-term care institutional services that the member will receive. In developing the care plan, the MCO will consider appropriate options for the beneficiary related to his/her medical, behavioral health, psychosocial, case-specific needs at a specific point in time, as well as for longer term strategic planning and will be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. Service plans will be updated annually or more frequently in conjunction with the health and functional assessment.

c) **Ombudsman Program.** An Ombudsman Program will be available to all beneficiaries under the demonstration. The purpose of the program is to ensure access to care, to promote quality of care, and to strive to achieve recipient satisfaction with QUEST Integration. The Department of Human Services (DHS) will seek a qualified independent organization to assist and represent members in the resolution of problems and conflicts between the health plan and its members regarding QUEST Integration services to act as the Ombudsman prior to the initial date for delivery of services.

i. **Delivery of Ombudsman Services.** The Ombudsman will assist in the resolution of issues/concerns about access to, quality of, or limitations to, services. The contracting organization must not be affiliated with any of the QUEST Integration health plans contracted by DHS and operate independently of the Med-QUEST Division.
ii. **Services Offered by Ombudsman Program.** Ombudsman services will be available to QUEST Integration members to navigate and access covered health care services and supports to include choice counseling, general

program-related information, access point for complaints, concerns related to health plan enrollment, and access to services.

iii. **Scope of the Ombudsman Program.** The Ombudsman Program will not replace the grievance and appeals process that all health plans that contract with the state must have in place, nor replace the right of a recipient to an administrative hearing. The Ombudsman may assist and represent members up to the point of an Administrative Hearing under state law. They may also assist a member during the hearing process but must not represent the member in an Administrative Hearing. The QUEST Integration member shall file a grievance or appeal with the contracted health plan. An Administrative Hearing may be filed once the health plan's appeal process has been exhausted.

VIII. COST SHARING

29. **Cost sharing.** Cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447(b) applies to the demonstration.

30. **Enrollment fee.** Notwithstanding subparagraph (a), the following enrollment fee is permitted under QUEST Integration:

Population	Amount
Medically Needy with Spend-down	An enrollment fee equal to the spend-down obligation or, where applicable, the amount of patient income applied to the cost of long-term care.

IX. DELIVERY SYSTEM: MANAGED CARE

31. **Implementation Activities for QUEST Integration.** At the beginning of the QUEST Integration demonstration renewal period, implementation will be contractually through the QUEST and QUEST Expanded Access (QExA) programs with identical requirements to include, but not limited to, primary and acute care benefits, grievances and appeals, and enrollment and disenrollment procedures. Beneficiaries who require access to certain benefits, including long-term services and supports, will be disenrolled from their QUEST health plan and enrolled in a QExA health plan.

    Through its next procurement, Hawaii intends to contractually combine the scope for both the QUEST and QExA programs into a single contract to serve the full continuum of Medicaid beneficiaries. The following deliverables shall be submitted by the state for CMS review and/or approval in preparation for the execution and implementation of the single, comprehensive managed care contract to govern the QUEST Integration program, which is anticipated no earlier than January 1, 2015.

    (1) Transition Plan. The state must conduct an assessment of the plan transition needs when moving from the QUEST and QExA programs to the QUEST

Integration program. The Transition Plan submitted to CMS for review will explain the States policies to promote beneficiary continuity and continuation of care, particularly for beneficiaries who will no longer have access to his or her physician or provider for long term services and supports. In addition, the Plan will describe the communication plan for beneficiaries and providers regarding potential changes for service delivery under QUEST Integration, including policies around continuity of care. This Transition Plan shall be submitted to CMS for review no later than 90 days prior to implementation of QUEST Integration.

(2) Readiness Review. The state must assess plan readiness in accordance with the requirements of 42 C.F.R. 438. Readiness reviews will include, but are not limited to, documentation and confirmation of adequate capacity, access to care outside of the network, access to care for enrollees with special health care needs, and cultural considerations. The state will also notify CMS of its intent to conduct a readiness review 30 days in advance of the review and provide CMS the opportunity to observe the readiness review. The state will provide CMS a copy of their readiness review feedback/corrective action plan letter and approval letters for each readiness review.

(3) Certification of Network Adequacy under QUEST Integration Contracts. The state shall submit documentation of network adequacy as described in STC 37 to the Regional Office for review and certification. The state may not begin activities related to enrollment before receiving such certification.

32. **Contracts.** All contracts and contract modifications of existing contracts between the state and MCOs must be prior approved by CMS in accordance with 42 C.F.R. 438.6. The state will provide CMS with a minimum of 45 days to review changes for consideration of approval.

33. **Transition to Home and Community-Based Services.** A key objective of the QUEST Integration program is to develop capacity within the community so that all recipients can be served in the most appropriate, least restrictive cost-effective setting. Contracts may contain financial incentives, as allowed by Title XIX and CMS regulations, which expand capacity for HCBS beyond the annual thresholds established by the state. Contracts may also contain sanctions penalizing plans that fail to expand community capacity at an appropriate pace. Should health plans be awarded financial incentives for health plans that expand community capacity such plan will be required, as determined appropriate by federal and state law, to share a portion of any bonuses with providers in order to ensure that provider capacity is maintained and improved. However, the plans may not pass sanctions along to the providers.

34. **Statewideness.** If there are Islands on which only one health plan is available, the health plan will be required to assure that members have a choice of primary care providers (PCPs).

35. **Dual-eligible Beneficiaries.** Dual eligible beneficiaries may select a PCP and will be assigned a service coordinator to assure coordination of Medicare and Medicaid services.

36. **Network Requirements.** The state must ensure the delivery of all covered benefits. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services for all of its members. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the state's MCO contracts:

    a. Special Health Care Needs. Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 CFR. §438.208(c)(4).
    b. Out of Network Requirements. Each MCO must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the state.

37. **Demonstrating Network Adequacy**. Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, behavioral health, specialty, and HCBS services for the anticipated number of enrollees in the service area.

    a. The state must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
        i. The number and types of providers available to provide covered services to the demonstration population;
        ii. The number of network providers accepting the new demonstration population; and
        iii. The geographic location of providers and demonstration populations, as shown through GeoAccess, similar software or other appropriate methods.

    b. The state must submit the documentation required in subparagraphs i – iii above to CMS at an agreed upon time prior to program implementation, as well as with each contract renewal or renegotiation, or at any time that there is a significant impact to each MCO's operation, including service area reduction and/or population expansion.

38. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**. The MCOs must fulfill the state's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

39. **Required Components of a Comprehensive State Quality Strategy**. The Quality Strategy shall meet all the requirements of 42 CFR §438 Subpart D. The state shall adopt and implement a comprehensive and holistic, continuous Quality Improvement Strategy that focuses on all aspects of quality improvement in QUEST Integration including acute, primary, behavioral and long term services and supports. The Quality Strategy must address the following: administrative authority, level of care determinations, service plans, health and welfare, and qualified providers. The Quality Strategy must include State Medicaid Agency and MCO responsibilities, with the State Medicaid Agency retaining ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. Additionally, it must also include information on how the State will monitor and evaluate

each MCO's compliance with the contract requirements specific to the QUEST Integration demonstration as outlined in these STCs, including level of care evaluations, service plans, qualified providers as well as how the health and welfare of enrollees will be assessed and monitored. Pursuant to STC 64, the state must also provide CMS with annual reports on the implementation and effectiveness of their comprehensive Quality Strategy as it impacts the demonstration.

40. **Revisions to the State Quality Strategy.** The state must update its Quality Strategy to reflect the new QI program and submit to CMS for approval. The State must obtain the input of beneficiaries and other stakeholders in the development of its revised comprehensive Quality Strategy and make the Strategy available for public comment. Any revised performance measures should focus on outcomes, quality of life, effective processes, as well as community integration for those individuals receiving HCBS. The comprehensive Quality Strategy must be submitted to CMS for final approval within 120 days from the approval date of the demonstration. In the interim time period, the state will maintain its existing quality strategies. The state must revise the strategy whenever significant changes are made, including changes through this demonstration and consistent with STC 6.

41. **Required Monitoring Activities by State and/or External Quality Review Organization (EQRO).** The state's EQRO process shall meet all the requirements of 42 CFR §438 Subpart E. In addition, the state, or its EQRO having sufficient experience and expertise and oversight by the SMA, shall monitor and annually evaluate the MCOs' and/or contracting providers performance on the HCBS requirements under QUEST Integration. These include but are not limited to the following:

    a. Level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with the Community Benefit have been assessed to meet the required level of care for those services.
    b. Service plans – to ensure that MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.
    c. MCO credentialing and/or verification policies – to ensure that HCBS services are provided by qualified providers.
    d. Health and welfare of enrollees – to ensure that the MCO, on an ongoing basis, identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.

X. UNCOMPENSATED CARE

42. **Overview.** The Tax Relief and Health Care Act of 2006 (TRHCA 2006) established a FY 2007 disproportionate share hospital (DSH) allotment for Hawaii. The DSH program established in Hawaii under section 1923(f)(6)(B) of the Act must be a State Plan program and DSH payments made by the state must be made on the basis of a State Plan amendment approved by CMS. However, changes to the amount of the statutory DSH allotments will require reconsideration of the budget neutrality agreement. Federal financial participation for hospital uncompensated care (UCC) payments described in this section are separate from the

State Plan DSH program, will be provided as set forth below and must be reported under budget neutrality as a demonstration expenditure. The state must make DSH and UCC payments directly to the providers of the services as specified at section 1923(i) of the Act.

When determining hospital specific DSH limits and DSH payments, the state must take into account all Medicaid State Plan payments and demonstration projects including UCC amounts paid to hospitals under this section, as well as any payments by or on behalf of individuals with no source of third-party coverage.

43. **Available FFP for UCC.** Annually, FFP is authorized to pay for hospital and nursing facility UCC until June 30, 2016. Payments made by the state are limited to no more than the total of actual UCC incurred in any given year as defined in STCs 42 through 55 and 91, and attachment D. Expenditures may be made to the list of providers found in attachment A for hospital UCC costs in governmentally operated hospitals and private hospitals and for long term care UCC costs in governmentally-operated hospital-based and governmentally operated freestanding nursing facilities, provided the requirements of paragraph 44 are met.

    CMS may only consider a request to amend this STC if the state has submitted an amendment request in conformity with STCs 6 and 7, and the state has submitted the evaluation required in STC 44. The, evaluation should provide information on the need for uncompensated care. This evaluation must include evidence based proposals with strategies regarding hospital and nursing facility payment rate reform to reduce or eliminate Medicaid shortfall for hospitals and nursing facilities in the state that will address the shortfall amounts in the future. This evaluative analysis and report is required to precede, in accordance with STC 44, any amendment request regarding possible continuation of the UCC Pool.

44. **Evaluation of Uncompensated Care Pool:** The state shall conduct an evaluation of the use of the uncompensated care pool beginning January 1, 2014. The hypothesis test for the evaluation must focus on the effect of the Affordable Care Act coverage expansion on the existing UCC payments and how this affects future needs for both the uninsured and Medicaid shortfall scenarios. This evaluation must include changes in pool payments following the implementation of QUEST Integration and the Marketplace in Hawaii. Baseline data shall be established using the 2013 calendar year UCC pool payments.

    The evaluation must be submitted to CMS no later than January 1, 2016 and must contain the following:

    a. A detailed analysis of UCC pool payments for all pre- and post-periods of the following:
        i. Comparison of UCC pool payments that are expended on each of the following provider types:
            a. Governmentally operated hospitals;
            b. Governmentally operated nursing facilities; and
            c. Privately operated hospitals.
        ii. For each such provider type, comparison of UCC pool payments that are attributable to each of the following :
        iii. Uninsured individuals; and
        iv. Medicaid beneficiaries.

b. For the amount attributable to Medicaid beneficiaries, for each provider type, comparison of the funds that are attributable, in aggregate and by age-band to the following:
    i. QUEST Integration (managed care) shortfall; and
    ii. Fee-for-service shortfall.
c. A detailed analysis of how the allocation of the payments described changes over the evaluation period by provider type, type of individual, and type of shortfall.
d. The total amount of uncompensated care that is provided by each provider type to each of the following: unqualified aliens, qualified aliens subject to a 5-year ban, and those from countries which have entered into a compact of Free Association with the United States and a comparison of this amount to the one percent adjustment for unallowable costs of services applied in the UCC protocol in attachment D. This analysis must include use of age-banding as determined appropriate.
e. An analysis of factors that contribute to the necessity of UCC payments for uninsured individuals, including the following:
    i. The number of uninsured individuals in the state ; and
    ii. Factors that impact access to coverage, at a minimum these must include geographic location, state of residency or homelessness rates.
f. An analysis of the findings and conclusions drawn from the factors that contribute to the necessity of UCC payments overall as well as specifically for Medicaid shortfall, including the causal and solution role of fee-for-service payment rates and managed care contracting requirements.

45. **Availability of UCC Funds.** To the extent that in any demonstration year the state has a DSH allotment under section 1923 of the Act, any expenditures of that allotment must be made pursuant to an approved state plan amendment and the UCC payments authorized under this demonstration must be in addition to any such expenditures. Combined payments may not exceed a hospital's uncompensated care costs.

46. **Coverage of Uncompensated Care Costs.** The state will be permitted to make payments to governmentally-operated hospitals (as detailed in Attachment D), governmentally-operated nursing facilities (as detailed in Attachment D, Supplement 1) and private hospitals to cover UCCs for furnished hospital and long-term care services as follows. UCC payments will be made directly to the providers who incur uncompensated care costs.

47. **Governmentally--operated Hospitals.** The costs are limited to the following:

    i. The costs of providing hospital inpatient and outpatient services to the uninsured; reduced by any applicable uninsured hospital inpatient and outpatient revenues, and any payments made by or on behalf of the uninsured for the provision of said services to this population (Uninsured shortfall);
    ii. The costs of providing inpatient and outpatient hospital and long term care services to QUEST Integration enrollees, reduced by any applicable Medicaid managed care revenues for the provision of said services to this population (QUEST Integration shortfall); and
    iii. The costs of providing outpatient hospital services to Medicaid fee-for-service

(FFS) beneficiaries, reduced by any applicable Medicaid outpatient revenues for the provision of said services to this population (FFS Outpatient shortfall).

48. **For Governmentally-operated Hospitals.** UCCs ***must not include***:

    i. Inpatient Medicaid FFS shortfall, as governmental hospitals already receive inpatient payments only up to cost;
    ii. The costs of providing non-emergency care to individuals who are unqualified non-citizens, qualified non-citizens subject to a 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S., except that UCC may include the costs of providing care to individuals who are lawfully residing in the U.S. and who are enrolled under the Medicaid state plan or CHIP state plan; and
    iii. The costs of providing drugs to individuals eligible for Medicare Part D.

49. **For Governmentally-Operated Hospitals.** DSH and UCC payments to governmentally operated hospitals will be funded with certified public expenditures (CPE). The state must follow the CPE protocol in Attachment D. The UCC payments described in this section must follow the cost determination in the protocol.

    The CPE method in the protocol prescribes CPE procedures and methods that follow CMS CPE standards, and are consistent with the CPE procedures and methods approvable by CMS for CPE-funded Medicaid State Plan payments (including hospital Medicaid State Plan supplemental payments and DSH payments). In addition, the CPE method must be updated or changed to come into compliance with any future legislation or CMS regulation or policy change.

    The CPE method will be in effect for all demonstration CPE-funded claims (including interim payments, reconciliations to as-filed cost reports, and reconciliations to finalized cost reports) made on or after the approval date of these Special Terms and Conditions.

50. **Governmentally-Operated Hospital-Based and Governmentally-Operated Freestanding Nursing Facilities.**
    i. The UCCs are limited to:

        1. The costs of providing routine long term care services to QUEST Integration enrollees, reduced by any applicable Medicaid managed care revenues for the provision of said services to this population (QUEST Integration shortfall).

    ii. UCCs *must not include*:

        1. Medicaid FFS shortfall, as governmentally-operated nursing facilities hospitals already receive payments only up to cost under the state plan;
        2. The costs of providing routine long term care services to the uninsured;

3. The costs of providing non-emergency care to individuals who are unqualified non-citizens, qualified non-citizens subject to a 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S., except that UCC may include the costs of providing care to individuals who are lawfully residing in the U.S. and who are enrolled under the Medicaid state plan or CHIP state plan; and
4. The costs of providing drugs to individuals eligible for Medicare Part D.

UCC payments to governmentally operated nursing facilities will be funded with certified public expenditures (CPE). The state must follow the CPE protocol in Attachment D, Supplement 1. The UCC payments described in this section must follow the cost determination in the protocol.

The CPE method in the protocol prescribes CPE procedures and methods that follow CMS CPE standards, and are consistent with the CPE procedures and methods approvable by CMS for CPE-funded Medicaid State Plan payments (including nursing facility Medicaid State Plan supplemental payments). In addition, the CPE method must be updated or changed to come into compliance with any future legislation or CMS regulation or policy change.

The CPE method will be in effect for all demonstration CPE-funded claims (including interim payments, reconciliations to as-filed cost reports, and reconciliations to finalized cost reports) made on or after the approval date of these Special Terms and Conditions.

51. **Privately-operated Hospitals.** For private hospitals, direct payments may cover UCCs up to the amount of funds made available by the state for this purpose. UCCs for private hospitals will include the following:

    i. The Uninsured shortfall as described above;
    ii. QUEST Integration shortfall as described above;
    iii. FFS outpatient shortfall as described above; and
    iv. The costs of providing inpatient hospital services to Medicaid FFS enrollees reduced by the amount of payments received from Med-QUEST for the provision of said services to this population (FFS inpatient shortfall).

52. **For Privately-operated Hospitals.** UCCs ***must not include***:

    i. The costs of providing non-emergency care to individuals who are unqualified non-citizens, qualified non-citizens subject to a 5-year ban, and those from countries which have entered into a Compact of Free Association with the U.S., except that UCC may include the costs of providing care to individuals who are lawfully residing in the U.S. and who are enrolled under the Medicaid state plan or CHIP state plan; and
    ii. The costs of providing drugs to individuals eligible for Medicare Part D.

53. **Eligible Providers.** The state may pay governmentally-operated hospitals, governmentally-operated freestanding and hospital-based nursing facilities, and private hospitals listed in Attachment A UCC payments. Any changes to Attachment A must be approved by CMS. The state must report to CMS any changes to the ownership and/or operational status of any hospital listed in Attachment A.

54. **Reporting UCC Payments to Hospitals and Nursing Facilities.** The state will report all expenditures for UCC payments to hospitals and nursing facilities under this demonstration on the Forms CMS-64.9 Waiver and/or 64.9P Waiver under the appropriate waiver name. In addition, the state must provide CMS with an annual report that identifies all hospital UCC and DSH payments and nursing facility UCC payments paid in that demonstration period, by provider.

55. **Aggregate Annual Limit of UCC and DSH Payments** - In any given year, the aggregate of federal share of the waiver UCC payments made under this section, combined with the federal share of aggregate DSH payments made pursuant to Hawaii's DSH allotment and under its state plan DSH methodology, should not exceed the amount equal to the federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project (paragraph 94). Furthermore, in any given DSH state plan year, each hospital's DSH payments cannot exceed its hospital-specific uncompensated care cost limit pursuant to Section 1923(g) of the Social Security Act. Each hospital's uncompensated care cost is net of the waiver UCC payments received under this section. Any excess waiver UCC payments made to an individual private hospital above its uncompensated care costs will be recouped and redistributed to other private hospitals, using the same methodology as the original private hospital UCC payments, which are distributed proportionately based on the hospitals' uncompensated care costs. The redistribution will only be made to the extent that such redistribution does not result in any hospital receiving UCC payments in excess of its uncompensated care costs. Any excess waiver payments will be redistributed to other qualifying hospitals.

XI. GENERAL REPORTING REQUIREMENTS

56. **General Financial Requirements.** The state must comply with all general financial requirements under Title XIX and Title XXI set forth in section XIII entitled, Monitoring Budget Neutrality in the demonstration.

57. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in these STCs.

58. **Corrected Budget Neutrality Information.** The state must submit corrected budget neutrality data upon request.

59. **Compliance With Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR section 438 *et. seq.*, except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

60. **Managed Care Data Requirements**. All managed care organizations shall maintain an information system that collects, analyzes, integrates and reports data as set forth at 42 CFR 438.242. This system shall include encounter data that can be reported in a standardized format. Encounter data requirements shall include the following:

    a. Encounter Data (Health Plan Responsibilities) – The health plan must collect, maintain, validate and submit data for services furnished to enrollees as stipulated by the state in its contracts with the health plans.

    b. Encounter Data (State Responsibilities) - The state shall, in addition, develop mechanisms for the collection, reporting, and analysis of these, as well as a process to validate that each plan's encounter data are timely, complete and accurate. The state will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The state shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. Additionally, the state shall contract with its EQRO to validate encounter data through medical record review.

    c. Encounter Data Validation Study for New Capitated Managed Care Plans - If the state contracts with new managed care organizations, the state shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of demonstration enrollees.

    d. Submission of Encounter Data to CMS - The state shall submit encounter data to the Medicaid Statistical Information System (MSIS) and when required T-MSIS (Transformed MSIS) as is consistent with federal law. The state must assure that encounter data maintained at managed care organizations can be linked with eligibility files maintained at the state.

61. **Monitoring Calls.** CMS will schedule periodic conference calls with the state. The purpose of these calls is to discuss any significant, actual or anticipated, developments affecting the demonstration as well as to plan for future changes or renewals. Areas to be addressed include, but are not limited to MCO operations (such as contract amendments and rate certifications), quarterly reports, health care delivery, enrollment, including, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers or state plan amendments the state is considering submitting. CMS must update the state on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the Project Officer and the Regional Office) must jointly develop the agenda for the calls.

62. **Monthly Enrollment Data.** The state must provide monthly enrollment data for each eligibility group as specified in Attachment B.

63. **Quarterly Progress Reports.** The state must submit quarterly progress reports in the format specified by CMS in Attachment B, no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:
    a. An updated budget neutrality monitoring spreadsheet;
    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
    c. Adverse incidents including abuse, neglect, exploitation, mortality reviews and critical incidents that result in death as known as reported;
    d. State efforts related to the collection and verification of encounter data, and utilization data;
    e. Action plans for addressing any policy, administrative, or budget issues identified;
    f. Monthly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population;
    g. Number of participants who chose an MCO and the number of participants who change plans after being auto-assigned (including the number of plan change requests described in paragraph 26); and
    h. Complaints, grievances and appeals filed during the quarter by type including access to urgent, routine, and specialty care
    i. Evaluation activities and interim findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished as well as challenges encountered and how they were addressed. The discussion shall also include interim findings, when available; status of contracts with independent evaluator(s), if applicable; status of Institutional Review Board approval, if applicable; and status of study participant recruitment, if applicable.
    j. Identify any quality assurance/monitoring activity in current quarter. As part of the annual report, pursuant to STC 54, the state must also report on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

64. **Annual Report.** The state must submit a draft annual report containing, at a minimum, the requirements below. The state must submit the draft annual report to CMS no later than March 31 each year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted to CMS.

    a. All items included in the quarterly report pursuant to STC 53 must be summarized to reflect the operation/activities throughout the DY;

b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutral agreement;

d. Managed Care Delivery System. The state must document accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration. The state must provide the CAHPS survey, outcomes of any focused studies conducted and what the state intends to do with the results of the focused study, outcomes of any reviews or interviews related to measurement of any disparities by racial or ethnic groups, annual summary of network adequacy by plan including an assessment of the provider network pre and post implementation and MCO compliance with provider 24/7 availability, summary of outcomes of any on-site reviews including EQRO, financial, or other types of reviews conducted by the state or a contractor of the state, summary of performance improvement projects being conducted by the state and any outcomes associated with the interventions, outcomes of performance measure monitoring, summary of plan financial performance; and

e. Expenditures for uncompensated care costs.

In addition, as required by 42 CFR 457.750(a), the state must report by January 1 following the end of each federal fiscal year, the results of the state's assessment of the operation of the Title XXI state plan. This data shall be submitted to CMS through the CHIP Annual Report Template System (CARTS).

65. **Title XIX and Title XXI Enrollment Reporting.** Each month the state must provide CMS with enrollment figures by demonstration population using the quarterly report format as defined in Attachment B. In addition, each quarter the state must provide CMS with an enrollment report by demonstration population showing the end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System (SEDS) by the state within 30 days after the end of each quarter.

66. **Final Report.** Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XII. GENERAL FINANCIAL REPORTING REQUIREMENTS FOR DEFINED AUTHORIZED EXPENDITURES

67. **Quarterly Reports.** The state must provide quarterly expenditure reports using the form

CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS must provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section XIII entitled, Monitoring Budget Neutrality in the demonstration.

68. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures under the demonstration:

    a. In order to track expenditures under this demonstration, Hawaii must report demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All demonstration expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered, or for which capitation payments were made).

    b. Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the demonstration is properly credited with premium collections, the QUEST Integration premium collections (both total computable and federal share) must also be reported on the Form CMS-64 Narrative.

    c. For monitoring purposes, cost settlements must be recorded on Line 10.b., in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments must be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual.

    d. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides an increased federal medical assistance of 100 percent for the amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may exclude from the budget neutrality test for this demonstration the portion of the increase for which the federal government pays 100 percent. These amounts should be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their "P" counterparts), and not on any waiver form.

    e. For each demonstration year, 19 separate waiver forms, using Forms CMS-64.9 Waiver and/or 64.9P Waiver, must be completed, using the waiver names in

parentheses below, to report expenditures for individuals enrolled in the demonstration and for hospital and long-term care facility uncompensated care payments as follows:

Expenditure and Eligibility Group Reporting	Required CMS 64.9 Waiver and CMS 64.9P Waiver forms	Description of Waiver form
State Plan Children	State Plan Children	Mandatory Title XIX Children
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrants/COFAs	Mandatory Title XIX Adults, excluding-pregnant immigrants/COFAs, newly eligible adults, and expansion state adults; Mandatory Title XIX Pregnant Immigrants/COFAs
Aged	Aged w/ Mcare Aged w/o Mcare	Aged with Medicare Aged without Medicare
Blind or Disabled	B/D w/ Mcare B/D w/o Mcare BCCTP	Blind or Disabled with Medicare Blind/Disabled without Medicare Breast and Cervical Cancer Treatment Program
Expansion State Adults	Expansion State Adults	Expansion State Adults
Newly Eligible Adults	Newly Eligible Adults	Newly Eligible Adults
Optional State Plan Children	Optional State Plan Children	Optional Title XIX Children, including medically needy children and Title XXI children if Title XXI allotment is exhausted
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old
Medically Needy Adults	Medically Needy Adults	Medically Needy Adults
Demonstration Eligible Adults	Demonstration Eligible Adults	Demonstration Eligible Adults
Demonstration Eligible Children	Demonstration Eligible Children	Demonstration Eligible Children
VIII-Like Group	VIII-Like Group	VIII-Like Demonstration Eligible Adults
UCC-Governmental	UCC-Governmental	Hospital payments to governmentally-operated hospitals
UCC-Governmental LTC	UCC-Governmental LTC	Long term care payments to governmentally-operated nursing facilities
UCC-Private	UCC-Private	Hospital payments to private hospitals

69. **Expenditures Subject to the Budget Neutrality Ceiling.** For purposes of this section, the term "expenditures subject to the budget neutrality ceiling" must include all Medicaid expenditures on behalf of individuals who are enrolled in this demonstration and for hospital

uncompensated care payments as described in section XI, entitled General Reporting Requirements of these STCs. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

70. **Premium Collection Adjustment.** The state must include section 1115 demonstration premium collections as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis on the CMS-64 Summary Sheet.

71. **Administrative Costs.** Administrative costs must not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

72. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

73. **Reporting Member Months.** The following describes the reporting of member months for demonstration populations:

    a. For the purpose of calculating the budget neutrality expenditure cap, and for other purposes, the state must provide to CMS on a quarterly basis the actual number of eligible member months for all Medicaid and Demonstration Eligibility Groups (EGs) defined in section XIV, entitled Monitoring Budget Neutrality in the demonstration. This information must be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBES or as a stand-alone report. To permit full recognition of "in-process" eligibility, reported counts of member months must be subject to minor revisions for an additional 180 days after the end of each quarter. For example, the counts for the quarter ending September 30, 2008, due to be reported by November 30, 2008, are permitted to be revised until June 30, 2009.

    b. The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

    c. For the purposes of this demonstration, the term "demonstration eligibles" refers to the eligibility groups described in section XIII, entitled Monitoring Budget

Neutrality in the demonstration. The term "demonstration eligibles" specifically excludes unqualified aliens, including aliens from the Compact of Free Association countries.

74. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. Hawaii must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality cap and separately report these expenditures by quarter for each federal fiscal year on the appropriate Form for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS must make federal funds available, based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS must reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

75. **Extent of Federal Financial Participation.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS must provide FFP at the applicable federal matching rates for the following, subject to the limits described in section XIII, entitled Monitoring Budget Neutrality in the demonstration.

    a. Administrative costs, including those associated with the administration of the demonstration;
    b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and
    c. Net expenditures made with dates of service during the operation of the demonstration.

76. **State Certification of Funding Conditions.** The state certifies that matching funds for the demonstration are state/local appropriations. The state further certifies that such funds must not be used as matching funds for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding and distribution of monies involving federal match are subject to CMS approval.
    a. CMS may review the sources of the non-federal share of funding and distribution methods for demonstration funding at any time. All funding sources and distribution methodologies deemed unacceptable by CMS must be addressed within the time frames set by CMS.
    b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

77. **Medicaid Statistical Information System (MSIS) Data Submission.** The state must submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The state must ensure, within 120 days after approval of the demonstration, that all prior reports are accurate and timely.

78. **Monitoring the Demonstration.** The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame. Within 6 months of the date of the award of this demonstration, the state will implement appropriate controls approved by CMS to ensure oversight of demonstration claiming and expenditures.

General Financial Requirements under Title XXI

Beginning January 1, 2008, the state will not receive FFP under Title XXI for expenditures for QUEST children who are not authorized in the CHIP State Plan.

79. **Expenditures Subject to the Allotment Neutrality Limit.** Eligible Title XXI demonstration expenditures subject to the allotment neutrality agreement are expenditures for services provided through this demonstration to Title XXI children with FPL levels within the approved CHIP State Plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the state's available Title XXI funding.

80. **Quarterly Expenditure Reporting through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES).** In order to track Title XXI expenditures under this demonstration, the state must report quarterly demonstration expenditures through the MBES/CBES, following routine CMS-64.21 and CMS-21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual.

    Title XXI Medical Assistance Payment (MAP) expenditures for immigrant/COFA Title XXI children (HI-02) and non-immigrant/non-COFA Title XXI children (HI-01) must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered, or for which capitation payments were made—e.g., 11-W00001/DY). Once the appropriate waiver form is selected for reporting expenditures, the state is required to identify the program code and coverage (i.e., children).

    Title XXI Administration expenditures for immigrant/COFA Title XXI children and non-immigrant/non-COFA Title XXI children must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver; identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which administration services were rendered) .

81. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver.

82. **Standard Medicaid Funding Process.** The standard CHIP funding process will be used during the demonstration. Hawaii must estimate matchable Medicaid expansion CHIP (M-CHIP) expenditures on the quarterly Form CMS-37 for Medical Assistance Payments (MAP), and separately estimate State and Local Administrative Costs (ADM) on the quarterly Form CMS-21B. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64.21U Waiver and/or CMS-64.21UP Waiver, and Forms CMS-21 Waiver and/or CMS-21P Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21U and CMS-21 Waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

83. **Administrative Costs.** All administrative costs are subject to the Title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

84. **State Certification of Funding Conditions.** The state will certify that state/local monies are used as matching funds for the demonstration. The state further certifies that such funds must not be used as matching funds for any other federal grant or contract, except as permitted by federal law. All sources of non-federal share of funding and distribution of monies involving federal match are subject to CMS approval. Upon review of the sources of the non-federal share of funding and distribution methodologies of funds under the demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS must be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

85. **Limitation on Title XXI Funding.** Hawaii will be subject to a limit on the amount of federal Title XXI funding that the state may receive for demonstration expenditures during the demonstration period. Federal Title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available Title XXI federal funds for the claiming period, no further enhanced federal matching funds will be available for costs of the demonstration children until the next allotment becomes available.

86. **Exhaustion of Title XXI Funds.** After the state has exhausted Title XXI funds, expenditures for optional targeted low-income children within the CHIP State Plan approved income levels, may be claimed as Title XIX expenditures, as approved in the Medicaid state plan. The state shall report expenditures for these children, identified as "Optional State Plan Children," as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with the instructions that can be found in STC 68 (entitled Reporting Expenditures Under the Demonstration).

87. **Exhaustion of Title XXI Funds Notification**. The state must notify CMS in writing of any anticipated Title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures. The state must follow Hawaii Medicaid state plan criteria for the beneficiaries

unless specific waiver and expenditure authorities are granted through this demonstration.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

88. **Limit on Title XIX Funding.** The state must be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a combined per capita cost method and aggregate DSH method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

89. **Risk.** Hawaii must be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles in the EGs 1 through 6 as described below under this budget neutrality agreement, but not for the number of Medicaid eligibles in each of the groups. By providing FFP for all eligibles in the specified EGs, Hawaii must not be at risk for changing economic conditions that impact enrollment levels. However, by placing Hawaii at risk for the per capita costs for Medicaid eligibles in each of the EGs under this agreement, CMS assures that federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

90. **Eligibility Groups (EG) Subject to the Budget Neutrality (BN) Agreement.** The 6 EGs subject to this budget neutrality agreement are:

EG subject to BN	Expenditure and eligibility reporting groups
EG 1 - Children	• State Plan Children • Opt. State Plan Children • Foster Care Children, 19-20 Years Old
EG 2 – Adults	• State Plan Adults
EG 3– Aged*	• Aged
EG 4 – Blind/Disabled*	• Blind or Disabled • Medically needy adults
EG 5 – VIII-Like Adults	• VIII-Like Adults
EG 6 – VIII Group Combined	• Newly Eligible Adults • Expansion State Adults

* The demonstration expansion populations that are included in EG 3 and 4 (i.e. the 217-like group and certain medically needy individuals) are "pass-through" or "hypothetical" populations. Therefore, the State may not derive savings from these populations.

91. **Budget Neutrality Ceiling.** The following describes the method for calculating the budget neutrality ceiling:

    a. For each year of the budget neutrality agreement an annual limit is calculated for the EGs described above, on a total computable basis. The annual limit for the

demonstration is the sum of the projected annual limits for EGs 1 through 4, plus a DSH adjustment for that year described in STC 94, plus the EGs included in the supplemental budget neutrality tests below.

b. The budget neutrality ceiling is the sum of the annual PMPM limits for the demonstration period plus the sum of the DSH adjustment, plus the amount of unused budget authority carried over from prior demonstration years. The federal share of the budget neutrality ceiling represents the maximum amount of FFP that the state may receive for expenditures on behalf of eligibles described in STC 90 during the demonstration period. The Federal share of this ceiling will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in STC 97 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (State Plan Children, Opt. State Plan Children, Foster Care Children, 19-20 Years Old, State Plan Adults, Aged, Blind or Disabled, Medically Needy adults, Demonstration Eligible Adults, Demonstration Eligible Children, UCC-Governmental, UCC-Governmental LTC, and UCC-Private), plus any excess spending from the Supplemental Tests described in STCs 95 and 96.

92. **Capita Budget Neutrality Limit.**

a. For each EG 1 through 4, the annual limit for the EG must be calculated as a product of the number of eligible member months reported by the state under paragraph 86 for that EG, times the appropriate estimated per member per month (PMPM) cost from the table in subparagraph (c) below.

b. The PMPM costs in subparagraph (c) were determined by applying the growth rate for each EG.

c. The following are the ceiling PMPM costs for the calculation of the budget neutrality expenditure ceiling for EG 1 through 4. The PMPM costs below must be the net of premiums paid by QUEST Integration eligibles.

Eligibility Group	Growth Rate	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM	DY 24 PMPM	DY 25 PMPM
EG 1 - Children	1.01	$421.09	$424.24	$428.49	$432.77	$437.10	$441.47
EG 2 - Adults	1.037	$749.94	$755.56	$783.51	$812.50	$842.56	$873.74
EG 3 - Aged	1.034	$1,596.99	$1,608.95	$1,663.66	$1,720.22	$1,778.71	$1,839.19
EG 4 – Blind/Disabled	1.045	$2,057.78	$2,073.20	$2,166.49	$2,263.98	$2,365.86	$2,472.33

93. **DSH Adjustment.** The DSH adjustment is based upon Hawaii's DSH allotment for 1993 and calculated in accordance with current law. The total computable DSH for each subsequent year must be the previous demonstration year's adjustment trended by the policy contained in current law. In this manner, Hawaii will have available funding for DSH adjustments similar to other states. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation that impacts the calculation of DSH allotments.

94. **DSH Adjustment Limits.** The following are the aggregate DSH adjustment limits for demonstration years 20, 21, 22, and 23 of the demonstration.

	Growth Rate	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM *
DSH adjustment	1.024	$48,848,589	$99,450,504	$101,837,316	$51,832,471

* The amount for DY 23 is only for the period from January 1, 2016 through June 2016.

95. **Supplemental Budget Neutrality Test 1: VIII-like group.** The budget neutrality test for this demonstration includes an allowance for the VIII-like group. The expected costs of the VIII-like group is reflected in the "without-waiver" budget neutrality expenditure limit. The state must not accrue budget neutrality "savings" from this population. To accomplish these goals, a separate expenditure cap is established for the VIII-like group, to be known as Supplemental Budget Neutrality Test 1.

a. The MEGs listed in the table below are for the Supplemental Budget Neutrality Test 1.

Eligibility Group	Growth Rate	DY 20 PMPM
EG 5 – VIII-Like group	N/A	$663.42

b. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for the group in the above table for the DY, times the number of eligible member months for that group and DY. The federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 2.

c. Supplemental Budget Neutrality Test 1 is a comparison between the Federal share of Supplemental Cap 1 and total FFP reported by the State for the VIII-like group.

d. If total FFP for the VIII-like group should exceed the Federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in paragraph 91.

96. **Supplemental Budget Neutrality Test 2: VIII Group.** Adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality. The state will not be allowed to obtain budget neutrality "savings" from this population. Therefore, a separate expenditure cap is established for this group, to be known as Supplemental Budget Neutrality Test 1.

a. The MEGs listed in the table below are for the Supplemental Budget Neutrality Test 2.

Eligibility Group	Growth Rate	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM	DY 24 PMPM	DY 25 PMPM
EG 6 – VIII group combined	1.051	N/A	$684.37	$719.27	$755.95	$794.51	$835.03

b. If the state's experience of the take up rate for the VIII group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the VIII group, the state may submit an adjustment to paragraph (a) for CMS review without submitting an amendment pursuant to paragraph 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

c. The Supplemental Cap 2 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of the Supplemental Cap 2 is obtained by multiplying total computable Supplemental Cap 2 by the Composite Federal Share 3.

d. Supplemental Budget Neutrality Test 2 is a comparison between the federal share of the Supplemental Cap 2 and total FFP reported by the State for VIII Group.

e. If total FFP for VIII Group should exceed the federal share of Supplemental Cap 2 after any adjustments made to the budget neutrality limit as described in paragraph b, the difference must be reported as a cost against the budget neutrality limit described in STC 91.

97. **Composite Federal Share:** The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures for EG 1 through 4 and the DSH adjustment under STC 92 and 94; Composite Federal Share 2, based on the expenditures for the VIII-like group under STC 95(a); and Composite Federal Share 3, based on the expenditures for the VIII-group under STC 96(a). Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

98. **Reporting Actual Member Months.** For the purpose of monitoring budget neutrality,

within 60 days after the end of each quarter, the state must provide a report to CMS in the format provided by CMS in Attachment B, identifying the state's actual member months for each EG and corresponding actual expenditures for each EG, less the amount of premiums paid by QUEST Integration eligibles.

99. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

DY	Cumulative Target Definition	Percentage
Year 21	Cumulative budget neutrality limit plus:	1,0 percent
Years 22 through 23	Cumulative budget neutrality limit plus:	0.5 percent
Year 24 and 25	Cumulative budget neutrality limit plus:	0 percent

In addition, the state may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the demonstration will exceed the cap during this extension.

100. **Exceeding Budget Neutrality.** If, at the end of this demonstration period the budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test must be based on the time elapsed through the termination date.

XIV. EVALUATION OF THE DEMONSTRATION

101. **State Must Evaluate the Demonstration.** The evaluation report as approved by CMS for the prior extension is due no later than the date that is 120 days after the date of approval of the extension of this demonstration. In addition, the state must submit to CMS for approval a draft evaluation design with appropriate revisions to accommodate programmatic changes no later than that date.

a. **Goals, objectives, and hypothesis**: The draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the demonstration.
b. **Outcome measures:** The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population.
c. **Data Sources:** The evaluation design must also discuss the data sources, including the use of Medicaid encounter data, enrollment data, EHR data, and consumer and provider surveys, and sampling methodology for assessing these outcomes.
d. **Detailed Analysis plan:** The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration shall be isolated from other initiatives occurring in the state.
e. **Level of Analysis:** The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and

include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups.

f. **Identification of evaluator:** The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

The state must also submit the evaluation required under STC 44 not later than January 1, 2016.

102. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft design within 60 days of receipt, and the state must submit a final design within 60 days of receipt of CMS comments. The state must implement the evaluation design and submit its progress in the quarterly reports. The state must submit to CMS a draft of the evaluation report 120 days prior to the expiration of the demonstration. CMS must provide comments within 60 days of receipt of the report. The state must submit the final report prior to the expiration date of the demonstration. The Final Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the demonstration; the evaluation questions and hypotheses tested; and key findings and policy implications.

b. Demonstration Description. This includes a description of the demonstration programmatic goals and strategies, particularly how they relate to the Triple Aim and interventions implemented.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses, type of study design, impacted populations; data sources; and data collection and analysis techniques.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful demonstration strategies to be replicated in other State Medicaid programs.

103. **HCBS and LTC Baseline Data and Reporting.** After collaboration between the state and federal governments to establish the baseline data appropriate for monitoring programmatic and beneficiary trends in the HCBS and LTC program, the state must report to CMS quarterly and annual reporting on these data elements. These data must be established no later than October 31, 2008.

104. **Public Access.** The state shall post the final approved Evaluation Plan, Quarterly and Annual Progress Reports, Interim Evaluation Report, if applicable, and Final Evaluation Report on the State Medicaid website within 30 days of approval by CMS.

In addition, CMS must be notified prior to the public release or presentation of these reports and related journal articles, by the contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

105. **Electronic Submission of Reports.** The state shall submit all required plans and reports using the process stipulated by CMS, if applicable.

106. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the state must fully cooperate with federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.

XV. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION PERIOD

Due Date	Deliverable
30 days from approval letter date	State Acceptance of Demonstration Extension, STCs, Waivers, and Expenditure Authorities.
120 days from approval letter date	Quality Strategy (STC 39)
120 days from approval letter date	Ensure that all prior MSIS reports are timely and accurate (STC 68)
120 days from approval letter date	Evaluation Report for Demonstration through September 30, 2013
120 days from approval letter date	Submit Draft Evaluation Design
60 days after receipt of CMS comments	Submit Final Evaluation Design
March 31, 2014, and each subsequent year	Post Award Forum Transparency deliverable
March 31, 2014, and each subsequent year	Submit Draft Annual Report (STC 54)
January 1, 2014 and each subsequent year	CARTS report for previous fiscal year (STC 64)
90 days prior to implementation of QUEST Integration single contract	Transition plan (STC 31)
30 days before conducting a readiness review	Notice of readiness review (STC 31)
45 days before a new contract or contract change	Contract for CMS review (STC 32)
Before beginning enrollment in QUEST integration single contract	Documentation of network adequacy (STC 31)
January 1, 2016	UCC evaluation (STC 44)
120 prior to expiration of demonstration	Submit draft evaluation report (STC 102)

Quarterly	Deliverable
	Quarterly Reports meeting requirements of Attachment B (STC 63)
	Title XXI Enrollment Reporting (SEDS) (STC 65)
	Expenditure Reports Title XXI (STC 80)
Monthly	**Deliverable**
	Participate in monthly monitoring calls (STC 61)
	Submit monthly enrollment data (STC 62)

ATTACHMENT A
HOSPITALS AND LONG-TERM CARE FACILITIES THAT MAY RECEIVE PAYMENTS FOR UNCOMPENSATED CARE COSTS

Governmental Hospitals

Hale Ho'ola Hamakua
Hilo Medical Center
Kau Hospitals
Kauai Veterans Hospital
Kohala Hospital
Kona Community Hospital
Kahuku Hospital
Kula Hospital & Clinic
Lanai Community Hospital
Maui Memorial Hospital
Samuel Mahelona Memorial

Private Hospitals

Castle Medical Center
Hawaii Medical Center - East
Hawaii Medical Center - West
Kahi Mohala
Kaiser Permanente Medical Center
Kapiolani Medical Center at Pali Momi
Kapiolani Medical Center for Women and Children
Kuakini Medical Center
Molokai General Hospital
North Hawaii Community Hospital
Rehabilitation Hospital of the Pacific
Straub Clinic & Hospital
The Queen's Medical Center
Wahiawa General Hospital
Wilcox Memorial Hospital

Nursing Facilities

Hilo Medical Center
Kona Community Hospital
Leahi Hospital
Maluhia

Approval Period: October 1, 2013 through December 31, 2018

Attachment B
Quarterly Report Format

Under Section XI, paragraph 53, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – Hawaii QUEST
Title Line Two - Section 1115 Quarterly Report
Date Submitted to CMS

Demonstration/Quarter Reporting Period:
Demonstration Year:
Federal Fiscal Quarter:

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This is likely to be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state must indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state must indicate that by "0".

Enrollment Counts
Note: Enrollment counts must be person counts, not member months.

Expenditure and Eligibility Group Reporting	CMS 64.9 Waiver and CMS 64.9P Waiver forms	Current Enrollees (to date)
State Plan Children	State Plan Children	
State Plan Adults	State Plan Adults State Plan Adults-Pregnant Immigrants/COFAs	
Aged	Aged w/ Mcare Aged w/o Mcare	
Blind or Disabled	B/D w/ Mcare B/D w/oMcare	

	BCCTP	
Expansion State Adults	Expansion State Adults	
Newly Eligible Adults	Newly Eligible Adults	
Optional State Plan Children	Optional State Plan Children	
Foster Care Children, 19-20 years old	Foster Care Children, 19-20 years old	
Medically Needy Adults	Medically Needy Adults	
Demonstration Eligible Adults	Demonstration Eligible Adults	
Demonstration Eligible Children	Demonstration Eligible Children	
VIII-Like Group	VIII-Like Group	
UCC-Governmental	UCC-Governmental	
UCC-Governmental LTC	UCC-Governmental LTC	
UCC-Private	UCC-Private	

And

State Reported Enrollment in the Demonstration (as requested)	**Current Enrollees**
Title XIX funded State Plan	
Title XXI funded State Plan	
Title XIX funded Expansion	
Enrollment Current as of	Mm/dd/yyyy

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Expenditure Containment Initiatives

Identify all current activities, by program and or demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address these issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Without Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
EG 1 - Children				
EG 2 – Adults				
EG 3– Aged				
EG 4 – Blind/Disabled				
EG 5 – VIII-Like Adults				
EG 6 – VIII Group Combined				

B. For Informational Purposes Only

With Waiver Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
State Plan Children				
State Plan Adults				
Aged				
Blind or Disabled				
Expansion State Adults				
Newly Eligible Adults				
Optional State Plan Children				
Foster Care Children, 19-20 years old				
Medically Needy Adults				
Demonstration Eligible Adults				
Demonstration Eligible Children				
VIII-Like Group				
UCC-Governmental				
UCC-Governmental LTC				
UCC-Private				

QUEST Integration Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Corrective actions and the number of outstanding issues that remain unresolved must be included. Also, discuss feedback received from consumer groups.

Enrollment of individuals eligible for Long term services and supports

A summary and detail of the number of beneficiaries assisted monthly. The monthly auto assignment rate including MCO information and island of residence. The number of requests to change plans, the outcome of the request, and the monthly disenrollment requests both granted and declined over monthly MCO enrollment.

Behavioral Health Programs Administered by the DOH

A summary of the programmatic activity for the quarter for demonstration eligibles. This shall include a count of the point in time demonstration eligible individuals receiving MQD FFS services through the DOH CAMHD and AMHD Programs.

QUEST Integration transition

A summary and detail of state and MCO activities performed during the quarter, or long-term planning items in progress that are performed with the goal of transitioning to a single QUEST Integration contract.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

An up-to-date-budget neutrality worksheet must be provided as a supplement to the quarterly report. In addition, any items identified as pertinent by the state may be attached. Documents must be submitted by Title along with a brief description in the quarterly report of what information the document contains.

State Contact(s)

Identify individuals by name, Title, phone, fax, and address that CMS may contact should any questions arise.

The following are the provider guidelines and service definitions for HCBS provided by section 1915(c) waivers, as well as the QUEST integration program.

Service/Provider Term	Service Definition
Adult Day Care Center	Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants in accordance with HAR§17-1417. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services. Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency. Adult Day Care Centers are licensed by the Department of Human Services and maintained and operated by an individual, organization, or agency. Included in the sub-set of services for the "At Risk" population.
Adult Day Health Center	Adult Day Health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96 and HAR §11-94-5. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community. Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse. In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, meals which do not constitute a full nutritional program, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services. Adult Day Health Centers are licensed by the Department of Health. Included in the sub-set of services for the "At Risk" population.
Assisted Living Facility	Assisted living services include personal care and supportive care services (homemaker, chore, attendant services, and meal preparation) that are furnished to members who reside in an assisted living facility. Assisted living facilities are home-like, non-institutional settings. Payment for room and board is prohibited. Section 30.200 describes Assisted Living Facilities as a facility, as defined in HRS 321-15.1, that is licensed by the Department of Health. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.
Community Care Management Agency (CCMA)	CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. A health plan may, at its option, demonstrate the ability to provide CCMA services by contracting with an entity licensed under HAR subchapters 1 and 2. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to

Service/Provider Term	Service Definition
	the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of members; ongoing face-to-face monitoring and implementation of the member's care plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. CCMAs shall (1) communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders, (2) work with families regarding service needs of member and serve as an advocate for their members, and (3) be accessible to the member's caregiver twenty-four (24) hours a day, seven (7) days a week. CCMA's are agencies licensed by the DHS or its designee under HAR chapter 17-1454, subchapters 1 and 2, to engage in locating, coordinating and monitoring comprehensive services to residents in community care foster family homes or members in E-ARCHS and assisted living facilities. A health plan may be a community care management agency.
Community Care Foster Family Home (CCFFH)	CCFFH services is personal care and supportive services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted under state law) provided in a certified private home by a principal care provider who lives in the home. The number of adults receiving services in CCFFH is determined by HAR, Title 17, Department of Human Services, SubTitle 9, Chapter 1454-43. CCFFH services are currently furnished to up to three (3) adults who receive these services in conjunction with residing in the home. All providers must provide individuals with their own bedroom. Each individual bedroom shall be limited to two (2) residents. Both occupants must consent to the arrangement. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four (4). In accordance with HAR, Title 17, Department of Human Services, SubTitle 9, Chapter 1454-42, members receiving CCFFH services must be receiving ongoing CCMA services. A CCFFH is a home issued a certificate of approval by the DHS to provide, for a fee, twenty-four (24) hour living accommodations, including personal care and homemaker services. The home must meet all applicable requirements of HAR §17-1454-37 through HAR §17-1454-56.
Counseling and Training	Counseling and training activities include the following: member care training for members, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling. Counseling and training is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member.
Environmental Accessibility Adaptations	Environmental accessibility adaptations are those physical adaptations to the home, required by the individual's care plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air

Service/Provider Term	Service Definition
	conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.
Expanded Adult Residential Care Home (E-ARCH) or Residential Care Services	Residential care services are personal care services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principal care provider who lives in the home. Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH), allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the DHS to live in a Type I home with no more than two (2) of whom may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. An E-ARCH's is a facility, as defined in HAR §11-100.1.2 and licensed by the Department of Health, that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of expanded care ARCHs in accordance with HRS § 321-1562 as described above.
Home Delivered Meals	Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization. Included in the sub-set of services for the "At Risk" population
Home Maintenance	Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.
Moving Assistance	Moving assistance is provided in rare instances when it is determined through an assessment by the care coordinator that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.
Non-Medical Transportation	Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH

Service/Provider Term	Service Definition
	are not eligible for this service.
Personal Assistance Services (Level I)	Personal assistance services Level I are provided to individuals requiring assistance with instrumental activities of daily living (IADLs) in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I may be self-directed and consist of companion services and homemaker services. Homemaker services include • Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish; • Care of clothing and linen by washing, drying, ironing, mending; • Marketing and shopping for household supplies and personal essentials (not including cost of supplies); • Light yard work, such as mowing the lawn; • Simple home repairs, such as replacing light bulbs; • Preparing meals; • Running errands, such as paying bills, picking up medication; • Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available; • Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer; • Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate; and • Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service. Included in the sub-set of services for the "At Risk" population
Personal Assistance Services (Level II)	Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform activities of daily living (ADLs) and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. The following activities may be included as a part of personal assistance services Level II: • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing; • Assistance with bowel and bladder care; • Assistance with ambulation and mobility; • Assistance with transfers; • Assistance with medications, which are ordinarily self-administered when ordered by member's physician; • Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician; • Assistance with feeding, nutrition, meal preparation and other dietary activities; • Assistance with exercise, positioning, and range of motion; • Taking and recording vital signs, including blood pressure; • Measuring and recording intake and output, when ordered; • Collecting and testing specimens as directed; • Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter

Service/Provider Term	Service Definition
	16-89, Hawaii Administrative Rules; • Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished; • Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and • Maintaining documentation of observations and services provided. When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the care plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may also be provided. Personal assistance services Level II may be self-directed. Personal Assistance is care provided when a member, member's parent, guardian, family member or legal representative employs and supervises a personal assistant who is certified by the health plan as able to provide the designated services whose decision is based on direct observation of the member and the personal assistant during the actual provision of care. Documentation of this certification will be maintained in the member's individual plan of care. Included in the sub-set of services for the "At Risk" population
Personal Emergency Response Systems	PERS is a twenty-four (24) hour emergency assistance service which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items: • 24-hour answering/paging; • Beepers; • Med-alert bracelets; • Intercoms; • Life-lines; • Fire/safety devices, such as fire extinguishers and rope ladders; • Monitoring services; • Light fixture adaptations (blinking lights, etc.); • Telephone adaptive devices not available from the telephone company; and • Other electronic devices/services designed for emergency assistance. All types of PERS, described above, shall meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting.

Service/Provider Term	Service Definition
	Included in the sub-set of services for the "At Risk" population
Private Duty Nursing	Private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses (as defined in HAR § 16-89) within the scope of state law. Included in the sub-set of services for the "At Risk" population
Respite Care	Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; foster home/expanded-care adult residential care home; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the state. Respite care services are authorized by the member's PCP as part of the member's care plan. Respite services may be self-directed.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation and may include: • Specialized infant car seats; • Modification of parent-owned motor vehicle to accommodate the child (i.e., wheelchair lifts); • Intercoms for monitoring the child's room; • Shower seat; • Portable humidifiers; • Electric bills specific to electrical life support devices (ventilator, oxygen concentrator); • Medical supplies; • Heavy duty items including, but not limited to, patient lifts or beds that exceed $1,000 per month; • Rental of equipment that exceeds $1,000 per month such as ventilators; and • Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month. Items reimbursed shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies shall be recommended by the member's PCP.

Attachment D
Certified Public Expenditure (CPE)/ Government-Owned Hospital
Uncompensated Care Cost (UCC) Protocol

Introduction

This document serves as an attachment to the QUEST Integration section 1115 demonstration special terms and conditions (STCs). The state must modify this protocol in accordance with Section III of these STCs to reflect any changes in CPE regulations or generally applicable policy adopted by the Centers for Medicare & Medicaid Services (CMS).

This protocol directs the method that must be used to determine uncompensated care (UCC) payments to government-owned hospitals as allowed by Section X of the STCs.

Summary of Medicare Cost Report Worksheets

Expenditures will be certified according to costs reported on the hospitals' 2552 Medicare cost reports, as follows:

Worksheet A
The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:

(i) overhead;
(ii) routine;
(iii) ancillary;
(iv) outpatient;
(v) other reimbursable; and,
(vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B
Allocates overhead (originally identified as General Service Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C
Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the hospitals records. The cost to charge ratios are used in the Worksheet D series to determine program costs.

The cost-to-charge ratio for inpatient and outpatient service to be used in making the interim quarterly expenditure payments are from the Medicare cost report worksheets as follows:

1. Inpatient Cost to Charge Ratio

Routine Charges: Worksheet C, Part I, Column 6, lines 30 to 43 (Routine Acute Charges, excluding any LTC unit cost centers)
Routine Cost: Worksheet C, Part I, Column 1 lines 30 to 43 (Routine Acute Costs, excluding any LTC unit cost centers) – Line 201 (Observation Beds Cost)
Ancillary Inpatient Charges: Worksheet C, Part I, Column 6, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable
Ancillary Total Charges: Worksheet C, Part I, Column 8, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Inpatient Costs: (Ancillary Inpatient Charges/Ancillary Total Charges) x (Worksheet C Part 1, Column 1, line 200 (Total Cost) – Lines 30 to 45 (Routine Costs including LTC) – Any non-hospital component cost center if applicable (e.g., HHA))

Inpatient Cost to charge Ratio = [Routine Cost + Ancillary Inpatient Costs]/[Routine Charge + Ancillary Inpatient Charges]

2. Outpatient Cost to Charge Ratio

Ancillary Total Charges: Worksheet C, Part I, Column 8, line 200 (Total Costs) – Lines 30 to 45 (Routine Charges including LTC) – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Outpatient Charge: Worksheet C, Part I, Column 7, line 200 – Any non-hospital component cost center if applicable (e.g., HHA)
Ancillary Outpatient Cost: (Ancillary Outpatient Charges/Ancillary Total Charges) x (Worksheet C, Part 1, Column 1 line 200 (Total Cost) – Lines 30 to 45 (Routine Costs line LTC) – Any non-hospital component cost center if applicable (e.g., HHA))

Outpatient Cost to charge Ratio = [Ancillary Outpatient Costs]/[Ancillary Outpatient Charges]

The governmentally-operated hospital's (hospital) will utilize the Medicare cost report to determine uncompensated care costs described in the subsequent instructions. The above Medicare cost- to- charge ratio will be applied to the uncompensated care population program charges to determine cost. The cost will be reduced by actual payments received to determine the hospital's uncompensated care cost. Any direct payments to hospitals by state related to this CPE computation will not be reflected in the payment received to determine hospital's uncompensated care cost. Non-Medicaid payments, funding and subsidies made by a state or unit of local government shall not be offset (e.g., state- only, local-only, or state-local health programs).

NOTES:

For the purpose of utilizing the Medicare cost report to determine uncompensated care costs described in the subsequent instructions, the following terms and methodology are defined as follows:

The term "filed Medicare cost report" refers to the cost report that is submitted by the hospital to Medicare Fiscal Intermediary and is due 5 months after the end of the hospitals fiscal year end period.

The term "finalized Medicare cost report" refers to the cost report that is settled by the Medicare Fiscal Intermediary with the issuance of Notice of Program Reimbursement (NPR).

The "Uncompensated care costs (UCC)" includes covered inpatient and outpatient hospital services costs from the Medicaid Fee for Services (Medicaid FFS), Medicaid QUEST Integration, and Uninsured population, less payments received from Medicaid FFS, QUEST Integration, and from uninsured patients, and excluding costs attributable to services to unqualified aliens. However, UCC are subject to the limitations as set forth in STC section X. Specifically, paragraph 44b, for government-operated hospitals, excludes inpatient Medicaid FFS shortfall, non-emergency care to unqualified aliens, and costs of drugs for individuals eligible for Part D.

Nothing in this document shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicare program. Any revision to the finalized Audit Report as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

Certified Public Expenditures -Determination of Allowable Payments to cover Uncompensated Care Costs (UCC)

To determine governmentally operated hospital's (hospital) allowable UCC when such costs are funded by a state through the certified public expenditure (CPE) process, the following steps must be taken to ensure federal financial participation (FFP) as defined with limitations in the STCs:

Interim Quarterly Expenditure Payment

The purpose of the interim quarterly expenditure payment is to identify the UCC from hospitals eligible for FFP claimed through the CPE process. The interim quarterly expenditure payment funded by CPEs is the state's initial claim for the drawing federal funds in a manner consistent with the instructions below.

The process of determining the CPEs to cover UCC eligible for FFP begins with the use of each hospital's most recently filed Medicare cost report for purposes of obtaining cost to charge ratios for inpatient and outpatient services using the methodology described in this document. The inpatient cost to charge ratio is applied to the inpatient program charges for the current quarter to determine inpatient costs. The outpatient cost to charge ratio is applied to the outpatient program charges for the current quarter to determine outpatient costs. The service period for inpatient is determined by the discharge date and for outpatient it is the service date. UCC is the cost of providing inpatient and outpatient services as computed above, reduced by an appropriate

adjustment for the cost of undocumented aliens and any applicable revenue collected for the provision of services. Only inpatient and outpatient program charges related to medical services that are eligible under the UCCs will be used to compute inpatient and outpatient program costs for this CPE process. Payments that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments. Direct UCC waiver payments, computed in this protocol, to hospitals by the state will not be included in the total program payments. Non-Medicaid payments, fundings, and subsidies made by a state or unit of local government shall not be offset.

Charges and payments for Medicaid FFS originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured charges and payments will originate from the provider's auditable records.

Annual Reconciliation Payment

Each hospital's interim quarterly payments will be reconciled to its filed Medicare cost reports for the spending year in which CPE payments were made. If, at the end of the annual reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government. The annual reconciliation payment is based on the recalculation of inpatient and outpatient program costs using the cost center per diems and cost-to-charge ratios derived from its filed Medicare cost report for the service period. Days, charges and payments for Medicaid FFS services originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges and payments will originate from the provider's auditable records.

For each inpatient hospital routine cost center, a per diem is calculated by dividing total costs of the cost center (from ws B, Part I, column 25) by total days of the cost center (from ws S-3, Part I, column 6). For each ancillary hospital cost center, a cost to charge ratio is calculated by dividing the total costs of the cost center (from ws B, Part I, column 25) by the total charges of the cost center (from ws C, Part I, column 8). The Adult and Pediatric (A&P) routine per diem, in accordance with CMS-2552 worksheet D-1, should be computed by including observation bed days in the total A&P patient day count and excluding swing bed nursing facility costs and non medically necessary private room differential costs from the A&P costs.

For inpatient UCC cost computation, each routine hospital cost center per diem is multiplied by the cost center's number of eligible UCC days, and each ancillary hospital cost center's cost-to-charge ratio is multiplied by the cost center's UCC-eligible inpatient charges. Eligible UCC days and charges pertain only to the UCC populations and services as defined in the STCs and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's inpatient hospital UCC cost is the hospital's inpatient UCC cost prior to the application of payment/revenue offsets and an appropriate adjustment of one percent to remove the unallowable cost of services to undocumented aliens.

For outpatient UCC cost computation, each ancillary hospital cost center cost-to-charge ratio is

multiplied by the cost center's UCC-eligible outpatient charges. Eligible UCC charges pertain only to the UCC populations and services as defined in the STCs and exclude any non-hospital services such as physician/practitioner professional services. The sum of each cost center's outpatient hospital UCC cost is the hospital's outpatient UCC cost prior to the application of payment/revenue offsets and an appropriate adjustment of one percent to remove the unallowable cost of services to undocumented aliens.

The cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then reconciled to the interim quarterly UCC payments made.

Payments that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, including payments from managed care entities, for serving QUEST Integration enrollees, will be included in the total program payments under this annual initial reconciliation process. Non-Medicaid payments, fundings, and subsidies made by a state or unit of local government will not be included in the total program payment offset.

The interim annual reconciliation described above will be performed and completed within 12 months after the filing of the hospital Medicare cost report.

Final Reconciliation Payment

Each hospital's annual reconciliation payment in a spending year will also be subsequently reconciled to its finalized Medicare cost report for the respective cost reporting period. The hospital will adjust, as necessary, the aggregate amount of UCC reported on the CPE determined under the final reconciliation payment. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, such overpayment or underpayment will be properly reported to the federal government. The same methodology detailed in the annual reconciliation payment will be used for the final reconciliation payment. The final reconciliation payments are based on the recalculation of program costs using the cost center per diems and cost-to-charge ratios from the finalized Medicare cost report for the service period. The hospital will update the program charges to include only paid claims from Medicaid FFS, QUEST Integration in computing program costs for the reporting period. For the uninsured population, the hospital will update any payment made by or on behalf of the uninsured through the quarter prior to the receipt of all of the finalized government-owned hospital Medicare cost reports for each respective fiscal year. Days, charges and payments for Medicaid FFS originating from the provider's auditable records will be reconciled to MMIS paid claims records. Medicaid managed care and uninsured days, charges and payments will originate from the provider's auditable records. The hospital will report inpatient and outpatient UCC based on program data related to medical services that are eligible for federal financial participation for the uncompensated care costs under this CPE process and Section X of the STCs.

The inpatient and outpatient cost computed above will be offset by all applicable payments received for the Medicaid and uninsured services included in the UCC computation and then

reconciled to the interim quarterly UCC payments and any interim annual reconciliation payments made.

Payments that are made independent of the claims processing system for hospital services of which the costs are included in the program costs described above, must be included in the total program payments under this final reconciliation process. Non-Medicaid payments, fundings, and subsidies made by a state or unit of local government shall not be offset. Using CPEs as a funding source, federal matching funds may be claimed for UCCs up to the hospitals eligible uncompensated costs as determined in this process.

The final reconciliation described above will be performed and completed within 6 months after the issuance of all of the finalized government-owned hospital Medicare cost reports for each respective fiscal year. The state is responsible to ensure the accuracy of the CPE amounts used for federal claiming.

Attachment D: Supplement 1
Certified Public Expenditure (CPE)/Governmental Hospital-based or Freestanding Long Term Care Facility
Uncompensated Care Cost (UCC) Protocol

Introduction

This document serves as an attachment to the QUEST Integration section 1115 demonstration special terms and conditions (STCs). The state must modify this protocol in accordance with Section III of these STCs to reflect any changes in CPE regulations or generally applicable policy adopted by the Centers for Medicare & Medicaid Services (CMS).

This protocol directs the method that must be used to determine payments for uncompensated care cost (UCC) to government-owned nursing facilities as allowed by Section X of the STCs.

For governmental nursing facilities, uncompensated care costs include covered routine nursing facility services costs pertaining to Medicaid QUEST Integration population, less payments received for Medicaid QUEST Integration patients. UCC are subject to the limitations as set forth in STCs section X.

To determine a governmental hospital-based or freestanding nursing facility's allowable Medicaid uncompensated care costs, the following steps must be taken to ensure federal financial participation (FFP):

(1) *Interim Payment*

The state will make quarterly interim payments to approximate actual Medicaid uncompensated care costs for the expenditure period. The uncompensated care cost for any given period is the difference between the nursing facility's allowable routine cost pertaining to Medicaid services furnished to the Medicaid population and all revenues received by the facility for those same services.

(a) The process of determining allowable Medicaid nursing facility uncompensated routine costs eligible for FFP begins with the use of each governmental nursing facility's most recently filed cost report (the last cost report filed to the Medicare contractor). For hospital-based nursing facilities, such costs are reported on the CMS-2552. For freestanding nursing facilities, such costs are reported on the CMS-2540.

(b) On the latest as-filed Medicare cost report, the allowable hospital-based nursing facility routine per diem cost is identified on the CMS-2552-10, worksheet D-1, Part III, line 71 (or the equivalent line on any later version of the 2552). This amount represents the allowable NF cost from worksheet B, Part I, line 44 and/or 45 column 26; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part I; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 19 and/or 20 column 8.

On the latest as-filed Medicare cost report, the allowable freestanding nursing facility routine per diem cost is identified on the CMS-2540-96, worksheet D-1, Part I, line 16 (or the equivalent line on any later version of the 2540). This amount represents the allowable NF cost from

worksheet B, Part I, line 16 and/or 18, column 18; adjusted by any applicable private room differential adjustments computed on worksheet D-1, Part 1; and divided by the total NF days during the cost reporting period identified on worksheet S-3, Part I, line 1 and/or 3, column 7.

The routine per diems above are computed in accordance with Medicare cost principles and trended forward by the CMS Nursing Home without Capital Market Basket inflation factor as necessary.

The above computation is performed separately for the NF component and, if applicable, the SNF component to arrive at separate NF and SNF per diems.

(c) The routine per diem from step b) above is multiplied by the number of Medicaid NF routine days during the current quarter for which the interim payment is being computed. The source of the number of Medicaid NF routine days must be supported by auditable documentation, such as provider patient accounting records and/or managed care encounter data reports.

If applicable, this step is also performed for the SNF component, by multiplying the SNF per diem from step (b) by the number of Medicaid SNF days for the period.

Note that Medicaid routine days should only include Medicaid managed care (Medicaid QUEST Integration) routine days and should not include any Medicaid FFS routine days, as Medicaid FFS routine services are fully cost-reimbursed under the Hawaii State plan; there is no Medicaid FFS uncompensated nursing facility cost, for governmental nursing facilities, that needs to be accounted for as part of this protocol.

(d) The allowable Medicaid NF routine costs, including any applicable Medicaid SNF component costs, computed from step c above is offset by all revenues received by the facility for the same Medicaid services, including but not limited to Medicaid managed care payments, payments from third party payers, and payments from or on behalf of the patients. The result is the net Medicaid NF routine loss reimbursable as interim uncompensated care cost payment.

2) *Interim Reconciliation to As-Filed Cost Report*

Each governmental nursing facility's interim uncompensated care cost payments will be reconciled to actual cost based on its as-filed CMS-2552 or 2540 for the expenditure year. If, at the end of the interim reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The interim reconciliation is based on each governmental nursing facility's allowable routine cost from its as-filed cost report (filed to the Medicare contractor) for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552. For freestanding nursing facilities, such costs are reported on the CMS-2540.

The same methodology detailed in the interim payment section above will be used for the interim reconciliation. The per diems computed using the as-filed cost report covering the expenditure period will be applied to Medicaid NF days (or SNF days if applicable) furnished during the expenditure period, and all applicable revenues for the period will be applied as offsets. The state will perform this interim reconciliation within twelve months from the filing of the cost report for the expenditure period.

3) *Final Reconciliation to Finalized Cost Report*

Each governmental nursing facility's interim uncompensated care cost payments will also be reconciled to actual cost based on its finalized CMS-2552 or 2540 for the expenditure year. If, at the end of the final reconciliation process, it is determined that expenditures claimed were overstated or understated, the overpayment or underpayment will be properly credited/debited to the federal government.

The final reconciliation is based on each governmental nursing facility's allowable routine cost from its finalized cost report (finalized/settled by the Medicare contractor with the issuance of a Notice of Provider Reimbursement or a revised Notice of Provider Reimbursement) for the expenditure period. For hospital-based nursing facilities, such costs are reported on the CMS-2552. For freestanding nursing facilities, such costs are reported on the CMS-2540.

The same methodology detailed in the interim payment section above will be used for the final reconciliation. The per diems computed using the finalized cost report covering the expenditure period will be applied to Medicaid NF days (or SNF days if applicable) furnished during the expenditure period. All applicable revenues for the period will be applied as offsets. The state will perform this final reconciliation within six months from the finalization of the cost report for the expenditure period.

OVERVIEW

The Med-QUEST Division (MQD) is responsible for providing behavioral health services to all its beneficiaries. MQD provides standard behavioral health services to all beneficiaries and specialized behavioral health services to beneficiaries with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral disorder (SEBD).

Regardless of the type of behavioral health service a beneficiary receives or where the beneficiary receives his/her behavioral health services, the beneficiary continues to have access to all of the other services for which he/she is eligible, including:

- Primary and acute care services from his/her health plan;
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services if he/she is under the age of 21;
- Home and community based services/long-term supports and services (HCBS/LTSS) services under the section 1115 demonstration waiver; and
- Services or under the Developmental Disabilities or Intellectual Disabilities (DD/ID) 1915(c) waiver.

All beneficiaries have access to standard behavioral health services through the contracted managed care health plans. The standard behavioral health services include inpatient psychiatric hospitalization, medications, medication management, psychiatric and psychological evaluation and management, and alcohol and drug dependency treatment services.

Beneficiaries with SMI, SPMI, or SEBD may be in need of specialized behavioral health services. For children (individuals <21), the SEBD services are provided through the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD); for adults (individuals ≥21) the SMI/SPMI services are provided through the DOH Adult Mental Health Division (AMHD), the MQD's behavioral health program Community Care Services (CCS), or the managed care health plans. Regardless of how adults with SMI/SPMI access specialized behavioral health services, all have access to the same services, and MQD ensures no duplication. The available specialized services include:

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

See Addendum A for an overview of the behavioral health services delivery systems for individuals with SMI, SPMI, or SEBD; and see Addendum B for a detailed description of the

services provided by CAMHD, AMHD, CCS, and the managed care health plans.

I. RECEIPT OF BEHAVIORAL HEALTH SERVICES BY CHILDREN (INDIVIDUALS <21 YEARS)

A. Clinical Criteria

Beneficiaries <21 years old with a diagnosis of SEBD are eligible for additional behavioral health services within CAMHD if meeting the following criteria:

- The beneficiary is age three through twenty (3-20) years;
- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least six (6) months or is expected to demonstrate the qualifying diagnosis for the next six (6) months; and
- The beneficiary's Child and Adolescent Functional Assessment Scale (CAFAS) score is > 80.
- Beneficiaries who do not meet the eligibility criteria, but based upon assessment by the CAMHD medical director that additional behavioral health services are medically necessary for the member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

B. Service Delivery

MQD has a Memorandum of Understanding (MOU) with CAMHD to provide services to Medicaid beneficiaries. The CAMHD is responsible for providing SEBD services to all individuals age three through twenty (3-20) years who meet eligibility criteria. CAMHD provides services to approximately 900 children. CAMHD had previously functioned as a Pre-paid Inpatient Health Plan (PIHP) but changed to billing these services to MQD through a fee-for-service (FFS) process effective October 1, 2008.

The health plan can make a referral to CAMHD through use the SEBD Referral Form developed by CAMHD. The health plan will continue to provide behavioral health services even after CAMHD admits the individual into their program. In these cases, the health plan will not provide services offered by CAMHD, and CAMHD will not provide services offered by the health plan. The MQD informs the health plans, via the 834-transaction file, when an individual is receiving services through the CAMHD program. When a child is no longer eligible for services through CAMHD, CAMHD will coordinate transition of care with the child's health plan. The health plan will be notified that the individual is no longer receiving services via CAMHD via the 834-transaction file.

Referrals to CAMHD can also occur through the school, parent, child, or the health plan. CAMHD considers all referrals through an assessment process. Even if a child qualifies for SEBD services, parents can choose to have their children's behavioral health services provided through the child's health plan. However, the health plans are only able to provide the standard and specialized behavioral health services identified in their

contract. CAMHD would need to be involved for any specialized behavioral health services. These additional behavioral health services include both intensive case management and targeted case management and are distinct from the services provided through the health plans.

II. RECEIPT OF SPECIALIZED BEHAVIORAL HEALTH SERVICES BY ADULTS (INDIVIDUALS ≥21 YEARS)

A. Clinical Criteria

For the beneficiaries >/=21 years old with a SMI or SPMI are eligible for specialized behavioral health services if they meet the following criteria:

- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The beneficiary meets at least one of the criteria below demonstrating instability and/or functional impairment:
  - Global Assessment of Functioning (GAF) < 50;
  - Clinical records demonstrate that the beneficiary is currently unstable under current treatment or plan of care. (Examples include, but are not limited to:
    - multiple hospitalizations in the last year and currently unstable; substantial history of crises and currently unstable; consistently noncompliant with medications and follow-up; unengaged with providers; significant and consistent isolation; resource deficit causing instability; significant co-occurring medical illness causing instability; poor coping/independent living/problem solving skills causing instability; at risk for hospitalization); or
    - Beneficiary is under Protective Services or requires intervention by housing or law enforcement officials.
- Beneficiaries who do not meet the requirements listed above, but based upon an assessment by a programmatic medical director, that additional behavioral health services are medically necessary member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

B. Service Delivery

The current organization for the delivery of specialized behavioral health services is largely historical. Around the time that the QUEST program was implemented in the mid-1990's, for which specialized behavioral health services were carved out, the CCS program was created due to the lack of behavioral health services for Medicaid beneficiaries with a SMI/SPMI. (AMHD had a limited service package at that time.) In the early 2000 timeframe, AMHD expanded its services significantly, largely modeling the CCS services, due to a mandated court decree that was withdrawn in 2006. However, MQD continued to offer its CCS program despite the expansion of services within AMHD.

CCS predominately served non-Aged, Blind and Disabled (ABD) individuals, and AMHD largely served ABDs. When QExA was implemented as managed care for the ABD population, specialized behavioral health services remained carved out. Over the years as individuals were offered choice, an increasing number of non-ABDs began to receive their services through AMHD, and an increasing number of ABDs began to receive their services through CCS.

In an effort to improve integration between medical and behavioral health care, effective July 1, 2010, the MQD transitioned all behavioral health services provided to QUEST adult beneficiaries by AMHD and the CCS program into the QUEST health plans. MQD observed that neither behavioral health outcomes nor medical outcomes were improved for this population, and the fragmentation among multiple health plans created confusion for patients and providers alike.

Effective March 1, 2013, CCS will be converted from primarily a third party administrator contract to a Pre-paid Inpatient Health Plan (PIHP), and MQD intends to transition all adults to receive their specialized behavioral health services through CCS. The state anticipates completing this transition by January 1, 2015. The following describes the current alternative service delivery options for adults until all adults can be transitioned to the CCS program to receive their specialized behavioral health services as described in this protocol.

1. AMHD

   MQD had a MOU with AMHD to provide services to Medicaid beneficiaries. Currently, AMHD provides specialized behavioral health services to approximately 1,200 Medicaid ABD adults, until this population can be transitioned to the CCS program. AMHD bills specialized behavioral health services to the MQD through a FFS process.

   Referrals to AMHD occur through either the beneficiary (self-referral) by calling the AMHD access line, or by beneficiary choice after a health plan referral and determination of eligibility. AMHD considers all referrals through an assessment process and uses the same criteria as listed in section A above. If the individual meets criteria, AMHD will notify MQD, develop an individual service plan, and begin providing services.

   Currently, the QExA health plans make referrals for adult members identified with a SMI/SPMI. All referrals are reviewed by a MQD physician for eligibility. Eligible beneficiaries can choose to receive their specialized behavioral health services through AMHD or CCS, until the transition at which time they will only be able to receive the specialized behavioral health services through CCS.

   The specialized behavioral health services provided by AMHD include both intensive case management and targeted case management. These services are distinct from the services provided through the managed care health plans.

2. CCS
   The CCS program provides specialized behavioral health services to approximately 900 Medicaid ABD adults. MQD awards the CCS program to a contractor through a Request for Proposals (RFP) to provide specialized behavioral health services to eligible adults as a PIHP. Certain new services may be reimbursed on a fee-for-service basis until able to be incorporated into the capitation rates.

   Currently, the QExA health plans make referrals for adult members identified with a SMI/SPMI. All referrals are reviewed by a MQD physician for eligibility. Eligible beneficiaries can choose to receive their specialized behavioral health services through AMHD or CCS, until the transition at which time they will only be able to receive the specialized behavioral health services through CCS. Once enrolled in CCS, CCS performs an assessment and develops an individual service plan.

3. Managed Care Health Plans
   All managed care health plans provide all their beneficiaries with standard behavioral health services. Currently, the QUEST health plans also provide approximately 2,000 adults with specialized behavioral health services, until this population is transitioned to receive specialized behavioral health services through CCS. Payment to the health plans is incorporated into their capitation rates. The health plans identify adult members with a SMI/SPMI and perform an assessment to develop an individual service plan. Certain specialized services are provided by CCS instead of the health plan.

Regardless of the specialized behavioral health service delivery option an adult utilizes, the individual will have access to the same specialized behavioral health services. This will be clear, and the delivery system will be more integrated, once MQD successfully transitions all adults with SMI/SPMI to receive their specialized behavioral health services through the CCS program.

III. COVERED SPECIALIZED BEHAVIORAL HEALTH SERVICES

The standard behavioral health services are State plan services. The covered specialized behavioral health services include those covered under the State plan and those covered under the section 1115 demonstration. These services may be provided through CAMHD or through AMHD, CCS, or health plans. The State plan services are listed below with details available in the State plan. The 1115 demonstration services are described in detail in subparagraph (C) below, and these services are not available through the health plans. The delivery system for these services are futher clarified in exhibit 2. Individuals receiving specialized behavioral health services through the health plans in need of these additional services can receive them either through AMHD or CCS.

Attachment E
Behavioral Health Services Protocol

A. State Plan Standard Behavioral Health Services (including substance abuse treatment)

1. Acute Psychiatric Hospitalization
2. Diagnostic/Laboratory Services
3. Electroconvulsive Therapy
4. Evaluation and Management
5. Methadone Treatment
6. Prescription Medications
7. Substance Abuse Treatment
8. Transportation

B. State Plan Specialized Behavioral Health Services

1. Assertive Community Treatment (intensive case management and community-based residential programs)
2. Biopsychosocial Rehabilitation
3. Crisis Management
4. Crisis Residential Services
5. Hospital-based Residential Programs
6. Intensive Family Intervention
7. Intensive Outpatient Hospital Services
8. Therapeutic Living Supports and Therapeutic Foster Care Supports (Addendum D includes the State plan pages for these Community Mental Health Rehabilitative Services)
9. Peer Support and Peer Specialist

C. 1115 Demonstration Specialized Behavioral Health Services

1. Financial management services

a. Services provided by an individual or organization for a beneficiary that cannot manage his or her money. This benefit is only for those without access to the social security representative payee program.

b. The financial manager shall direct the use of the beneficiary's income to pay for the current and foreseeable needs of the beneficiary and properly save any income not needed to meet current needs. The individual or organization must also keep records of expenses. Reports shall be provided quarterly to the beneficiary (if appropriate), and the beneficiary's legal guardian (or other designated responsible individuals).

2. Supportive Employment

a. Supported employment includes activities needed to obtain and sustain paid work within the general workforce by beneficiaries and includes assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the beneficiary, transitioning the beneficiary from volunteer work to paid employment, and assisting the beneficiary in maintaining an individual job in the general workforce at or above the state's minimum wage.

b. Supported employment support is conducted in a variety of settings to include self-employment. With regard to self-employment, individual employment support services may include:
   i. Aiding the beneficiary to identify potential business opportunities;
   ii. Assisting in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business;
   iii. Identifying the supports that are necessary in order for the beneficiary to operate the business; and
   iv. Providing ongoing assistance, counseling and guidance once the business has been launched.

3. Supportive Housing
   a. This is housing-based care management focused on identifying and securing affordable housing resources to include assistance with finding and retaining housing such as Section 8, Section 811, other Housing and Urban Development (HUD) programs, public housing and advocating for increased housing resources through state and local consolidated planning processes.
   b. Transitioning beneficiaries into housing and supporting them by providing housing stabilization and retention services to include but not limited to training in being a good tenant, establishing procedures and contacts to maintain/upkeep housing accommodations (lease compliance), obtaining reasonable accommodations and modifications

Exhibit 1 to Attachment E

Overview of Behavioral Health Services Delivery

	Adults without SMI/SPMI	Non-ABD Adults with SMI/SPMI	ABD Adults with SMI/SPMI Enrolled in AMHD	Adults with SMI/SPMI Enrolled in CCS	Children with SEBD Enrolled in CAMHD
Standard Behavioral Health Services					
Acute Psychiatric Hospitalization	HP	HP	HP	CCS	HP
Diagnostic/laboratory Services	HP	HP	HP	CCS	HP
Electroconvulsive Therapy	HP	HP	HP	CCS	HP
Evaluation and Management	HP	HP	HP	CCS	CAMHD/ HP
Methadone Treatment	HP	HP	HP	CCS	HP
Prescription Medications	HP	HP	HP	CCS	HP
Substance Abuse Treatment	HP	HP	HP	CCS	HP
Transportation	HP	HP	HP	CCS	HP
Specialized State Plan Behavioral Health Services					
Biopsychosocial Rehabilitation	n/a	HP	AMHD	CCS	n/a
Community Based Residential Programs	n/a	n/a	n/a	n/a	CAMHD
Crisis Management	n/a	HP	AMHD	CCS	CAMHD
Crisis Residential Services	n/a	HP	AMHD	CCS	CAMHD
Hospital-based Residential Services	n/a	n/a	n/a	n/a	CAMHD
Intensive Case Management	n/a	HP	AMHD	CCS	CAMHD
Intensive Family Intervention	n/a	n/a	n/a	n/a	CAMHD
Intensive Outpatient Hospital Services	n/a	HP	AMHD	CCS	CAMHD
Therapeutic Living Supports and Therapeutic Foster Care Supports	n/a	HP	AMHD	CCS	CAMHD

Specialized 1115 Behavioral Health Services					
Financial management services	n/a	CCS	AMHD	CCS	n/a
Supportive Employment	n/a	CCS	AMHD	CCS	n/a
Supportive Housing	n/a	CCS	AMHD	CCS	n/a

Legend:

ABD	Aged, Blind, or Disabled
AMHD	Adult Mental Health Division in the Department of Health
HP	Health Plan
CAMHD	Child and Adolescent Mental Health Division in the Department of Health
CCS	Community Care Services program
SEBD	Support for Emotional and Behavioral Development
SMI	Severe Mental Illness
SPMI	Serious and Persistent Mental Illness

Exhibit 2 to Attachment E

Behavioral Health Services in the QUEST Integration Program

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Payment methodology	**N/A**	**Payment to health plans** Capitation	**Payment to DOH-AMHD** Billed FFS to MQD	**Payment to the Behavioral Health Organization** Capitation/FFS	**Payment to DOH-CAMHD** Billed FFS to MQD
Standard Behavioral Health Services					
Acute psychiatric hospitalization	Hospitals[3] licensed to provide psychiatric services	Twenty-four (24) hour care for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services as needed	Provided by health plan	Twenty-four hour acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services, as needed o Other medically	Provided by health plan

[3] Excludes Institutions of Mental Disease (IMDs) as defined at 42 CFR 435.1010

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		o Other medically necessary services o Pharmaceuticals o Rehabilitation services, as needed		necessary services o Pharmaceuticals o Rehabilitation services, as needed	
Diagnostic/ laboratory services	Laboratories	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol problems Other medically necessary diagnostic services	Provided by health plan	Diagnostic/laboratory services including: o Psychological testing o Screening for drug and alcohol Other medically necessary diagnostic services	Provided by health plan
Electroconvulsive Therapy (ECT)	Acute Psychiatric Hospital Outpatient facility	ECT o Medically necessary, may do more than one/day Inclusive of anesthesia	Provided by health plan	ECT o Medically necessary, may do more than one/day Inclusive of anesthesia	Provided by health plan
Evaluation and Management	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health	Psychiatric or psychological evaluation Individual and group counseling and	Psychiatric or psychological evaluation for SMI/SPMI Individual and group	Psychiatric, psychological or neuropsychological evaluation for SMI/SPMI	Psychiatric, psychological or neuropsychological evaluation for SEBD Individual and group

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	monitoring	counseling and monitoring for SMI/SPMI HP provides individual and group counseling and monitoring for non-SMI/SPMI	Individual and group counseling and monitoring for SMI/SPMI HP provides individual and group counseling and monitoring for non-SMI/SPMI	counseling and monitoring for children requiring SEBD HP provides individual and group counseling and monitoring for all other children
Methadone treatment	Methadone clinics	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan
Prescription Medications	Providers licensed to prescribe (e.g. Psychiatrist and APRN Rx). Medications are dispensed by licensed pharmacies.	Prescribed drugs including medication management and patient counseling	Provided by health plan	Prescribed drugs including medication management and patient counseling	Provided by health plan
Substance Abuse	Licensed providers and certified	Substance Abuse-Residential	Provided by health plan	Substance Abuse-Residential	Provided by health plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	substance abuse counselors* Specialized residential treatment facilities Facilities licensed to perform substance abuse treatment	o Medically necessary services based on American Society of Addiction Medicine (ASAM) Substance Abuse – Out-patient o Screening o Treatment and treatment planning o Therapy/counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary o Screening for drugs and alcohol.		o Medically necessary services based on American Society of Addiction Medicine (ASAM) Substance Abuse – Out-patient o Screening o Treatment and treatment planning o Therapy/counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary o Screening for drugs and alcohol.	
Transportation	Approved	Transportation	Provided by health	Transportation	Provided by health

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	transportation providers to include medical vans, taxi cabs, bus services, and handicap bus services.	o Air o Ground for medically necessary services	plan	o Air o Ground for medically necessary services	plan
Specialized Behavioral Health Services					
Biopsychosocial Rehabilitative Programs (including Clubhouse services)	AMHD Qualified Mental Health Provider**	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Not provided
Community Based Residential Programs[4]	Small homes certified to perform community based residential programs. Each home is staffed with several qualified mental health professionals.	Not provided	Not provided	Not provided	These programs provide twenty-four (24) hour integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression, or deviance, which prevent the youth from taking part in family and/or community life.+

[4] Meet inpatient psych under 21 requirements under 42 CFR 440.160

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Crisis Management	Qualified Mental Health Provider**	Crisis Management a. 24-hour crisis telephone consultation b. Mobile outreach services Crisis intervention/ stabilization services	Crisis Management c. 24-hour crisis telephone consultation d. Mobile outreach services e. Crisis intervention/ stabilization services	Crisis Management a. 24/7 Crisis hotline (through 800#) b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization	Crisis Management a. 24/7 Crisis hotline (through 800#) b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization d.
Crisis Residential Services	Qualified Mental Health Provider**	Not provided	Crisis Residential Services	Crisis Residential Services	Crisis Residential Services
Hospital based residential treatment[5]	Acute psychiatric hospital	Not provided	Not provided	Not provided	Hospital based residential treatment
Intensive Case Management	Qualified Mental Health Provider**	Care Coordination/Case Management	Intensive Case Management/ community-based care management Targeted Case Management	Care Coordination/Case Management o Case assessment o Case planning (service planning, care planning) o Outreach o Ongoing monitoring and service coordination	Intensive Case Management/ community-based care management Targeted Case Management

[5] Excludes services in IMD as defined at 42 CFR 435.1010.

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Intensive family intervention	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists	Not provided	Not provided	Not provided	Intensive family intervention
Intensive Outpatient Hospital Services	Acute psychiatric Hospitals Qualified Mental Health Provider**	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and	Intensive Outpatient Hospital Services: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and	Intensive Outpatient Hospital Services: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		aftercare o Other medically necessary services	aftercare o Other medically necessary services	aftercare o Other medically necessary services	aftercare o Other medically necessary services
Peer Specialist	Certified peer specialist	Structured activities within a peer support center that promote socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promote socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promote socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Not provided
Financial management services*	Licensed Organization or Individual	Not provided	Assist beneficiary in managing their financial status.	Assist beneficiary in managing their financial status.	Not provided
Supportive Employment	Qualified Mental Health Provider**	Not provided	Activities to obtain and sustain paid work by beneficiaries.	Activities to obtain and sustain paid work by beneficiaries.	Not provided
Therapeutic Living Supports and Therapeutic Foster Care Supports	Specialized residential treatment facility	Specialized residential treatment facility	Specialized residential treatment facility	Specialized residential treatment facility	Therapeutic living and therapeutic foster care supports

Legend:

* Approved waiver services

** Medicaid provider that offers multiple behavioral health services in one organization in order to provide continuity for the participants in the behavioral health program. Qualified providers are licensed or certified as required by Hawaii Revised Statutes.

Exhibit 3 to Attachment E

Eligibility Diagnoses for Specialized Behavioral Health Services

Eligible Diagnoses:

- Demonstrates the presence of a primary DSM (most current edition) Axis I diagnosis for at least six (6) months or is expected to demonstrate the diagnosis for the next six (6) months. See excluded diagnoses in the next section.

Excluded Diagnoses*

- *Mental Retardation** (317, 318.0, 318.1, 318.2, 319)
- Pervasive Developmental Disorders** (299.0, 299.80, 299.10)
- Learning Disorders (315.0, 315.1, 315.2, 315.9)
- Motor Skills Disorders (315.3)
- Communication Disorders (315.31, 315.32, 315.39, 307.0, 307.9)
- Substance Abuse Disorders
- Mental Disorders Due to a General Medical Condition
- Delirium, Dementia, Amnestic, and other Cognitive Disorders
- Factitious Disorders
- Feeding Disorders of Infancy or Childhood
- Elimination Disorders
- Sexual Dysfunctions
- Sleep Disorders

*If a diagnosis listed above is the **ONLY** DSM (most current edition) diagnosis, the child/youth is ineligible for SEBD services. However, these diagnoses may and often do co-exist with other DSM diagnoses, which would not make the child/youth ineligible for SEBD services.
**Co-occurring diagnoses of Mental Retardation and Pervasive Developmental Disorders require close collaboration and coordination with State of Hawaii Department of Health (DOH) and State of Hawaii Department of Education (DOE) services. The health plan, with CAMHD, is responsible for coordinating these services. These diagnoses may be subject to a forty-five (45) day limit on hospital-based residential services, after which utilization review and coordination of services with DOE need to occur.

Severe Mental Illness/Serious and Persistent Mental Illness

Eligible Diagnoses:

- Schizophrenic Disorders (295.1X, 295.2X, 295.3X, 295.6X, 295.9X)
- Schizoaffective Disorders (295.70)
- Delusional Disorders (297.1)
- Mood Disorders - Bipolar Disorders (296.0, 296.4X, 296.5X, 296.6X, 296.7, 296.89)
- Mood Disorders - Depressive Disorders (296.24, 296.33, 296.34)
- Post-traumatic stress disorder
- Substance induced psychosis

`LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Coverage Management Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

September 28, 2004

MEMORANDUM OF AGREEMENT

BETWEEN
DEPARTMENT OF HUMAN SERVICES
AND
DEPARTMENT OF HEALTH

This MEMORANDUM OF AGREEMENT (MOA) between the Med-QUEST Division (MQD) of the Department of Human Services (DHS) and the Child and Adolescent Mental Health Division (CAMHD) of the Department of Health (DOH) is to provide behavioral services for QUEST and Medicaid Fee-For-Service (FFS) children and adolescents age 3 through age 20 who are eligible and determined to be Seriously Emotionally and Behaviorally Disturbed (SEBD) and in need of intensive mental health services. This MOA covers the period from July 1, 2004 to June 30, 2005. The above-mentioned state agencies agree to the following provisions specified herein.

I. THE CAMHD OF THE DEPARTMENT OF HEALTH SHALL:

A. Provide the following services to youth covered under this MOA as specified in Attachment I.

B. Determine level and medical appropriateness of behavioral health managed care services as documented in the client's individualized behavioral health treatment plan in accordance with state quality assurance and utilization review standards.

C. Have an internal Grievance and Appeals process in place. All grievances and appeals should be resolved within thirty (30) days from the receipt of the written or verbal expression of dissatisfaction, unless a fourteen (14) day Extension or Expedited appeal is initiated. The policies and procedures for resolution of grievances and appeals shall be included as part of the CAMHD Quality Assurance Program and be in compliance with the grievance and appeal requirements of the MQD. CAMHD shall provide MQD with a quarterly grievance and appeals report in a format determined by the MQD.

D. Comply with any DHS Administrative Appeals Office (AAO) decision relating to the provision of behavioral health services covered by the MOA. A recipient shall utilize the CAMHD Grievance System before appealing to the DHS AAO. CAMHD shall notify the recipient/family of the right to appeal to DHS. Appeals shall be limited to Medicaid covered services. Any appeal to DHS shall not waive the recipient's right to judicial appeal.

E. Provide a continuation of benefits during an appeal or state fair hearing.

F. Implement in full the Quality Assurance Program (QAP) approved by the MQD. CAMHD shall implement changes to operations, policies and procedures, and provider contracts to remain in compliance with the approved QAP.

G. Maintain staffing level and proficiency and an adequate provider network to provide the quality and extent of services and activities required under the state and federal regulations applicable to a Prepaid Inpatient Health Plan. CAMHD clinical staff and providers shall be qualified and trained in the principles and techniques of mental health treatment and services. Providers shall meet state licensing requirements for professions where licensing is required to provide mental health services.

H. Establish monitoring schedules and criteria, and monitor CAMHD providers of services and staff on a regular basis to ensure compliance with the QUEST program.

I. Maintain documentation that CAMHD providers are maintaining records of services provided by providers' staff and contractors in compliance with the QAP requirements. Maintain confidentiality of such records as required by state and federal laws.

J. Comply with requests from the state and federal government and/or their representatives to review all medical and financial records of CAMHD, and its subcontractors and providers, and CAMHD staff to ensure compliance with the terms and condition of this Agreement and the state and federal rules and regulations.

K. Process electronic transmission of daily and monthly rosters for eligibility for QUEST and Medicaid FFS youth covered under this MOA and support the electronic transmission of daily and monthly rosters for eligibility.

L. Submit a monthly invoice to support billing for QUEST and Medicaid FFS youth covered under this Agreement.

M. Provide a monthly (if network changes take place) or a quarterly submission of CAMHD's provider network in accordance with instructions and filing requirements established by the MQD.

N. Provide a monthly submission of encounter data in accordance with instructions and filing requirements established by the MQD.

O. Provide a signed Letter of Certification at the time of the encounter and provider data submission. The letter of certification shall be signed by the Chief Executive Officer, Chief Financial Officer or an individual who has been delegated authority to sign for and who reports directly to one of the above organizational officers. The letter must certify that the data is accurate, complete and truthful.

P. Pay for behavioral health services for eligible children and adolescents that CAMHD determines to be necessary but are not covered under this agreement.

Q. Inform MQD of recipients who are accepted into or disenrolled from CAMHD services within thirty (30) days. CAMHD shall be responsible to verify the enrollment and disenrollment date of recipients from the daily and/or daily and monthly rosters provided by MQD.

R. Minimize the disruption of behavioral health services during the transition of care for recipients covered under this Agreement when transitioning from the QUEST plans to CAMHD. Assure the continued provision of comparable services and preserve existing therapeutic relationships between the child and provider as medically necessary for the child/adolescent.

S. CAMHD shall inform the QUEST plan when a transition or termination of a recipient's services is to occur due to a change in their status and pay for all behavioral health services provided by a QUEST plan prior to the transition or termination. CAMHD will be responsible for notifying MQD of referrals between CAMHD and the QUEST plan.

T. If a recipient is enrolled in the CAMHD plan under this MOA and is in need of urgent care and/or crisis intervention and a CAMHD provider is not available to provide the services, CAMHD agrees that the QUEST plan shall provide the service if possible and if it is determined to be medically necessary by the QUEST plan. The CAMHD shall be responsible to reimburse the QUEST plan through MQD for the service(s) provided plus a 10 % administrative fee.

U. Provide written information to recipients and their families informing them of their benefits, rights, and responsibilities within the acceptable timeframe established by the MQD.

V. Meet the terms of the medical Request for Proposal (RFP) rules and requirements as they apply to CAMHD as a Prepaid Inpatient Health Plan.

W. Comply with all federal and state rules and regulations to include the Balanced Budget Act of 2002, implemented August 13, 2004.

II. THE MQD OF THE DEPARTMENT OF HUMAN SERVICES SHALL:

A. Pay the CAMHD a monthly reimbursement rate of $ 542.87 per member per month for each youth/adolescent covered under this MOA that are not classified under Section 504 as needing mental health services. Payment shall be made no later than thirty (30) calendar days subsequent to receiving the submission of encounter data and shall be reconciled annually to actual costs based on utilization reported as encounters and priced at Medicaid rates. Any adjustment for the year will be applied retroactively.

- The monthly reimbursement rate payment shall be paid on a prorated basis for the number of days during the month in which the child was enrolled with CAMHD.

- The date of disenrollment from CAMHD shall be effective at the end of the month in which DHS is notified through use of the Enrollment/Disenrollment

B. Pay for services on a Fee-For-Service basis for behavioral health services provided by CAMHD to Medicaid eligibles that are classified as blind or disabled and are not enrolled in a QUEST health plan. FFS claims for behavioral health services covered under the Hawaii State Medicaid program shall be submitted to the MQD's fiscal agent. Claims billing and processing shall be conducted in accordance with established billing and payment procedures.

C. Review the operations and policies of the CAMHD on a continuing basis to determine if Hawaii QUEST quality assurance (QA) standards for a written QAP are met. The MQD reserves the right to delay re-implementation of this MOA until all quality assurance standards are met.

D. Monitor CAMHD to ensure that it has implemented its written QAP. MQD reserves the right to withhold and/or deny payments if CAMHD cannot implement its QAP.

E. Ensure that clients meet eligibility and enrollment criteria for Medicaid.

F. Ensure that enrollments and disenrollments of youth covered under this MOA are done accurately and in an efficient and timely manner and in accordance with agreed upon procedures.

G. Provide the directives to CAMHD during the transition period of youth covered under this MOA into CAMHD to assure the continued provision of comparable services and to preserve existing therapeutic relationships if it is medically necessary for the child/adolescent.

H. Inform other QUEST plans regarding their responsibility to transition indicated youth to the CAMHD behavioral health plan.

Reimbursement for Services:

a) The CAMHD shall submit a monthly invoice and be reimbursed by DHS for behavioral health services provided to recipients who are covered by this MOA at the Monthly Reimbursement rate of $ 542.87 per member per month subject to annual reconciliation to actual costs. DHS shall pay CAMHD based on the monthly eligibility roster. The above rate includes federal and state funding.

b) The monthly reimbursement rate is calculated based on the estimated per member per month based on historical encounters and enrollments, and will be reconciled to actual costs incurred by CAMHD on an annual basis. Within ninety (90) days of the end of the fiscal year, or by September 30th of each year, CAMHD shall supply MQD with encounters, in the format specified in the Health Plan Manual, for all services provided to children covered under this agreement during the fiscal year for purposes of reconciliation. The costs indicated by the encounter data shall be the sole source of reporting costs incurred by CAMHD to the MQD.

MQD shall then reconcile monthly payments against the federally funded portion of the actual costs incurred. If the total payments exceed the federally funded portion of actual costs, CAMHD shall refund the difference to MQD. If the total payments are less than the federally funded portion of actual costs, MQD shall pay the difference to CAMHD. At the end of each reconciliation, the reimbursement rate will be re-determined for the next Fiscal Year based on the previous years federally funded actual costs for similar services.

c) Federal funds are not available for children classified as needing mental health treatment services under Section 504; therefore CAMHD shall not receive reimbursement from DHS for these children. CAMHD will be responsible for determining whether individuals who require 504 accommodations include mental health services.

d) The DHS shall pay the DOH for the federal share at the Hawaii Federal Medical Assistance Percentage (FMAP) in place for the month for which reimbursement is made. The DOH is responsible for the state's share of the expenditures.

e) The total amount of this AGREEMENT shall not exceed $7.5 million in federal funds per state fiscal year.

f) The CAMHD shall reimburse MQD any amount disallowed by CMS for services provided under this MOA.

g) For services covered by this MOA, MQD agrees to coordinate reimbursement from CAMHD for intensive behavioral health services provided by QUEST plans plus a 10% administrative fee for services provided to CAMHD recipients covered under this MOA during their assessment and transition. The reimbursement shall be a net against the capitation payment.

h) For services not covered by this MOA, if CAMHD provides and pays for services for which the QUEST medical plans are financially responsible, MQD agrees to coordinate reimbursement from the QUEST medical plans plus a 10% administrative fee to CAMHD for services provided to QUEST recipients.

i) The MOA period shall be for a period of one year. For purposes of continuity of care the DHS shall have the option to renew and/or extend the contract with CAMHD for the next fiscal year. Any renewal or extension of the contract will be subject to available funding.

This Agreement is for the sole benefit of the parties hereto, and is not for the benefit of any third party beneficiaries, including any members of the Hawaii QUEST Program. The MEMORANDUM OF AGREEMENT may also be terminated by either party for any reason with thirty (30) calendar days written notice to the other party. Amendments, as mutually agreed upon, may be made, as appropriate, in writing.

DEPARTMENT OF HUMAN SERVICES	DEPARTMENT OF HEALTH
_____/s/_____	_____/s/_____
Lillian B. Koller, Esq.	Chiyome Fukino, M.D.
Director	Director
Date: _____	Date: _____

FY04-FY05

Scope of Services

To be included but not limited to:

1. CRISIS MANAGEMENT
    a. 24-hour crisis telephone consultation
    b. Mobile outreach/stabilization services
    c. Crisis intervention/stabilization services
2. OUTPATIENT BEHAVIORAL HEALTH SERVICES
    a. Psychosexual assessments/evaluations
3. INTENSIVE FAMILY INTERVENTION SERVICES
    a. Intensive Family Intervention
    b. Multi-systemic Therapy (MST)
4. CRISIS RESIDENTIAL SERVICES
5. INTENSIVE OUTPATIENT HOSPITAL SERVICES
6. THERAPEUTIC LIVING SUPPORTS AND THERAPEUTIC FOSTER CARE SUPPORTS
    a. Foster Homes with Therapeutic Services
    b. Mental Health Respite Homes
    c. Community-Based Residential Programs
    d. Therapeutic Group Homes
7. RESIDENTIAL TREATMENT IN A HOSPITAL SETTING

Exhibit 5 to Attachment E

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

November 5, 2010

MEMORANDUM OF AGREEMENT

BETWEEN

DEPARTMENT OF HUMAN SERVICES AND DEPARTMENT OF HEALTH

This MEMORANDUM OF AGREEMENT (MOA) between the Med-QUEST Division (MQD) of the Department of Human Services (DHS) and the Adult Mental Health Division (AMHD) of the Department of Health (DOH) is to provide mental health services for all Medicaid recipients over 18 years old with serious mental illness. This MOA covers the period from **July 1, 2009 through June 30, 2012**. At the end of the MOA, MQD shall have the option to renew the MOA for another defined term. The above-mentioned state agencies agree to the following provisions specified herein.

I. THE AMHD OF THE DEPARTMENT OF HEALTH SHALL:

A. Implement processes for certifying Provider Agencies or State Operated Facilities to determine eligibility for participation in the Community Mental Health Program. Any revisions to the current process shall be approved by MQD. Specifically, the AMHD agrees to:

1. Determine Provider Agencies' or State Operated Facilities' eligibility for participation in the Community Mental Health Program subject to Hawaii Administrative Rules (HAR) chapter 11-172 .

2. Gather and review all applications from Provider Agencies or State Operated Facilities seeking eligibility for participation in the Community Mental Health Program. AMHD will provide MQD information on Provider Agencies or State Operated Facilities who have been approved to participate in the Community Mental Health Program. AMHD will be responsible for communicating decisions regarding eligibility to the Provider Agencies or State Operated Facilities submitting an application.

3. Notify MQD immediately regarding changes in the Provider Agencies' or State Operated Facilities' eligibility.

4. Recertify Provider Agencies or State Operated Facilities every three years. Annually, AMHD will perform on-site reviews of each eligible Provider Agency or State Operated Facility to ensure they comply with programmatic, operational and fiscal requirements established in HAR chapters 11-172 and 17-1736. AMHD will establish monitoring schedules and criteria, and provide information on these reviews to MQD on an annual basis.

5. AMHD may submit claims to the MQD for qualified mental health providers (QMHP) to include psychiatrists, licensed psychologists, licensed clinical social workers, licensed mental health counselors, and licensed marriage family therapists as long as the QMHP is a Medicaid provider.

B. Implement a utilization management process to evaluate the appropriateness of services, lengths of stay and quality of services. AMHD will utilize established utilization management policies and procedures for conducting these reviews. All utilization management decisions will be provided to Provider Agencies or State Operated Facilities in accordance with the AMHD utilization management policies. Appeals by Provider Agencies or State Operated Facilities regarding these decisions will be reviewed in accordance with AMHD due process procedures set forth in AMHD Policy 60.908.

C. Coordinate within the Department of Health, in general, to develop methodology and receive approval from the Department of Health and Human Services, Division of Cost Allocation for claiming the federal reimbursement for administrative services.

D. Receive and pay all claims for MQD covered mental health services from Provider Agencies or State Operated Facilities eligible for participation in the Community Mental Health Program based on the fee schedule in Attachment II. Covered mental health services are provided in Attachment I.

E. Submit a list of all Medicaid clients receiving services through the AMHD to the MQD on a monthly basis. The format shall be 834 or similar format mutually

agreed upon by MQD and AMHD. MQD shall use this information to assure that claims are processed in accordance with established Medicaid standards.

F. Provide a paid, adjusted, and voided claims file to the MQD or its fiscal agent on a bi-monthly basis or as otherwise agreed to by the parties, in accordance with instructions and filing requirements established by MQD. The format shall be *837/835* or similar format mutually agreed upon by MQD and AMHD. As required by 42 CFR §433.51 (a), (b), and (c), the AMHD will certify that the public funds expended as the state's share represent expenditures eligible for federal financial participation (FFP) for each filing. This certification also requires the claims data supporting the payment and proof of the AMHD payments made to the providers. Targeted Case Management services provided by the AMHD Community Mental Health Centers (CMHC) will be submitted to the MQD on a regular basis using a valid HIPAA format.

G. Maintain a current provider manual for the Community Mental Health Program, as approved by MQD. AMHD will distribute the manual to eligible Provider Agencies and State Operated Facilities.

H. Ensure the provision of services to consumers between the age of eighteen (18) and twenty-one (21) are in accordance with federal Early, Periodic, Screening, Detection, and Treatment (EPSDT) requirements.

I. Provide sufficient professional staff to coordinate, supervise and implement their responsibilities under this MOA.

J. Agree to pay the state share for Community Mental Health Program services, which are determined to be eligible for federal financial participation and furnished to Medicaid recipients.

K. Agree to return any federal share that is disallowed by the federal government, or determined to be inappropriate for reimbursement by the MQD. Cooperate with the activities of the MQD Fraud Unit and assist in recovering any overpayments or inappropriate payments from certified AMHD providers and State Operated Facilities. AMHD shall monitor AMHD providers for fraud and report suspected fraudulent activity in writing to MQD and the Department of the Attorney General, Medicaid Investigations Division within thirty (30) days of discovery.

II. <u>THE MQD OF THE DEPARTMENT OF HUMAN SERVICES SHALL</u>:

A. Pay the AMHD on a monthly basis the federal reimbursement for eligible paid claims based on the paid claims file and the Targeted Case Management file submitted by AMHD. Reimbursement shall be allowed on clean claims determined payable after review by the edits in the MQD claims processing system. Clean claims reimbursement shall be paid within thirty (30) days of

submittal by AMHD. Claims denied by MQD's claims processing system will be returned to AMHD for resolution.

B. Establish and/or terminate Provider Agencies or State Operated Facilities within thirty (30) days of receipt of information from AMHD.

C. Provide eligibility information to AMHD on a regular basis, but no less than monthly, using a batch process agreed upon by MQD and AMHD.

D. Pay AMHD the federal reimbursement based upon the methodology approved by the Department of Health and Human Services, Division of Cost Allocation for the Medicaid Administration activities performed by AMHD staff, including skilled medical professional staff, to coordinate, supervise, and implement its responsibilities under this MOA.

E. Review, during the term of this MOA, the operations and policies of AMHD as necessary to determine if the terms of this MOA are met.

F. Conduct desk reviews and audits of Provider Agencies' and State Operated Facilities' claims and inform AMHD of the results of such reviews and audits within thirty (30) days of their completion.

Either party for any reason may terminate this MEMORANDUM OF AGREEMENT upon ninety (90) calendar day's written notice to the other party. Amendments, as mutually agreed upon, may be made, as appropriate, in writing.

DEPARTMENT OF HUMAN SERVICES	DEPARTMENT OF HEALTH
/s/	_____/s/_____
Lillian B. Koller, Esq.	Chioyme Leinaala Fukino, M.D.
Director of Human Services	Director of Health
_____	_____
Date	Date

ATTACHMENT I

1. Crisis Management

    a. 24-hour crisis telephone consultation
    b. Mobile outreach services
    c. Crisis intervention/stabilization services

2. Crisis Residential Services

3. Intensive Outpatient Hospital Services

4. Therapeutic Living Supports

    a. Community-Based Specialized Residential

5. Biopsychosocial Rehabilitative Programs

6. Assertive Community Treatment

7. Intensive Case Management/Community Based Case Management

8. Targeted Case Management

    Targeted case management shall be provided in accordance with Hawaii Administrative Rules 17-1738 http://hawaii.gov/dhs/main/har/har_current/AdminRules/document_view. In the event any of the terms of this agreement conflict with or are not required by HAR §17-1738, the HAR shall control.

ATTACHMENT II

DOH—AMHD
With MQD rates and HCPCS Codes

SPA	AMHD Service	HCPCS Code	Unit	MQD Rate	Comments
Crisis Management	Crisis Mobile Outreach (CMO)	H2011	15 minutes	$ 27.50	
	Crisis Support Management (CSM)	H2015	15 minutes	$ 20.25	Must bill as Intensive Case Management/ Community Based Case Management
Crisis Residential	Licensed Crisis Residential Services (LCRS)	H0018	Daily	$211.80	Must be licensed, only treatment covered
Biopsychosocial Rehabilitation	Psychosocial Rehabilitation	H201 7	15 minutes	$ 3.30	Clubhouse not included
Intensive outpatient hospital services	Intensive Outpatient Hospital Services	H0035	Daily	$250.00	
Therapeutic Living Supports	Community Based Specialized Residential	H0019	Daily	$236.14	Must be licensed, only treatment covered
Assertive Community Treatment	Assertive Community Treatment, face-to-face contact	H0039	15 minutes	$ 27.00	75% of Assertive Community Treatment claims must be face-to-face
	Assertive Community Treatment, case assessment	H0039U1	15 minutes	$ 27.00	
	Assertive Community Treatment, treatment planning	H0039U2	15 minutes	$ 27.00	
	Assertive Community Treatment, collateral contact with no consumer contact	H0039U3	15 minutes	$ 27.00	
	Assertive Community Treatment, telephonic treatment planning with **11311,** Kahi Mohala	H0039HT	15 minutes	$ 27.00	
	Assertive Community Treatment, telephonic consultation with consumer	H0039U5	15 minutes	$ 27.00	

DOH—AMHD
With MQD rates and HCPCS Codes

SPA	AMHD Service	HPCPS Code	Unit	MQD Rate	Comments
Intensive Case Management/ Community Based Case Management	Intensive Case Management/Community Based Case Management, face-to-face contact	H2015	15 minutes	$20.25	75% of Intensive Case - Management/Community Based Case Management claims must be face-to-face.
	Intensive Case Management/Community Based Case Management, case assessment	H2015U1	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, treatment planning	H2015U2	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, collateral contact with no consumer contact	H2015U3	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, telephone treatment planning with HSH, Kahi Mohala	H2OI5HT	15 minutes	$20.25	
	Intensive Case Management/Community Based Case Management, telephone consultation with consumer	H2015U5	15 minutes	$20.25	
	Targeted Case Management	T1017U5	15 minutes	$9.75	
	Targeted Case Management	T1017U6	15 minutes	$9.75	

Exhibit 6 to Attachment E

REFERRAL FOR SERIOUS MENTAL ILLNESS (SMI) COMMUNITY CARE SERVICES (CCS) PROGRAM

Name _____ ☐ MALE ☐ FEMALE
Last First MI

Home Address _____ Phone No. _____

Case No. _____

Mailing Address _____ Client ID No. _____

Social Security No. _____

Date of Birth _____ Age _____ ☐ HAWAII ☐ MAUI ☐ KAUAI COUNTY ☐ OAHU

Health Plan: ☐ Ohana ☐ UnitedHealthcare ☐ OTHER: _____

Primary Diagnosis _____ DSMIV Code _____

Secondary Diagnosis _____ DSMIV Code _____

Current Medical Conditions (Indicate, if none) _____

Date of Referral: _____ Name of PCP: _____ PCP NOTIFIED: Y / N

HOSPITALIZATIONS	**CURRENTLY AT:** ☐ **Castle** ☐ **Queen's** ☐ **Other:** _____ (list) **Admitted on** ____/____/____			
Past Hospitalizations- Facility	Location	Date Admitted	Date Discharged	Diagnosis

MEDICATIONS	Strength	Dosage	Start Date	End Date

OUTPATIENT THERAPISTS	Diagnosis	Start Date	End Date

Section below to be completed by MQD/CSO Evaluation Panel

Date of Evaluation _____ Date of Enrollment/Disenrollment of CCS Services _____

Approved for CCS Referral: ☐ Yes ☐ No ☐ Additional Information Needed
Re-Evaluation Required: ☐ Yes ☐ No If Yes, date to be re-evaluated: ____/____/____

Reason for denial/comments _____

Signature: _____

Client Name: _____ **Client I.D. No.:** _____

I. **MENTAL STATES**

A. *GENERAL*

1. Appearance: Within normal limits [ ] Other [ ] _____
2. Dress: Appropriate [ ] Bizarre [ ] Clean [ ] Dirty [ ]
3. Grooming: Neat [ ] Disheveled [ ] Needs improvement [ ]

B. *BEHAVIOR*

1. Eye Contact: Good [ ] Fair [ ] Poor [ ]
2. Posture: Good [ ] Slumped [ ] Rigid [ ] Other [ ] _
3. Body Mvemts: None [ ] Involuntary [ ] Akathisia [ ] Other [ ] ____

C. *SPEECH:* Clear [ ] Mumbled [ ] Rapid [ ] Whispers [ ] Monotone [ ]
Slurred [ ] Slow [ ] Loud [ ] Constant [ ] Mute [ ]
Other [ ] _____

D. *MOOD*: Anxious [ ] Fearful [ ] Friendly [ ] Euphoric [ ] Calm [ ]
Aggressive [ ] Hostile [ ] Depressed [ ]
Other [ ] _____

E. *AFFECT:* Full range [ ] Flat [ ] Constricted [ ] Inappropriate [ ]
Other [ ] _____

F. *THOUGHT*

1. Process or Form: Loose associations [ ] Poverty of content [ ] Flight of ideas [ ]
Neologism [ ] Perseveration [ ] Blocking [ ]
2. Content: Delusions [ ] Thought broadcasting [ ] Thought insertion [ ]
Thought withdrawal [ ] Other [ ] _____

G. *PERCEPTION – HALLUCINATIONS:*

Auditory [ ] Tactile [ ] Somatic [ ] Other [ ] _____

H. *REALITY ORIENTATION:*

1. Mark all areas which the recipient can name:
Time: Day [ ] Month [ ] Year [ ]
Place: (can describe location) Yes [ ] No [ ]
Person: Self [ ] Family or friend [ ]
2. Memory: Recent intact? Yes [ ] No [ ] Remote intact: Yes [ ] No [ ]

I. *INSIGHT:* Aware of illness [ ] Denies illness [ ] Other [ ] _____

J. *JUDGMENT:* Good [ ] Fair [ ] Poor [ ]

Client Name: _____ **Client I.D. No.:** _____

II. FUNCTIONAL SCALES: ***(check and specify any problem(s) in the following areas)***

[ ] Medical/Physical _____

_____

[ ] Family/Living _____

_____

[ ] Interpersonal Relations _____

_____

[ ] Role Performance _____

_____

[ ] Socio-Legal _____

_____

[ ] Self-Care/Basic Needs _____

_____

III. **ADDITIONAL COMMENTS:** Please supply any additional information which would be of assistance in reaching a decision with regard to this patient's evaluation.

Signed: _____ Date: _____

Reporting Psychiatrist/Psychologist *(Print Name)*: _____

Reporting Psychiatrist/Psychologist Phone No.: _____

Signed: _____ Date: _____

Medical Director or Attending Physician for in-patients *(Print Name)*: _____

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00001/9**

TITLE: **QUEST Integration Medicaid Section 1115 Demonstration**

AWARDEE: **Hawaii Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration extension be regarded as expenditures under the state's title XIX plan but are further limited by the Special Terms and Conditions (STCs) for the QUEST Integration Section 1115 demonstration.

For enrollees in All Components of the Demonstration:

1. **Managed Care Payments.** Expenditures to provide coverage to individuals, to the extent that such expenditures are not otherwise allowable because the individuals are enrolled in managed care delivery systems that do not meet the following requirements of section 1903(m):

   Expenditures for capitation payments provided to managed care organizations (MCOs) in which the state restricts enrollees' right to disenroll without cause within 90 days of initial enrollment in an MCO, as designated under section 1903(m)(2)(A)(vi) and section 1932(a)(4)(A)(ii)(I) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, as specified at section 1932(a)(4)(A)(ii)(II) of the Act, except with respect to enrollees on rural islands who are enrolled into a single plan in the absence of a choice of plan on that particular island.

   Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section 1932(a)(3) and federal regulations at 42 CFR section 438.52.

2. **Quality Review of Eligibility.** Expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.
3. **Demonstration Expansion Eligibility.** Expenditures to provide coverage to the following demonstration expansion populations:

   a. Demonstration Population 1. Parents and caretaker relatives who are living with an 18-year-old who would be a dependent child but for the fact that the 18-year-old has reached the age of 18, if such parents would be eligible if the child was

under 18 years of age.[1]

b. Demonstration Population 2. Aged, blind, and disabled individuals in the 42 C.F.R. § 435.217 like group who are receiving home- and community- based services, with income up to and including 100 percent of the federal poverty limit using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.

c. Demonstration Population 3. Aged, blind, and disabled medically needy individuals receiving home-and community-based services, who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment, subject to an enrollment fee equal to the spend down liability. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income.

d. Demonstration Population 4. Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance, who would not otherwise be eligible under the state plan, with the same income limit that is applied for Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance agreement under the state plan.

e. Demonstration Population 5. Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program (either Title IV-E assistance or non-Title IV-E assistance) when placed from age 16 to 18 years of age, or would otherwise be eligible under a different eligibility group but for income, and were enrolled in the State plan or waiver while receiving assistance payments.

f. Demonstration Population 6. Individuals who are not otherwise Medicaid eligible and who (i) have aged out of foster care; (ii) were receiving medical assistance under the state plan or the demonstration while in foster care; and (iii) are under age 26. The state will not impose an asset limit on this population. Authority for this demonstration population expires December 31, 2013.

g. Demonstration Population 7. Individuals who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Medicare part A or enrolled for benefits under Medicare part B and are not a mandatory state plan population and whose income (as determined using modified adjusted gross income) does not exceed 133 percent of the FPL, determined using modified

[1] For the period from October 1, 2013 to December 31, 2013, this demonstration expansion population shall not include the parents and caretakers of full time students who are 18 years of age, if these parents and caretakers are covered under the state plan during that time period.

adjusted gross income. Authority for this demonstration population expires December 31, 2013.

4. **Hospital Uncompensated Care Costs.** Expenditures for actual uncompensated care costs incurred by certain hospital providers and nursing facility providers for inpatient and outpatient hospital services and long-term care services provided to the uninsured as well as Medicaid managed care and fee-for-service shortfalls, subject to the restrictions placed on hospital and nursing facility uncompensated care costs, as defined in the STCs and the CMS approved Certified Public Expenditures/Government-Owned Hospital Uncompensated Care Cost Protocol. This expenditure authority is effective through June 30, 2016.

5. **Home and Community-Based Services (HCBS) and Personal Care Services.** Expenditures to provide HCBS not included in the Medicaid state plan and furnished to QUEST Integration enrollees, as follows:

    a. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

    b. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, *i.e.*, the "at risk" population.

    The state may maintain a waiting list, through a health plan, for home and community-based services (including personal care services). No waiting list is permissible for other services for QUEST Integration enrollees.

    The state may impose an hour or budget limit on home and community based services provided to individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "at risk" population), as long as such limits are sufficient to meet the assessed needs of the individual.

6. **Additional Benefits:** Expenditures to provide the following additional benefits.

    a. **Specialized Behavioral Health Services:** The services listed below (and further described in attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
        i. Supportive Housing.
        ii. Supportive Employment.
        iii. Financial management services.
    b. **Cognitive Rehabilitation Services:** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical,

occupational or speech therapist. Services must be medically necessary and prior approved.

c. **Habilitation Services.** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.

7. **Medicaid Eligibility Quality Control.** **Section 1903(u)**

Expenditures that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

All requirements of the Medicaid program expressed in law, regulation, and policy statement shall apply to the demonstration expansion populations, except those expressly identified on the waiver list or listed below as not applicable.

Title XIX Requirements Not Applicable to Demonstration Expansion Populations

Cost Sharing **Section 1902(a)(14) insofar as it incorporates 1916 and 1916A**

To enable the state to charge cost sharing up to 5 percent of annual family income.

To enable the state to charge an enrollment fee to Medically Needy Aged, Blind and Disabled QUEST Integration health plan enrollees (Demonstration Population 3) whose spend-down liability is estimated to exceed the QUEST Integration health plan capitation rate, in the amount equal to the estimated spend-down amount or where applicable, the amount of patient income applied to the cost of long-term care.