
Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to:

StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):

January 1, 2026 – December 31, 2026

2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* January 1, 2026

3. Identify the managed care program(s) to which this payment arrangement will apply:

This pre-print affects hospital payments for services covered by the QUEST-Integration (QI) program.

4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: \$423.66M

- a. Identify the estimated federal share of this state directed payment: \$309.59M

- b. Identify the estimated non-federal share of this state directed payment: \$114.07M

Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No
6. If this is not the initial submission for this state directed payment, please indicate if:
- a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.
 - b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.
 - i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
This preprint has been approved by CMS for the CY 2023, CY 2024, and CY2025 rating periods (where the CY 2025 preprint is the “grandfathered” directed payment arrangement under H.R. 1 and per CMS guidance).
 - c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
 - ☐ Payment Type Change
 - ☐ Provider Type Change
 - ☒ Quality Metric(s) / Benchmark(s) Change
 - ☒ Other; please describe: Updated the amounts given new data
 - ☐ No changes from previously approved preprint other than rating period(s).
7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).
Responses below are consistent by payment component with prior approved preprints updated for new contract dates.
- **DRG Fee Schedule Payment Arrangement**
 - Hawai'i's MCOs will continue to use the All Patient Refined Diagnosis Related Group (APR DRG) payment methodology for Medicaid fee-for-service (FFS) inpatient payment purposes for admissions, as approved by CMS in its state plan section 4.19a. This provides Hawai'i's MCOs with a mechanism to make a single case rate payment for similar services provided in a hospital inpatient stay. This program is predicated exclusively on utilization and delivery of services.
 - **Hospital Directed Access Payment Arrangement**
 - Under the hospital directed Access payment program, the State will direct Hawai'i Medicaid MCOs to apply hospital-specific percentage increases to claim payments for inpatient and outpatient services at eligible hospitals, to achieve the following hospital-specific benchmarks based on target percentages of Medicare in aggregate:

- **118.5%** of Medicare for combined **inpatient** base payments and Access payments, not to exceed 100% of the payments under average commercial rates (ACR).
- **100.0%** of Medicare for combined **outpatient** base payments and Access payments, not to exceed 100% of the payments under average commercial rates (ACR).

The target amounts included in the pre-print are intended to be paid out over the period of January 2026 – December 2026. This program is based on utilization and delivery of services, under the following methodology:

- **Pay hospitals an interim Directed Access payments using projected 2026 experience:**
Each hospital will receive monthly interim lump-sum payments equal to the ‘Interim Directed Access Payment Increase Percentage’ for eligible hospitals multiplied by the hospital’s ‘Projected 2026 Managed Care Payments’, divided by 12. The 2026 Interim Directed Access Payment Increase Percentages for each eligible hospital are based on the gap between each hospital’s estimated payments under the applicable benchmark (for Medicaid managed care services) and Medicaid QUEST Integration managed care base payments, divided by Medicaid QUEST Integration managed care base payments, separately for inpatient and outpatient. Hospitals within the eligible provider class will not receive Access payments for inpatient and/or outpatient if their inpatient and/or outpatient Medicaid managed care base payments exceed their respective benchmark. Interim payments will be based on Medicaid managed care billed charges and base payments from CY 2024 Medicaid managed care encounter data, and Medicare pay-to-charge ratios from Medicare cost reports with fiscal reporting periods that overlap with the encounter data. Adjustments for utilization and service mix changes for 2026 will be applied (including adjustments to reflect estimated payment impacts under the State’s APR DRG methodology and all expected revenue). Interim payments will establish an aggregate fixed payment pool, separately for inpatient and outpatient, the allocation of which is subject to potential adjustments in the reconciliation process based on actual utilization.
- **Measure differences in actual utilization compared to projections and compare to the reconciliation threshold:**
Approximately 12 months after the end of the contract period, the State will measure the weighted average (weighted by share of actual base payments) of the absolute values of percentage point change in each eligible hospital’s proportion of base payments from historical FYE 2024 base payments to actual QUEST Integration calendar year 2026 base payments. If the weighted average is less than 10.0%, the State will not adjust interim payments for the contract period, and if the weighted average is greater than or equal to 10.0%, the State will conduct reconciliation adjustments for the contract period.
- **Conduct reconciliation adjustments if the weighted average percentage point change meets or exceeds the 10% threshold:**
In the event the reconciliation adjustment are triggered, the State will scale the ‘Interim Directed Access Payment Increase Percentages’ by the same factor across each hospital, separately for inpatient and outpatient, based on actual 2026 QUEST Integration managed care payments to result in the total target statewide payment pools for inpatient and outpatient services. The State will then calculate Final Directed Access Payments for each hospital by multiplying the scaled Directed Access Payment Increase Percentages against each hospital’s actual 2026 QUEST Integration managed care base payments. Any differences in final vs. interim directed payments will be settled by the MCOs and each hospital through recoupment of payments (if the final payment amount based on actual utilization is less than the sum of the interim payments which were based on projected utilization) or an additional payment (if the final payment based on actual utilization is more than the sum of the interim payments which were based on projected

utilization). As the State is proposing a fixed payment pool, it does not anticipate there would ever be a need for recoupment from the MCOs as part of the annual reconciliation process; however, should an occasion arise where an MCO was paid more than their share at final settlement, the State would follow a similar process for recoupment with the MCO, as necessary. The State will revise the preprint as needed to reflect the final uniform percent increases.

- **HHSC**

- Under the directed uniform payment increases, Hawai'i's MCOs will make uniform payment increases for each inpatient day and outpatient visit within the government-owned class of safety net hospitals. This program is predicated exclusively on utilization and delivery of services.

- **Hospital Pay For Performance**

- The program includes a combination of metrics that are tied to either utilization of services by enrollees in the managed care contract; or the requirement set to meet or exceed a performance benchmark. The combination of metrics drive the quality metric scores of the hospitals, and thus this payment arrangement is based on the utilization and delivery of services as well as the meeting of performance benchmarks.

- a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
- b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

- **DRG Fee Schedule Payment Arrangement**

- The state plan amendment authority that defines this provider class is found here: https://medQUEST.hawaii.gov/content/dam/formsanddocuments/med-QUEST/hawaii-state-plan/SPA_21-0011_Public_Notice_05-21-21_and_Attachment_4_19-A_pg_1-4_CLEAN_Redline.pdf
- The state plan authority that defines this provider class is found here: <https://humanservices.hawaii.gov/wp-content/uploads/2017/12/4.19-A-from-Attachment-4-Rev.-07.2017.pdf>
- The 1115 waiver authority for these services can be found here: https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/section-1115-demonstration-renewal-for-2024/1115_Demonstration_Application_Public_Comment_FINAL_10132023.pdf

- **Hospital Directed Access Payment Arrangement**

- The 1115 waiver authority for these services can be found here: https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/section-1115-demonstration-renewal-for-2024/1115_Demonstration_Application_Public_Comment_FINAL_10132023.pdf

- **HHSC**

- The state plan authority that defines this provider class is found here: <https://humanservices.hawaii.gov/wp-content/uploads/2017/12/4.19-A-from-Attachment-4-Rev.-07.2017.pdf>
- The 1115 waiver authority for these services can be found here: https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/section-1115-demonstration-renewal-for-2024/1115_Demonstration_Application_Public_Comment_FINAL_10132023.pdf

- **Hospital Pay For Performance**

- The 1115 waiver authority for these services can be found here:
https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/section-1115-demonstration-renewal-for-2024/1115_Demonstration_Application_Public_Comment_FINAL_10132023.pdf

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

- a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

- b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☒ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform

☐ Performance Improvement Initiative

☐ Other Value-Based Purchasing Model

- 11.** Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If “other” was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

Hospital Pay For Performance

In the CY2017 rate development, the State established a pay for performance pool for private hospitals. Since then, a second pay for performance pool has been established for public hospitals. The total quality pool includes \$100.29 million for the private class and \$3.21 million for the public class (consistent with the grandfathered CY 2025 preprint). The final quality payment pool distribution will be based each facility’s performance on various quality metrics, using the methodologies outlined in Table 1. The State will direct Medicaid managed care plans to distribute 100% of the payment pools for each class for the contract year. Any unearned dollars will be distributed among facilities that demonstrate additional improvements from baseline. The number of metrics are expected to mature and expand over time, transitioning from process to outcome measures as various efforts that advance the state’s quality strategy goals are furthered through the pay for performance program.

- 12.** In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#) when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	Measure Steward/ Developer ¹	Baseline ² Year	Baseline ² Statistic	Performance Measurement Period ³	Performance Target	Notes ⁴
<i>Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay</i>	CMS	CY 2018	9.23%	Year 2	8%	Example notes
a. 30 – Day Readmissions	PQM	2023	1.13	2026	1.11	Uses O:E ratio.
b. Reducing ED Visits	Hawai'i	2018	24.6%	2026	24.11%	
c. OP-18 Time from ED Admit to Discharge	TJC	2023	72.75 state four quarter avg.	2026	90 th percentile nationally / improvements from prior year	
d. Precent Discharge to Community (higher is better) Percent Discharge to Acute care (lower is better)	CMS	2023	83.0% 11.7%	2026	84.6% 7.4%	
e. HSRN Screening	Hawai'i	2024	Less than 18: 52% 18+: 68%	2026	Improvement from prior year	

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

- a. Please describe the methodology used to set the performance targets for each measure.

The performance targets for payout are set differently for each measure used in 2026. MQD reviewed historic performance as well as national benchmarks where available to ensure that performance targets are reasonably expected to drive improvements in quality.

- b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

Hospital Pay For Performance

Yes, providers can receive a portion of the payment if they meet some but not all measures. The overall pool of funds available is parsed among the measures based on distribution determined at the outset of each program year. Then, hospitals independently work towards each of the measures. Hospitals also earn the allocated amounts for each measure independently of their performance on other measures.

- c. For state-developed measures, please briefly describe how the measure was developed?

Hospital Pay For Performance

MQD worked with the Healthcare Association of Hawaii as well as Hospital leaders to develop and refine the specifications for the measure for ED visits and HRSN Screening. The ED measure was modeled after similar measures used in peer reviewed literature to evaluate frequency of ED use, and the HRSN measure was developed to align with the Accountable Health Communities screening tool

14. Is the State seeking a multi-year approval of the state directed payment arrangement?

☐ Yes ☒ No

- a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.
- b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

Hospital Pay For Performance

The Hospital P4P program is still evolving, and at this time, the measures included in the program continue to undergo annual refinement. Hawai'i is currently evaluating hospital performance in the program in past years and identifying areas where changes may be needed, particularly to support Hawai'i's participation in the AHEAD model.

15. Use the checkboxes below to make the following assurances:

- a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

- b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.
- c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.
- d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*
- a. ☒ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates*¹ (42 C.F.R. § 438.6(c)(1)(iii)(B))
 - b. ☒ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
 - c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))
17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):
- a. Check the basis for the fee schedule selected above.
 - i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a).²
 - ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.
 - iii. ☒ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

- 1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

- **DRG Fee Schedule Payment Arrangement**

- The State is proposing to use a fee schedule based on the State-plan approved rates as defined in 42 C.F.R. § 438.6(a).

- **Hospital Directed Access Payment Arrangement**

- The State's proposed Access payments are based on uniform percent increases resulting in hospital-specific target percentages of Medicare

¹ Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

² Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

in aggregate (when including base payments):

- **118.5%** of Medicare for **inpatient**, not to exceed 100% ACR
- **100.0%** of Medicare for **outpatient**, not to exceed 100% ACR

- **HHSC**

- The alternative fee schedule is based on the average loss (estimated costs less claim payments) per service unit for Medicaid managed care services, separate for inpatient and outpatient.

- **Hospital Pay For Performance**

- Not applicable.

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

- **DRG Fee Schedule Payment Arrangement**

- The State believes the proposed state directed payment is reasonable and appropriate because the minimum and maximum fee schedules ensure budget neutrality to current Medicaid managed care base payments.

- **Hospital Directed Access Payment Arrangement**

- The directed Access payment percentage increases are based on the uniform target of payments under the respective benchmarks for each hospital, separately for inpatient and outpatient. We believe these benchmarks are a reasonable and appropriate target reimbursement level for maintaining access to services and achieving the state's goals and objectives.

- **HHSC**

- The grandfathered CY 2025 preprint directed uniform payment increases were based on the average loss per service unit for Medicaid managed care services, and the CY 2026 proposed payment pool is the same as CY 2025. We believe the legacy cost target is a reasonable reimbursement level.

- **Hospital Pay For Performance**

- Not applicable.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☒ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

- **DRG Fee Schedule Payment Arrangement**

- The plans and the providers must submit a request for exemption if they are under contractual obligations that result in the need to pay more than the maximum fee schedule, for special arrangements such pay-for-performance or other alternative payment models. The contract, and contractual provisions, show why a plan and the provider needs to pay more than the maximum fee schedule must be submitted to the State. Additionally, the plan and the providers must submit a justification for why there is a need to pay more than

the maximum fee schedule. The State will review the materials submitted by the plans and providers to make an informed determination of whether the contractual obligations resulting in a need to pay more than the maximum fee schedule will be approved as an exemption.

- c. Indicate the number of exemptions to the requirement:
- i. Expected in this contract rating period (estimate) **0**
 - ii. Granted in past years of this payment arrangement **0**
- d. Describe how such exemptions will be considered in rate development.

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

- a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)
- b. What is the magnitude of the increase (e.g., \$4 per claim or 3% increase per claim?)

• **Hospital Directed Access Payment Arrangement**

- As described previously in response to question 8, the State will direct Hawai'i Medicaid MCOs to make percentage increases to claim payments for contracted inpatient and outpatient services at eligible hospitals. As mentioned, the interim directed Access payment increase percentages are hospital-specific, separate for inpatient and outpatient, determined to bring each hospital up to a uniform target of approximately 118.5% of estimated payments under Medicare for inpatient and 100.0% of Medicare for outpatient utilization (when including base payments), not to exceed 100% of payments under ACR. Interim directed Access payment increase percentages for each hospital have been provided in a supplemental file.
- Final directed Access payment increase percentages will be determined during the reconciliation process. The 'Final Med-QUEST Payment Increase Percentage' by hospital reimbursement class will be determined during the reconciliation process.

• **HHSC**

- MQD proposes the following uniform dollar increases, separately for inpatient and outpatient:
 - \$3,376.65 per day for inpatient services
 - \$305.94 per visit for outpatient services

- c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

• **Hospital Directed Access Payment Arrangement**

- As described previously in response to question 8, hospitals will receive interim lump-sum monthly Access payments from MCOs as directed by the State. Approximately 12 months after the end of contract year, the State will measure the weighted average percentage point change in utilization (from projected to actual) across eligible hospitals. If the weighted average is less than 10.0%, the State will not adjust interim payments for the contract period, and if the weighted average is greater than or equal to 10.0%, the State will conduct reconciliation adjustments for the contract period. See our response to question 8 on details of the payment methodology.

• **HHSC**

- MCO encounter data will be used to directly link each hospitals' payments to utilization of inpatient and outpatient services for managed care enrollees. Each month, Med-QUEST will calculate each hospital's allocation of the payments by taking the current year utilization multiplied by the payment increase amount per service separately for inpatient and outpatient. This amount will then be used to allocate the directed payment funding to each hospital.
- d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract
- **DRG Fee Schedule Payment Arrangement**
 - Not applicable since payments were developed initially to be budget neutral.
 - **Hospital Directed Access Payment Arrangement**
 - Consistent with 2022 through 2025, the 2026 Interim Directed Access Payment Increase Percentages for each eligible hospital are based on the gap between each hospital's estimated payments for the respective benchmarks and Medicaid managed care base payments, divided by Medicaid managed care base payments, separately for inpatient and outpatient. The total CY 2026 access payment pool is \$241.69 million, the same as in the grandfathered CY 2025 preprint. See our response to Question 8 on details of the payment methodology.
 - As shown in Table 2, the projected average Medicaid managed care payment per unit (including base payments and directed payments) is at or below 100% of the ACR per unit for each provider class, separately for inpatient and outpatient. MQD believes this a reasonable and appropriate reimbursement level given it is within federal limits required under CMS' May 2024 managed care final rule.
 - **HHSC**
 - In the grandfathered CY 2025 preprint, these directed uniform dollar increases were based on the average loss per service unit for Medicaid managed care services, separately for inpatient and outpatient. The total CY 2026 directed uniform increase payment pool is \$78.47 million, the same as in the grandfathered CY 2025 preprint.
 - As shown in Table 2, the projected average Medicaid managed care payment per unit (including base payments and directed payments) is below 100% of the ACR per unit for each provider class, separately for inpatient and outpatient. MQD believes this a reasonable and appropriate reimbursement level given it is within federal limits required under CMS' May 2024 managed care final rule.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:
- a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):
- ☒ inpatient hospital service
 - ☒ outpatient hospital service
 - ☐ professional services at an academic medical center
 - ☐ primary care services
 - ☐ specialty physician services

- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

- **DRG Fee Schedule Payment Arrangement**

- This applies to in-state general acute hospitals and children's hospitals as approved in the State's recent SPA. Per the SPA, the APR DRG Payment methodology excludes Critical Access Hospitals, freestanding rehabilitation hospitals, freestanding psychiatric hospitals, long-term acute care hospitals, military hospitals, Veterans Association hospitals, out-of-state hospitals, and State of Hawai'i Organ and Tissue Transplant (SHOTT) services.

- **Hospital Directed Access Payment Arrangement**

- The eligible provider class consists of Hawai'i privately-owned hospitals, excluding charitable hospitals funded primarily through donations or other non-insurance sources of funding, and whose net patient revenue is less than 40% of operating expenses, per the Medicaid cost report.

- **HHSC**

- This payment arrangement pertains to Hawai'i government-owned safety net hospitals for inpatient and outpatient services.

- **Hospital Pay For Performance**

- There are two separate classes: 1) public hospitals, and 2) private hospitals

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

- **DRG Fee Schedule Payment Arrangement**

- The provider class is defined in the state's approved SPA found here: https://medQUEST.hawaii.gov/content/dam/formsanddocuments/med-QUEST/hawaii-state-plan/SPA_21-0011_Public_Notice_05-21-21_and_Attachment_4_19-A_pg_1-4_CLEAN_Redline.pdf

- **Hospital Directed Access Payment Arrangement**

- Directed Access payments for private hospitals provides additional funding to maintain access to services, to complement the separate directed payment arrangement for public hospitals. The exclusion for charitable hospitals is due to available funding separately from donations and other non-insurance sources.

- **HHSC**

- The state plan that defines this provider class is found here: <https://humanservices.hawaii.gov/wp-content/uploads/2017/12/4.19-A-from-Attachment-4-Rev.-07.2017.pdf>

- **Hospital Pay For Performance**

- The complete Hawai'i State Plan is found here:
<https://humanservices.hawaii.gov/reports/hawaii-medicaid-state-plan/> (see section 3 and Attachment 3).

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

- **DRG Fee Schedule Payment Arrangement**

- The payment methodology does not vary by provider and is predicated exclusively on utilization and delivery of services.

- **Hospital Directed Access Payment Arrangement**

- Under the hospital Directed Access payment program, each hospital is brought up to the same benchmarks, separately for inpatient and outpatient.

- **HHSC**

- Under the directed uniform payment increases, Hawai'i's MCOs will make uniform payment increases for each inpatient day and outpatient visit within the government-owned class of safety net hospitals. This program is predicated exclusively on utilization and delivery of services.

- **Hospital Pay For Performance**

- All Private Hospitals are evaluated using the same quality metrics; similarly, all Public Hospitals are evaluated using the same set of quality metrics. Where appropriate, the same measures are applied to both Private and Public Hospitals.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

- a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).
- b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).
- c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of PassThrough Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
[ALL AMOUNTS REMOVED FROM TABLE 2 IN THE PDF, AND HAVE BEEN INCLUDED IN THE SEPARATE EXCEL ADDENDUM]					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- a. ☐ Medicare payment/cost
- b. ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) (*Please note, this rate cannot include supplemental payments.*)
- c. ☒ Other; Please define: **Benchmarked as a percentage of Average Commercial Rates**

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column “Other State Directed Payments” in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. §438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column “Pass-Through Payments” in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

- **DRG Fee Schedule Payment Arrangement**

- This directed payment arrangement is not made in addition to the standard fee schedule, and is reflected in the Medicaid base payments.

- **Private Hospital Directed Access and Quality Payments**

- To estimate payments under ACR, we applied commercial pay-to-charge ratios (without trending or modifying) to projected Medicaid managed care billed charges. Commercial allowed-to-charge ratios were based on Milliman’s Consolidated Health Cost Guidelines™ Sources Database, or CHSD, for Hawai‘i hospital commercial payer claims experience for inpatient and outpatient hospital services incurred from July 1, 2023 through June 30, 2024. The commercial pay-to-charge ratios were based on the weighted average at the service line and Hawai‘i metropolitan statistical area (MSA) level (including “non-MSA” rural areas), and cross-walked to the projected Medicaid charges based on hospital location and service line. Projected Medicaid billed charges include an adjustment based on changes in CMS market basket index levels from the SFY 2024 Medicaid base period to the CY 2026 contract year. The ACR per unit amounts are calculated at the aggregate private hospital provider class level based on aggregate estimated payments under ACR divided by aggregate Medicaid utilization (days for inpatient and visits for outpatient).
- See the attached hospital directed payment exhibits for the Total Payment Rate and ACR demonstrations.

- **HHSC and Quality Payments**

- Payments under ACR for the public hospital class are based on the private class aggregate ACR per day for inpatient and ACR per visit for outpatient.
- See the attached hospital directed payment exhibits for the Total Payment Rate and ACR demonstrations.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

- **DRG Fee Schedule Payment Arrangement**

- The State believes the proposed state directed payment is appropriate and reasonable because the minimum and maximum fee schedules ensure budget neutrality to current Medicaid managed care base payments.

- **Hospital Directed Access Payment and Quality Payment Arrangements**

- Private hospital Access payments brings each eligible hospital up to approximately 118.5% of Medicare for inpatient and 100.0% of Medicare for outpatient (when including base payments), not to exceed 100% of payments under ACR at the hospital level. The State believes the Medicare target is reasonable and necessary for achieving its goals and objectives for this directed payment arrangement.

- **HHSC and Quality Pool Payments**

- The grandfathered CY 2025 preprint these CY 2026 payment pools were based on a target of approximately 100% of cost. The State believes the legacy cost-based target was reasonable and necessary for achieving its goals and objectives for this directed payment arrangement.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

- i.** What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

Hospital Pay For Performance: RFP-MQD-2021-008

- ii.** Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Hospital Pay For Performance: The contractual obligations are described in Section 7.2.C.1.b 8 in the QI contract RFP-MQD-2021-008.

- b.** If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

- a.** If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

- b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. Hawaii_QuestIntegration_20260101-20261231	10/02/2025	Yes	In the section labeled section I.4.D.ii
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent [Medicaid Managed Care Rate Development Guide](#) for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

- c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

All four of these directed payment arrangements are captured in the actuarial rate certification.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- a. ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.

- b. ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- c. ☒ Other, please describe: Both A and B apply; please see the attached appendix for a detailed response.

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

- **Hospital Directed Access Payment Arrangement**

- The funds for this proposal are included as a separate payment term and are itemized for this purpose. The State believes a separate payment term is appropriate to ensure adequate precision in the distribution of the directed payments. Continued implementation of the directed payments as a separate payment term results in administrative efficiencies for all parties involved in the directed payment arrangement. Without the use of a separate payment term, additional administrative burdens would exist, such as the need for an additional monthly reconciliation process to monitor and ensure that the aggregate interim directed payments made to providers are consistent with the target aggregate directed payment amounts. The State believes its proposed reconciliation process accomplishes the appropriate allocation of directed payments across providers based on actual contract year utilization.

- **HHSC**

- The funds for this proposal are included as a separate payment and are itemized for this purpose. The State believes a separate payment term is appropriate to ensure adequate precision in the distribution of the directed payments. Continued implementation of the directed payments as a separate payment term results in administrative efficiencies for all parties involved in the directed payment arrangement. Without the use of a separate payment term, additional administrative burdens would exist, such as the need for an additional monthly reconciliation process to monitor and ensure that the aggregate interim directed payments made to providers are consistent with the target aggregate directed payment amounts. The State believes its proposed reconciliation process already accomplishes the appropriate allocation of directed payments across providers based on actual contract year utilization.

- **Hospital Pay For Performance**

- The funds for this proposal are included as a separate payment term (capitation rate add-on) and are itemized for this purpose. The State believes a separate payment term is appropriate to ensure adequate precision in the distribution of the directed payments. Continued implementation of the directed payments as a separate payment term results in administrative efficiencies for all parties involved in the directed payment arrangement. Without the use of a separate payment term, additional administrative burdens would exist, such as the need for an additional monthly reconciliation process to monitor and ensure that the aggregate interim directed payments made to providers are consistent with

the target aggregate directed payment amounts. The State believes its proposed reconciliation process already accomplishes the appropriate allocation of directed payments across providers based on actual contract year utilization.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- a. ☒ State general revenue
- b. ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- c. ☒ Health Care-Related Provider tax(es) / assessment(s)
- d. ☐ Provider donation(s)
- e. ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- a. Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

- b.** ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
- c.** Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to

support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by provider taxes/assessments (option c in Question 34),

- a.** Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broadbased?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the “75/75” test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Hospital Sustainability Fee	Inpatient and Outpatient Hospital Services	No	No	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. Hospital Directed Access and Hospital Pay For Performance: Inpatient broad-based and uniform waiver.	2/27/2024	Approved	04/10/2024
ii. Hospital Directed Access and Hospital Pay For Performance: Outpatient broad-based and uniform waiver.	2/27/2024	Approved	4/10/2024
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

- a.** Is the donation bona-fide? ☐ Yes ☐ No
- b.** Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

- 39.** ☒ Use the checkbox below to make the following assurance, “In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340.”
- 40.** Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:
- a.** A hyperlink to State’s most recent quality strategy:
<https://medquest.hawaii.gov/en/resources/quality-strategy.html>
 - b.** The effective date of quality strategy. **October 1, 2023**
- 41.** If the State is currently updating the quality strategy, please submit a draft version, and provide:
- a.** A target date for submission of the revised quality strategy (month and year):
 - b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

- 42.** To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
<i>Example: Improve care coordination for enrollees with behavioral health conditions</i>	<i>Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%</i>	5
a. Align Payment Structures to Enhance Quality and Value of Care	Objective 17: Align payment structures to enhance quality and value of care	11
b. Maintain access to appropriate care	Objective 15: Increase coordination of care and decrease inappropriate care	11
c. Support community initiatives to improve population health	Objective 11: Assess and address social determinants of health needs	10
d.		

- 43.** Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

- DRG Fee Schedule Payment Arrangement**

- This payment arrangement allows Med-QUEST to continue to ensure adequate funding is available for hospitals to remain financially viable and to maintain participation in the Medicaid managed care program. The directed increases also ensure that enrollees receive medically necessary care in the most appropriate and cost-effective setting, meeting the goals of the state's Quality Strategy. We anticipate

that this will result in an increased extent to which our beneficiaries’ “get needed care” from their health insurance plans. Additionally, the State believes that continuing to provide funding to hospitals will ensure timely and efficient care.

- **Hospital Directed Access Payment Arrangement**

- This payment arrangement allows Med-QUEST to continue to ensure adequate funding is available for private hospitals to remain financially viable and to maintain participation in the Medicaid managed care program. The directed increases also ensure that enrollees receive medically necessary care in the most appropriate and cost-effective setting, meeting the goals of the state’s Quality Strategy. We anticipate that this will result in an increased extent to which our beneficiaries’ “get needed care” from their health insurance plans, thereby contributing to beneficiary satisfaction, and resulting in increases in the corresponding Getting Needed Care CAHPS measure. Additionally, the State believes that continuing to provide funding to private hospitals will ensure timely and efficient delivery of services.

- **HHSC**

- This payment arrangement allows Med-QUEST to continue to ensure adequate funding is available for the safety net hospitals to remain financially viable and to maintain participation in the Medicaid managed care program. The directed increases also ensure that enrollees receive medically necessary care in the most appropriate and cost-effective setting, meeting the goals of the state’s Quality Strategy. We anticipate that this will result in an increased extent to which our beneficiaries’ “get needed care” from their health insurance plans, thereby contributing to beneficiary satisfaction, and resulting in increases in the corresponding Getting Needed Care CAHPS measure. Additionally, we believe that continuing to provide funding to safety net hospitals will ensure timely and efficient delivery of emergency services, resulting in improvements in the Time from ED Admit to Discharge measure.

- **Hospital Pay For Performance**

- All measures included in the P4P program directly support various goals of the agency. Paying hospitals performance bonuses for quality metrics incentivizes them to focus on quality improvement activities targeting the Medicaid populations they serve. This year’s hospital P4P program significantly builds upon the P4P program Hawai‘i has implemented in prior years. Continuing to incentivize these measures signals to hospitals the agency’s intent to hold hospitals responsible for outcomes, incentivizing them to deploy quality improvement interventions. In total, the Hospital P4P program supports four key goals of the Medicaid program.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State’s quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the [CMS Adult and Child Core Set Measures](#), when applicable.

- a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their

External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

- b.** Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	Baseline Year	Baseline Statistic	Performance Target	Notes ¹
<i>Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039</i>	<i>CY 2019</i>	<i>34%</i>	<i>Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year</i>	<i>Example notes</i>
i. Ambulatory Care – ED Visits per 1000 member months (Total)	2024	38.64	Meet or exceed the national average	
ii. Plan All-Cause Readmissions (O/E Ratio, Total) – NQF# 1768	2024	.9917	Better than O/E Ratio of 1.25	
iii. Time from ED Admit to Discharge	2017	80.81 min (106 min national avg)	Meet or exceed the national average	
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

- c.** If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior

year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

Evaluation findings are included in a separate file.

PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

Directions

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 2. in the preprint, please delete Tabs 1.A and 3.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 2.A: Provider Payment Analyses

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	Free text	Percent (###%)	Percent (###%)	Percent (###%) or N/A	Percent (###%) or N/A	Percent (###%)
Example:	Rural Inpatient Hospital Services	80.0%	20.0%	N/A	N/A	100.0%
a.	Public HHSC Hospitals - Inpatient	23.8%	54.5%	N/A	N/A	78.3%
b.	Public HHSC Hospitals - Outpatient	62.2%	31.8%	N/A	N/A	94.0%
c.	The Queen's Medical Center - Inpatient	36.3%	41.9%	N/A	N/A	78.2%
d.	Molokai General Hospital - Inpatient	54.9%	45.1%	N/A	N/A	100.0%
e.	North Hawaii Community Hospital - Inpatient	35.3%	37.9%	N/A	N/A	73.2%
f.	Kapiolani Medical Center - WC - Inpatient	42.3%	10.5%	N/A	N/A	52.8%
g.	Pali Momi Medical Center - Inpatient	39.2%	40.1%	N/A	N/A	79.3%
h.	Straub Clinic Hospital - Inpatient	44.2%	32.2%	N/A	N/A	76.4%
i.	Wilcox Memorial Hospital - Inpatient	32.2%	39.6%	N/A	N/A	71.8%
j.	Maui Memorial Medical Center - Inpatient	30.5%	53.9%	N/A	N/A	84.4%
k.	Kaiser Foundation Hospital - Inpatient	45.1%	50.4%	N/A	N/A	95.5%
l.	Castle Medical Center - Inpatient	33.5%	27.7%	N/A	N/A	61.2%
m.	Kuakini Medical Center - Inpatient	33.2%	31.1%	N/A	N/A	64.4%
n.	Rehabilitation Hospital of the Pacific - Inpatient	23.8%	21.0%	N/A	N/A	44.8%
o.	The Queen's Medical Center - Outpatient	75.1%	20.5%	N/A	N/A	95.5%
p.	North Hawaii Community Hospital - Outpatient	58.8%	33.9%	N/A	N/A	92.6%
q.	Kapiolani Medical Center - WC - Outpatient	72.8%	2.3%	N/A	N/A	75.1%
r.	Pali Momi Medical Center - Outpatient	76.2%	10.1%	N/A	N/A	86.3%
s.	Straub Clinic Hospital - Outpatient	54.3%	15.2%	N/A	N/A	69.5%
t.	Wilcox Memorial Hospital - Outpatient	69.4%	6.0%	N/A	N/A	75.4%
u.	Castle Medical Center - Outpatient	42.4%	7.5%	N/A	N/A	50.0%
v.	Kuakini Medical Center - Outpatient	78.7%	21.3%	N/A	N/A	100.0%
w.	Rehabilitation Hospital of the Pacific - Outpatient	10.0%	2.6%	N/A	N/A	12.6%
x.	Lanai Community Hospital - Outpatient	87.6%	8.0%	N/A	N/A	95.6%
y.						
z.						
aa.						
bb.						
cc.						
dd.						
ee.						
ff.						
gg.						
hh.						
ii.						
jj.						
kk.						
ll.						
mm.						
nn.						
oo.						
pp.						
qq.						
rr.						
ss.						
tt.						
uu.						
vv.						
ww.						
xx.						
yy.						
zz.						
aaa.						
bbb.						
ccc.						
ddd.						
eee.						
fff.						
ggg.						
hhh.						
iii.						
jjj.						
kkk.						
lll.						
mmm.						
nnn.						
ooo.						
ppp.						
qqq.						
rrr.						
sss.						
ttt.						
uuu.						
vvv.						
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