State of Hawaii
"QUEST Integration" Section 1115 Demonstration
Section 1115(a) Renewal Application
[*Insert Date*]

Hawaii is pleased to submit this Section 1115(a) renewal application to extend the waiver duration for five more years and to gain approval for innovations outlined in the Hawaii 'Ohana Nui Project Extension (HOPE). In an effort to provide the Centers for Medicare & Medicaid Services (CMS) with the information in a helpful format, this application generally follows the Section 1115 Demonstration Program Template recently published by CMS. Because the template is designed for new demonstration applications, not renewals or extensions, Hawaii modified the template and added content to comply with the extension application requirements in 42 C.F.R. § 431.412(c). Hawaii has not listed the template's specific questions in this application, but has included content that addresses each question in the corresponding template section, to the extent the questions are applicable to this application or renewals generally. The State looks forward to working with CMS to renew this longstanding Section 1115 demonstration.

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Attachments
[PLACE HOLDER]

A. Summaries of EQRO Reports and Quality Assurance Monitoring, and Other Information and Documentation Regarding Quality of and Access to Care

B. Interim Demonstration Evaluation Report

C. Hawaii Med-QUEST Division Quality Strategy

D. CMS-416 Forms

E. Benefit Specifications and Provider Qualifications Forms; Long Term Services Benefit Specifications and Provider Qualifications Forms

F. Behavioral Health Protocol

G. Budget Neutrality Charts

H. for E-mail Notice

I. Abbreviated Public Notice

J. Full Public Notice Document

K. Tribal Notice

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I. Introduction:

Pursuant to Section 1115(a) of the Social Security Act, and as authorized by Section 1915(h)(2), the State of Hawaii, Department of Human Services (the State), is seeking a five-year renewal of the QUEST Integration Section 1115 demonstration project from CMS. Absent a renewal, the demonstration will expire on December 31, 2018

For nearly two decades, Hawaii's demonstration has efficiently and effectively delivered comprehensive benefits to a large number of beneficiaries, including expansion populations, through competitive managed care delivery systems. Under the renewal, "QUEST Integration" (QI) continues to build on this success by delivering services through managed care, while integrating the demonstration's programs and benefits to have a more patient-centered care delivery system and alignment of the demonstration with applicable requirements. All eligible beneficiaries will continue to be enrolled under QUEST Integration, and access to services will be determined by clinical criteria and medical necessity. The renewal continues to incorporate the simplified Medicaid eligibility structure under ACA into Hawaii's demonstration.

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

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

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

In order to accomplish the vision and goals, HOPE activities are focused on four strategic areas.

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

In addition, HOPE activities are supported by initiatives that enhance three foundational building blocks.

- Health information technology that drives transformation.
- Increase workforce capacity and flexibility.
- Performance measurement and evaluation.

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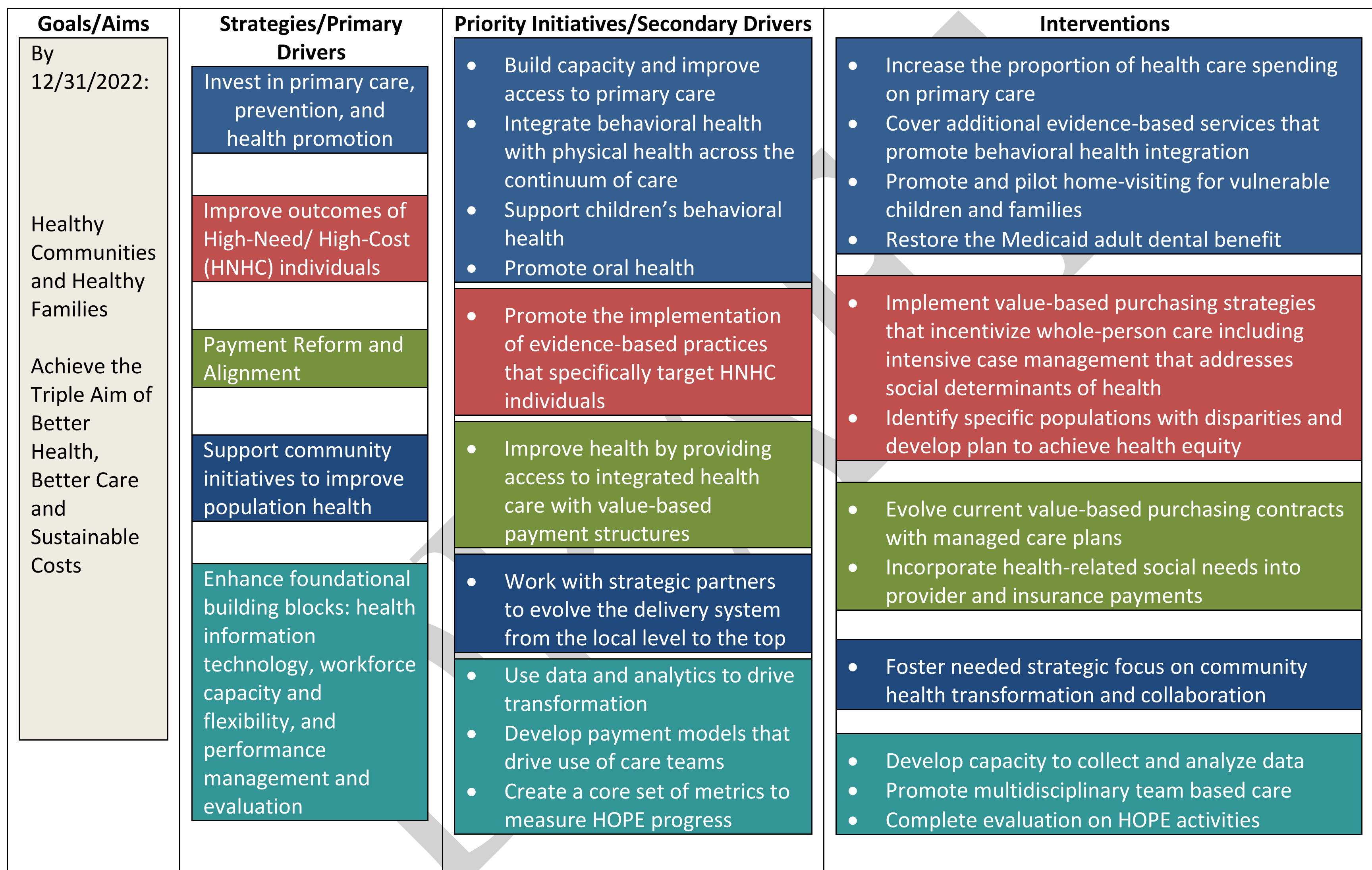
Figure 1: HOPE Driver Diagram



II. The Current Demonstration - QUEST Integration

A. Historical Narrative:

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

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

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

Since its implementation, the State has made many changes to the demonstration:

1. The first amendment, approved July 11, 1995, allowed the State to deem parental income for tax dependents up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing for expansion populations, impose a premium for self-employed individuals, and change the fee-for-service (FFS) window from the date of coverage to the date of enrollment.

2. The second amendment, approved on September 14, 1995, allowed the State to cap QUEST enrollment at 125,000 expansion eligibles.

3. The third amendment, approved on May 10, 1996, allowed the State to reinstate the asset test, establish the QUEST-Net program, and require participants to pay a premium.

4. The fourth amendment, approved on March 14, 1997, lowered the income thresholds to the mandatory coverage groups and allowed the State to implement its medically needy option for the AFDC-related coverage groups for individuals who become ineligible for QUEST and QUEST-Net.

5. The Fifth Amendment, approved on July 29, 2001, allowed the State to expand the QUEST-Net program to children who were previously enrolled in SCHIP, when their family income exceeds the Title XXI income eligibility limit of 200% of the federal poverty level (FPL).

6. In January 2006, the CMS approved an extension (with a retroactive start date of July 1, 2005) of the Section 1115 waiver for the demonstration, which incorporated the existing program with some significant changes, including:

    - Extension of coverage to all Medicaid-eligible children in the child welfare system;

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- Extension of coverage to adults up to 100% of the FPL who meet Medicaid asset limits through QUEST-ACE;
- Elimination of premium contributions for children with income at or below 250% of the FPL;
- Elimination of the requirement that children have prior QUEST coverage as a condition to qualifying for QUEST-Net; and
- Increase SCHIP eligibility from 200% of the FPL to 300% of the FPL.

7. In February 2008, the demonstration was renewed, and as part of the renewal the State implemented the QUEST Integration program and increased the eligibility level for QUEST-ACE from 100% to 200% of the FPL.

8. In April 2012, CMS approved the State's request to limit eligibility for non-pregnant, nondisabled adults not otherwise Medicaid eligible at 133% of the FPL.

9. In June 2012, CMS approved an amendment to align QUEST-Net and QUEST-ACE benefits with the QUEST benefits package, and to add certain benefits to the QExA benefit package.

10. In March 2013, CMS approved the State's request to expand coverage to former foster children under age 26 years with income up to 300 percent of the federal poverty level (FPL).

11. In June 2013, CMS approved the early adoption of the modified adjusted gross income (MAGI)-based eligibility determination methods effective October 1, 2013.

12. In September 2013, the demonstration was renewed, and as part of the renewal the State implemented the QUEST Integration program.

13. In March 2014, CMS approved the State's request to provide coverage under the adult group described at 42 C.F.R. 435.119, to individuals enrolled in the state's QUEST Integration Section 1115 demonstration program.

B. Overview of QUEST Integration Today:

QUEST Integration (QI) delivers most benefits through capitated managed care by offering a more patient centric Medicaid program to better serve our beneficiaries and utilize FFS for long-term supports and services for individuals with developmental or intellectual disabilities, applicants eligible for retroactive coverage only, medically needy non Aged Blind and Disabled (ABD) individuals, and medical services under the State of Hawaii Organ and Tissue Transplant (SHOTT) program, as well as for certain other benefits.

During the last demonstration waiver period, July 1, 2013 through December 31, 2018, QUEST Integration successfully implemented managed care for almost 99% of our Medicaid population. With the addition of the Affordable Care Act (ACA), Hawaii increased the number of individuals eligible for medical assistance by using Modified Adjusted Gross Income (MAGI) methodology to determine income eligibility for families with dependent children up to 100% of the FPL under Section 1931 of the Social Security Act; Low Income Adults up to 133% of the FPL; Pregnant Women up to 191% of the FPL; Children up to 308% of the FPL;

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and Former Foster Care children with no income limit. Individuals who were eligible under Section 1931 of the Act with increased earnings may qualify for a twelve month period of transitional medical assistance under Section 1925 of the Social Security Act. MAGI methodology also exempts assets.

Currently, Hawaii residents may become eligible for QUEST Integration through many programs, including various groups within the ABD population, such as institutionalized individuals who meet the eligibility requirements in the State plan; non-institutionalized individuals would meet the State plan eligibility requirements if they were living in an institution; ABD individuals who meet the SSI standards; and medically needy ABD individuals who meet the medically needy household income standards using SSI methodology. With the addition of new ACA provisions, total enrollment has grown to over 360,000 Medicaid beneficiaries.

C. QUEST Integration Evaluation Report, Summaries of EQRO Reports, MCO and State Quality Assurance Monitoring, and Other Information About Quality of Care and Access to Care Provided Under the Demonstration: [place holder]

III. Program Description - QUEST Integration

A. QUEST Integration Summary and Objectives:

Hawaii seeks a five-year renewal of its Section 1115 demonstration waiver for the period January 1, 2019 through December 31, 2024. The waiver will continue to operate statewide.

This renewal seeks to continue QUEST Integration (QI) which shall continue to build on the success by delivering services through managed care, while integrating the demonstration's programs and benefits to have a more patient-centered care delivery system and alignment of the demonstration with applicable requirements. All eligible beneficiaries will continue to be enrolled under QUEST Integration, and access to services will be determined by clinical criteria and medical necessity.

The goal of HOPE initiative is to achieve the Triple Aim of better health, better care, and sustainable costs for our community. Within five years, MQD anticipates that the investments in healthy families and healthy communities will translate to improved health and well-being, measurably lower prevalence of illness, and a more sustainable growth rate in healthcare spending. The goal is to bring the growth of health care spending more closely in line with the growth of our economy, so that we can invest a greater share of our productivity gains in education, housing and other priorities that have an even greater impact on health and well-being than the Medicaid delivery system.

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More specifically, the goals include:

Improved Health	Better Health Care and Consumer Experience	Lower Costs
Achieve or maintain top-quartile performance among states for adoption of best practices for outcomes in: • Health • Wellness • Disease prevention • Health improvement • Health-related social needs	Achieve high standards for quality and patient experience, including at least: • A X% (percent TOBD) reduction in the risk factors associated with chronic conditions • An increase in appropriate utilization of behavioral health services • Decrease in preventable utilization for individuals with chronic conditions.	Generate $[number TBD] in cumulative savings by: • Reducing unnecessary care • Shifting care to appropriate settings • Curbing increases in unit prices for health care products and services that are not tied to quality.

B. Description of Established Policies to Remain Unchanged

1. QUEST Integration Programs and Streamline Eligibility:

QI will continue the current programs and provide all beneficiaries enrolled under the demonstration with access to a single benefit package, of which access to certain services will be based on clinical criteria and medical necessity. The current programs will continue to ease administrative burdens, streamline the enrollment process, and facilitate access to care for enrollees with changing health status.

2. Utilize Capitated Managed Care to Deliver High-Quality, Cost- Effective Care:

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

The State plans to continue to provide most benefits through capitated managed care and mandate managed care enrollment for most beneficiaries, which will require waiver authority. The State will use a FFS system for long-term care services for individuals with developmental or intellectual disabilities, applicants eligible for retroactive coverage only, medically needy non- ABD individuals, and medical services under the SHOTT program, among other services.

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3. Health Plan Enrollment and Selection:

In an effort to balance beneficiary choice with service coordination and continuity, QI will continue the enrollment and health plan selection process.

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

All individuals will have a single 60-day period from their initial enrollment action to change their health plan. That is, an individual who chooses a health plan either at the time of eligibility notification or during the 15-day choice period, or switches health plans during the annual open enrollment, will have an additional 60-day period from the enrollment action to change plans.

Similarly, an individual who is auto-assigned for not selecting a health plan upon eligibility notification and during the 15-day choice period will also have 60 days from the auto-enrollment action to change health plans. An individual enrolled in a health plan who chooses to remain in that plan during the annual open enrollment will not be given a 60-day change period. Individuals will be able to change health plans for cause at any time. These rules apply to all enrollees, including ABD enrollees.

After a beneficiary selects a health plan, he or she will receive a survey or a welcome call from the health plan, which will identify if the beneficiary has any special health needs. A welcome call will be required for those who do not respond to the survey if applicable. If special health needs are identified, the health plan will assign a licensed or qualified professional as the beneficiary's service coordinator and perform a face-to-face assessment. In addition, health plans will still be required to perform a face-to-face assessment on individuals with identified special health care needs, such as those receiving long-term services and supports (LTSS). In the current demonstration, health plans are required to perform face-to-face assessments on initial enrollment for certain populations. Hawaii found that this requirement results in unnecessary assessments of individuals who do not have special health needs, and it is implementing the survey/welcome call process in an effort to identify enrollees' special health needs more efficiently.

4. Encourage Timely Enrollment By Limiting Retroactive Eligibility:

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

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

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the State.

For individuals applying for LTSS, Hawaii will continue to provide retroactive eligibility for up to three months. The State believes that there are unique issues implicated for individuals receiving LTSS that warrant continuing the more lenient retroactive eligibility rules.

5. Benefit Package, Expand Home and Community-Based Services (HCBS), and Offer Needs-Based HCBS to "At Risk" Enrollees

Under the QI demonstration one comprehensive set of benefits will continue to be available to all demonstration populations. The QI benefit package will include benefits consisting of full State plan benefits and will offer certain additional benefits based on medical necessity and clinical criteria. Structuring the benefits in this manner will help ensure that beneficiaries have access to all the services they need, even when their needs change, and will ease the administrative burden on the State.

The State will continue its robust and successful HCBS program, providing access to a comprehensive package of benefits for individuals who meet institutional level of care and are able and choose to receive care at home or in the community. In addition, the State will continue its efforts to expand access to HCBS by providing a set of HCBS to individuals who are assessed to be at risk of deteriorating to the institutional level of care (the "at risk" population).

The State continues to offer the following benefits, subject to clinical criteria and medical necessity:

- Cognitive rehabilitation therapy (either through the demonstration or the State plan).
- Covered substance abuse treatment services provided by a certified (as opposed to licensed) substance abuse counselor.
- Specialized behavioral health services (Clubhouse, Peer Specialist, Representative Payee, Supportive Employment, and Supportive Housing) for qualified individuals with a Serious and Persistent Mental Illness (SPMI), Severe Mental Illness (SMI), or requiring Support for Emotional and Behavioral Development (SEBD).

6. Continue Coverage of Certain Non-Medicaid Beneficiaries:

There are groups of individuals Hawaii is requesting waiver or expenditure authority to cover, including individuals who would be eligible under 42 C.F.R. § 435.217 if Hawaii offered its HCBS through a Section 1915(c) waiver, medically needy individuals receiving HCBS through the demonstration, and young adults formerly receiving adoption assistance or kinship guardianship assistance.

C. QUEST Integration Hypotheses, Evaluation Plans, and Evaluation Design:

The State's continuing goal is to ensure that our beneficiaries receive high quality care by providing effective oversight of health plans and contracts to ensure accountable and

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transparent outcomes. The State has adopted the Institute of Medicine's framework of quality, ensuring care that is safe, effective, efficient, customer-centered, timely, and equitable.

Waiver Renewal Hypotheses

The waiver is a vehicle to test new delivery and payment innovations, and MQD will continue to test two overarching hypotheses about its demonstration. (Note that these hypotheses are preliminary and may change during the waiver renewal process.)

- Capitated managed care delivers high quality care, while also slowing the rate of health care expenditure growth; and
- Capitated managed care provides access to HCBS and facilitates rebalancing of provided LTSS.

In addition, MQD will test the following overarching hypotheses about the proposed changes:

- Further integration of physical, behavioral, and oral health care will result in reduced growth of encounter-based spending and improved quality of care, access to care, and health outcomes for QUEST members.
- Increased focus on social determinants of health will result in improved population health outcomes as evidenced by a variety of health indicators.
    - Screening for health-related social needs and referrals/connections to resources such as housing supports.
    - Expansion and increased use of health-related social services will result in improved care delivery and member health and community-level health care quality improvements.
- A focus on health equity improvements for specific populations that have experienced disproportionately poor health outcomes will result in improved health outcomes, increased access to care, and a reduction in the gap between outcomes for populations of focus and those that historically experienced favorable health outcomes.
- Adoption and use of value-based payment arrangements will align MCO and their providers with health system transformation objectives and lead to improvements in quality, outcomes, and lowered expenditures.
- A move towards more outcomes-based measures that are tied to incentive programs will improve quality of care, advance state and MCO priorities (e.g. behavioral health and health equity), increased regional collaboration, and improve coordination with other systems (e.g. hospitals).
- Emphasis on homeless prevention, care coordination and supportive housing services for vulnerable and at-risk adults and families will result in reduction in avoidable hospitalizations and unnecessary medical utilization (e.g. lower emergency department utilization), transitions to more appropriate community-based settings, increased access to social services, reduction in overall Medicaid costs, and improved regional infrastructure and multi-sector collaboration.

These hypothesis collectively are focused on improving the Triple Aim of better health, better care and sustainable costs – the primary focus of the demonstration renewal.

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IV. Demonstration Eligibility

A. Affected Populations

Hawaii plans to cover the following groups in QUEST Integration:

Mandatory State Plan Groups		
Eligibility Group Name	**Authority**	**Income Level and Other Qualifying Criteria**
Parents or caretaker relatives	§1902(a)(10)(A)(i)(I), (IV), (V) § 1931(b), (d) 42 C.F.R.§ 435.110	Up to and including 100% FPL
Pregnant Women	§1902(a)(10)(A)(i)(III)-(IV) 42 C.F.R. § 435.116	Up to and including 191% FPL
Poverty Related Infants	§ 1902(a)(10)(A)(i)(IV) § 1902(l)(1)(B) 42 C.F.R. § 435.118(c)	Infants up to age 1, up to and including 191% FPL
Poverty Related Children	§1902(a)(10)(A)(i)(VI)-(VII) §1902(l)(1)(C)-(D) 42 C.F.R. §435.118(a)	Children ages 1 through 18, up to and including 133% FPL
Low Income Adult Age 19 Through 64 Group	§1902(a)(10)(A)(i)(VIII) 42 C.F.R. §435.119(b)	Up to and including 133% FPL
Former Foster Children under age 26	§1902(a)(10)(A)(i)(IX)	No income limit
SSI Aged, Blind, or Disabled	§1902(a)(10)(A)(i)(II)(aa), as qualified by Section 1902(f) 42 C.F.R. §435.121	SSI-related using SSI payment standard
Section 1925 Transitional Medicaid, Subject to Continued Congressional Authorization	§1925 §1931(c)(2)	Coverage for one twelve month period due to increased earnings, or for four months due to receipt of child support, that would otherwise make the individual ineligible under Section 1931

Optional State Plan Groups		
Eligibility Group Name	**Authority**	**Income Level and Other Qualifying Criteria**
Aged or Disabled	§1902(a)(10)(ii)(X) §1902(m) 42 C.F.R. § 435.230(c)(vi)	SSI-related net income up to and including 100% FPL
Optional targeted low- income children	§1902(a)(10)(A)(ii)(XIV) Title XXI 42 C.F.R. § 435.229	Up to and including 308% FPL including for children for whom the State is claiming Title XXI funding
Certain Women Needing Treatment for Breast or Cervical Cancer	§1902(a)(10)(A)(ii)(XVIII) §1902(aa)	No income limit; must have been detected through NBCCEDP and not have creditable coverage
Medically Needy Non- Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. § 435.301(b)(1) 42 C.F.R. §435.308 42 C.F.R. § 435.310	Up to and including 300% FPL, if spend down to medically needy income standard for household size

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Medically Needy Aged, Blind, or Disabled Children and Adults	§1902(a)(10)(C) 42 C.F.R. §§435.320, 435.322, 435.324, 435.330	Medically needy income standard for household size using SSI methodology

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

B. Methodologies for Determining Eligibility:

QUEST Integration will continue to utilize Modified Gross Income (MAGI) to the extent required by applicable law and regulations, which will include not having an asset test. Other than the use of MAGI methodology, there will be no changes in eligibility methodology. Eligibility for the Aged, Blind and Disabled groups will continue to be determined using current income and resource methodologies.

C. Eligibility and Enrollment Limits:

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

D. Projected Eligibility:

From July 1, 2016 to June 30, 2017, there was an average of 361,920 individuals enrolled in the current demonstration (and covered in part by a federal match). During the five-year renewal period, the annual increase in enrollment is expected to be 2.03% per year for non-ABD recipients and 2.10% for ABD recipients, or approximately 7,129

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recipients per year for the existing population. In addition, 24,000 recipients may become eligible under the new ACA eligibility guidelines.

D. Post Eligibility Treatment of Income

There will be no changes in the demonstration's treatment of post-eligibility income. All individuals receiving nursing facility services will be subject to the post-eligibility treatment of income rules set forth in Section 1924 and 42 C.F.R. § 435.733. The application of beneficiary income to the cost of care will be made to the nursing facility. Individuals receiving HCBS will be subject to the post-eligibility treatment of income rules set forth in Section 1924 of the Social Security Act and 42 C.F.R. § 435.735, if they are medically needy who would be eligible for Medicaid if institutionalized as set forth in 42 C.F.R § 435.217.

V. Demonstration Benefits and Cost Sharing Requirements:

A. QUEST Integration Benefits

Under QUEST Integration (QI), Hawaii will continue to provide one comprehensive set of benefits available to all demonstration populations. Hawaii will continue to offer one primary and acute care services package consisting of full State plan benefits to all demonstration populations, with certain additional benefits available based on clinical criteria and medical necessity. This benefit structure will be easier for beneficiaries to navigate, better equipped to serve patients with changing needs, and less burdensome for the State to administer.

Individuals who meet institutional level of care ("1147 certified") will have access to a wide variety of Long Term Support Services, including specialized case management, home maintenance, personal assistance, adult day health, respite care, and adult day care, among others. Moreover, Hawaii will provide Home and Community Based Services (HCBS) to certain individuals who are assessed to be at risk of deteriorating to institutional level of care, in order to prevent a decline in health status and maintain individuals safely in their homes and communities. These individuals (the "at risk" population) will have access to a set of HCBS that includes personal assistance, adult day care, adult day health, home delivered meals, personal emergency response system (PERS) and skilled nursing, subject to limits on the number of hours of HCBS or the budget for such services.

Hawaii also will continue to include in the QI benefit package the following benefits, subject to clinical criteria and medical necessity:

- Cognitive rehabilitation therapy (either through the demonstration or the State plan).
- Covered substance abuse treatment services provided by a certified (as opposed to licensed) substance abuse counselor.
- Specialized behavioral health services (Clubhouse, Peer Specialist, Representative Payee, Supportive Employment, and Supportive Housing) for qualified individuals with an SPMI, SMI, or SEBD (either through the demonstration or the state plan).

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The following chart specifies the benefit package that all QI eligibility groups will receive:

QUEST Integration Benefit Package Chart

Standard Benefit Plan	
Full State Plan Benefits	
Additional Benefits Based on Level of Need	
Level of Need	**Benefits**
If medically necessary	• Cognitive rehabilitation therapy (either through 1115 or State Plan). • Covered substance abuse treatment services provided by a certified substance abuse counselor. • Specialized behavioral health services (Clubhouse, Peer Specialist, Representative Payee, Supportive Employment, and Supportive Housing) for qualified individuals with an SPMI, SMI, or SEBD (either through the demonstration or the State plan).
Individuals who are assessed to be at risk of deteriorating to institutional level of care (“at risk” population)	• HCBS: o Personal assistance o Adult day care o Adult day health o Home delivered meals o Personal emergency response system (PERS) o Skilled nursing
Individuals who meet institutional level of care (“1147 certified”)	• HCBS:* o Adult day care Adult day health o Assisted living facility o Community care foster family homes o Counseling and training o Environmental accessibility adaptations o Home delivered meals o Home maintenance o Moving assistance o Non-medical transportation o Personal assistance o Personal emergency response system (PERS) o Residential care o Respite care o Skilled nursing o Specialized case management o Specialized medical equipment and supplies *Room and board is not a covered HCBS.

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Hawai‘i will request additional flexibility to make the following **targeted changes** in the waiver renewal**:**

- Increase the proportion of health care spending on primary care in order to promote the health system’s orientation toward high-value care.
- Continue to promote further developments in value-based purchasing and alternative payment methodologies.
- Promote best practices that address the needs of HNHC individuals (i.e. care coordination, palliative care, Dr. Ornish’s Program for Reversing Health Disease).
- Promote primary care and pay for value. Hawai‘i will request to advance the use of value-based payments to MCOs. MQD will request to provide new performance incentive payments to primary care providers.
- Cover additional evidence-based services that further integrate physical and behavioral health services such as the Collaborative Care Model.
- Promote increased investments in health related and flexible services.
- MCOs will be encouraged to invest in services that improve quality and outcomes, and MCOs that reduce costs through the use of these services can receive financial incentives to offset those cost reductions.
- Support workforce development efforts such as Project ECHO, a teaching program for providers

B. Access to Long Term Services and Supports (LTSS)

1. Choice of Institutional Services or Home and Community Based Services (HCBS)

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

The State’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.

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

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2. Election of HCBS

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

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

If the estimated costs of providing necessary HCBS to the beneficiary **exceed** the estimated costs of providing necessary care in an institution (hospital or nursing facility), a health plan may refuse to offer HCBS if the State or its independent oversight contractor so approves. In reviewing such a request by a health plan, the State will take into account the health plan's aggregate HCBS costs as compared to the aggregate costs that it would have paid for institutional care. Although the intent of HCBS is to utilize social supports, the State recognizes and seeks to accommodate temporary medical or social conditions that require additional services. Accordingly, adults will be able to receive up to 90 days per benefit period of 24 hours of HCBS per day.

3. 1915(c) DD/ID Waiver Enrollee:

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

4. Waiting List for HCBS:

The State requests authority to allow the QI health plans to establish waiting lists, upon approval by the State, for the provision of HCBS. Waiting list policies will be based on objective criteria and applied consistently in all geographic areas served. The State will monitor the waiting lists on a monthly basis, and will meet with the health plans on a quarterly basis to discuss any issues associated with management of the waiting lists. Members who are on a waiting list may opt to change to another health plan if it appears that HCBS are available in the other health plan.

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C. Access to Behavioral Benefits

QUEST Integration will continue to provide a full array of standard behavioral health services through managed care. It will also continue to offer additional, specialized behavioral health services covered under this demonstration as described above or under the State plan. Children requiring SEBD will receive specialized behavioral health services through the Hawaii Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD).

Qualified adults with a SPMI or SMI will receive specialized behavioral health services through either the DOH Adult Mental Health Division (AMHD), health plan, or behavioral health organization also referred to as the Community Care Services (CCS) program. Regardless of how adults access the specialized behavioral health services, all adults will have access to the same services. The State assures there will be no duplication of specialized behavioral health services. The State intends to transition all adults to receive specialized behavioral health services through the CCS program by the completion of the waiver period.

D. Premium Assistance, Premiums, and Cost Sharing

The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan.

The State will not charge any premiums, and co-payments may be imposed as set forth in the Medicaid state plan.

VI. Delivery System and Payment Rates for Services:

A. Delivery System for Demonstration Benefits:

The delivery system used to provide benefits for the Quest Integration (QI) demonstration will differ from Hawaii's State plan in that the vast majority of benefits will be provided through managed care, as opposed to Fee-For-Service (FFS). A statewide managed care delivery system will help Hawaii ensure access to high-quality, cost-effective care; establish contractual accountability among the health plans and health care providers; and continue the predictable and slower rate of expenditure growth associated with managed care. Savings generated from the managed care delivery system allows coverage of expansion populations.

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

- Long Term Services and Supports (LTSS) for individuals with developmental disabilities or intellectual disabilities, under the State's Section 1915(c) waiver.
- Intermediate Care Facilities for the Intellectually Disabled (ICF-ID), because this is a specialized program administered by another State department.
- Medical services to applicants eligible for retroactive coverage only, because there is no opportunity to manage care and it is for a very small population.

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- Medical services under the SHOTT program, because this is a specialized program serving a small population that incurs very high costs.
- Medical services to medically needy individuals who are not Aged, Blind and Disabled (ABD), because of the actuarial difficulty associated with a small volume of people that negatively affects capitation rates.
- Dental services, because these are specialized services.
- Targeted Case Management, School-based services, and Early Intervention Services, because those programs are administered by another State department.

The FFS payments will not deviate from State plan provider rates.

The following table depicts the delivery system for each benefit offered through QUEST Integration.

Benefits	Delivery System	Authority
State plan services	Managed Care - MCO	1115
QUEST Integration LTSS	Managed Care - MCO	1115
Cognitive rehabilitation therapy	Managed Care - MCO	1115 or State plan
Medical services to medically needy individual who are ABD	Managed Care - MCO	1115
Medical services to medically needy individuals who are non-ABD	Fee-for-service	1115
LTSS for individuals with developmental disabilities or intellectual disabilities	Fee-for-service	1915(c)
Intermediate Care Facilities for the Intellectually Disabled	Fee-for-service	State plan
Medical services to applicants eligible for retroactive coverage only	Fee-for-service	1115
Medical services under the SHOTT program	Fee-for-service	State plan
Dental services	Fee-for-service	State plan
Targeted Care Management	Fee-for-service	State plan
School-based services	Fee-for-service	State plan
Early Intervention Services	Fee-for-service	State plan
Covered substance abuse treatment services provided by a certified substance abuse counselor	As described in the behavioral health protocol	1115
Specialized behavioral health services for qualified individuals with a SPMI, SMI, or SEBD	As described in the behavioral health protocol	1115 or State plan

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B. QUEST Integration Health Plan Enrollment and Selection:

For information about health plan enrollment and selection, please see Section III.B.3.

C. Limitation on Retroactive Eligibility:

For information about retroactive eligibility, please see Section III.B.4.

D. Contracting Policies with the QUEST Integration Health Plans:

Under the QUEST Integration (QI) demonstration, all contracts and modifications of existing contracts between the State and the health plans will be approved by Centers for Medicare and Medicaid Services (CMS). Hawaii will provide CMS with at least 45 days to review any changes. The 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, and include other goals defined by the State and sanctions for non- performance. Should the health plans be awarded financial incentives for meeting State goals, the health plans will be required, as determined appropriate by federal and state law, to share a portion of any bonuses with providers.

Hawaii will procure the QI program under Section 103F of the Hawaii Revised Statutes. The procurement process includes the issuance of a Request for Information to provide an opportunity for stakeholders and other interested parties to provide input into the development of the Request for Proposals (RFP). Proposals submitted in response to the RFP are evaluated in compliance with State procurement requirements.

E. Medically Needy Non-ABD Individuals:

Medically needy non Aged, Blind and Disabled (ABD) individuals will not be enrolled in a QI health plan and will be subject to the medically needy spend-down. They will receive services on a Fee For Service basis. This category might include, for example, persons who become medically needy for a short-term period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically. This unpredictability (which is different than for ABDs, who typically become medically needy due to long-term care needs) can skew health plan capitation rates if included.

F. Medically Needy ABD Individuals:

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

G. Dual Eligible Beneficiaries:

Dual eligible individuals may be enrolled in a CMS-approved demonstration to integrate care for Medicare and Medicaid enrollees (MME), and may be subject to the terms of that demonstration. The State seeks to nest the MME demonstration within this 1115 demonstration and utilize the QI health plans to provide the Medicare benefits to

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their MME members.

H. Self-Direction Opportunities:

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

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

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

Beneficiaries will have the ability to hire family members (including spouses, children, and parents for beneficiaries over eighteen years of age), neighbors, and friends, as service providers. Beneficiaries may not hire their surrogate as their service provider. For family members to be paid as providers of self-directed services, the services cannot be an activity that the service provider would ordinarily perform as a family member. Self-direction service providers are not required to be part of the health plans' provider network. However, service providers will sign an agreement that specifies their responsibilities in provision of services to the beneficiary.

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

I. Additional Hospice Payment for Nursing Facility Residents:

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

J. Payment Rates

Rates will be developed in accordance with the Code of Federal Regulations, 42 C.F.R. § 438.6(c), and CMS's Appendix A, PAHP, PIHP and MCO contracts Financial Review Documentation for At-risk Capitated Contracts Rate setting. Rate development is based on recent experience data and is consistent with guidelines as set forth by the

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American Academy of Actuaries.

1. Quality-Based Supplemental Payments:

Value-driven health care is a payment methodology to providers that incorporates both quality and efficiency. Hawaii will require the QUEST Integration health plans to implement value-driven health care in their contracts with providers. This payment reform may include, but not be limited to, different reimbursement strategies such as Fee For Services FFS with incentives for performance, capitation payment to providers with assigned responsibility for patient care, or a hybrid. Measures used must be evidence-based and validated.

VII. Implementation of Demonstration:

The QUEST Integration (QI) renewal process itself and accompanying public input procedures have helped provide notice to beneficiaries of the future changes. In addition, demonstration beneficiaries will receive notice about the changes at various points of contact with the Med-QUEST Division and the health plans. Beneficiaries will also be informed of any changes that directly impact their eligibility or benefits.

For information about the contracting and procurement policies in QIplease see Section VI.D.

Beneficiaries will be enrolled pursuant to the enrollment and health plan selection process described in Section III.B.3. Upon a change in the number of health plans in which a beneficiary can choose to enroll, beneficiaries will be afforded the opportunity to change health plan and choose among all available health plans. For those who do not make a choice, every effort will be made to retain beneficiaries to the extent possible in the health plan with which they have an existing relationship.

VIII. Demonstration Financing and Budget Neutrality:

From July 1, 2014 to June 30, 2017, there was an average of 305,422 individuals enrolled in the demonstration (and covered in part by a federal match). During the five-year renewal period, the annual increase in enrollment is expected to be 3% per year for non-ABD recipients and 1.2% for ABD recipients, or approximately 8,200 recipients per year for the existing population.

Total aggregate expenditures for each renewal year are anticipated to be $2.2 billion in both State and federal funding. That is, the State expects costs due to required federal provisions, coupled with other State-requested changes to the demonstration, to result in approximately $400 million in increased State and federal annual expenditures during the renewal period.

The demonstration will be financed by a combination of State dollars and federal matching funds.

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IX. List of Proposed Waivers and Expenditure Authorities:

A. Waiver Authority

The State believes the following waiver authorities will be necessary to authorize the demonstration.

1. Medically Needy - Section 1902(a)(10)(C); Section 1902(a)(l7)

   To enable the State to limit medically needy spend-down eligibility to those non-ABD individuals whose gross incomes, before any spend-down calculation, are at or below 300% of the Federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which has no gross income limit.

2. Amount, Duration, and Scope - Section 1902(a)(10)(B)

   To enable the State to offer demonstration benefits that may not be available to all categorically eligible or other individuals.

   To enable the State to maintain waiting lists, through a health plan, for home and community-based services. No waiting list is permissible for other services for health plan enrollees.

   To enable the State to impose an hour or budget limit on the home and community-based services provided to the "at risk" population.

3. Retroactive Eligibility - Section 1902(a)(34)

   To enable the State to limit retroactive eligibility to a ten (10) day period prior to application, or up to three months for individuals requesting long- term care services. Individuals will be considered eligible for any portion of the 10-day retroactive period that extends into a month prior to the month for which determined eligible.

4. Freedom of Choice - Section 1902(a)(23)

   To enable Hawaii to restrict the freedom of choice of providers to groups that could not otherwise be mandated into managed care under Section 1932.

B. Expenditure Authorities:

The State believes the following expenditure authorities will be necessary to authorize 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):

   a) Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to

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disenroll without cause to within 60 days of initial enrollment in an MCO, as opposed to the 90 days designated under Section 1903(m)(2)(A)(vi) and Section 1932(a)(4)(A)(ii)(I) of the Social Security 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 health plan in the absence of a choice of health plan on that particular island.

b) Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more health plans, as required under Section 1903(m)(2)(A)(xii), Section 1932(a)(3) and Federal regulations at 42 C.F.R. § 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 Eligibility. Expenditures to provide coverage to the following populations:

a. Parents or caretaker relatives who would otherwise be eligible if the dependent child was under 18 years of age.

b. Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

c. 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 estimated to exceed the amount of the health plan capitation payment, subject to an enrollment fee equal to the spend-down liability.

d. Individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance.

e. Individuals who are younger than 26, aged out of the adoption assistance program or the kinship guardianship assistance program, are not eligible under any other eligibility group, and were enrolled in the State plan or waiver while receiving assistance.

4. Home and Community-Based Services (HCBS). 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 health plans, that

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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 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.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable, will apply to the demonstration beginning January 1, 2014, through December 31, 2018, except those waived or listed below as not applicable.

C. Title XIX Requirements Not Applicable to Demonstration Populations:

The State believes the following Medicaid requirement will need to be deemed not applicable to demonstration populations.

1. Cost Sharing - Section 1902(a)(14)

To enable the State to charge cost sharing with limits on cost-sharing amounts but no aggregate limit. To enable the State to charge an enrollment fee to Medically Needy Aged, Blind and Disabled health plan enrollees whose spend-down liability or cost share obligation is estimated to exceed the health plan capitation rate, in the amount equal to the estimated spend-down or cost share amount or, where applicable, the amount of patient income applied to the cost of long-term care.

X. Public Notice:

A. The State's Public Notice and Input Efforts
[Place holder: Insert Public Notice and Input Efforts]

B. Issues Raised by the Public and the State's Consideration of Those Issues
[Place holder: Insert Feedback]

C. Tribal Consultation

[Place holder: Insert Feedback]

D. The Post-Award Public Input Process

The State will comply with the post-award public notice and input procedures in 42 C.F.R. §431.420(c). Within six months of implementation of the renewal, and annually thereafter, the State will hold a public forum to solicit public comments on the progress of QUEST Integration, at which the public will have an opportunity to comment. The State will publish the date, time, and location of the public forum in a prominent location on its web site at least 30 days prior to the date of the public forum. The State will hold the forum at such time as to enable it to include a summary of the forum in the quarterly report associated with the quarter in which the forum will be held, as well as in its annual report to CMS.

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XI. Demonstration Administration

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