
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 Preprint affects nursing facility 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: \$20.66 million

- a. Identify the estimated federal share of this state directed payment: \$12.33 million

- b. Identify the estimated non-federal share of this state directed payment: \$8.33 million

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:
 - **LTC Access Payments**
 - This state directed payment has previously been approved by CMS for the contract years 2022 through 2025.
 - **Nursing Facility Quality Pool**
 - This state directed payment has previously been approved by CMS for the contract years 2021 through 2025.
 - 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:
 - ☐ 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).

- **LTC Access Payments**

- Under the directed uniform payment increases, Hawai'i's MCOs will make uniform payment increases for nursing facility days within the government-owned class of nursing facilities. This program is predicated exclusively on utilization and delivery of services.
- 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

1. LTC Access Payments

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/hawaii-state-plan/Hawaii_QUEST_Integration_1115_Demonstration_Extension_Approval_Package.pdf

2. Nursing Facility Quality Pool The 1115 waiver authority for these services can be found here: https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/Hawaii_QUEST_Integration_1115_Demonstration_Extension_Approval_Package.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).

Nursing Facility Quality Pool

The Hawai'i Med-QUEST Division (MQD) has established a nursing facility quality payment pool program. This program is modeled after the hospital quality payment pool program previously approved by CMS. Under this program, there are separate quality payment pools for private and public nursing facility classes, up to 1% of each class's historical Medicaid managed care revenues, and capped at the grandfathered pool amount from CY 2025. Within each class payment pool, the “initial facility allocation” are based on each facility's proportional share of historical Medicaid managed care revenues. The final quality payment pool distribution, based on the portion of the initial facility allocation earned by each facility, is based on each facility's quality scores.

MQD will direct Medicaid managed care plans to distribute 100% of the payment pools for each class for the contract year based on the following methodology:

- For each facility, points will be assigned for various quality metrics (described later in this Preprint) based on the facility's performance as compared to national benchmarks.
- Each facility will be assigned one of four Quality Tiers based on the facility's total score class
- Each facility's earned payment pool distribution will be based on the Quality Tier percentage (ranging from 75% for Quality Tier 4 to 100% for Quality Tier 1) multiplied by the initial facility allocation
- Quality Tier 1 and 2 facilities additionally receive a bonus payment based on the distribution of the unearned portion of the initial facility allocation for Quality Tier 3 and 4 facilities.

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>	<i>CMS</i>	<i>CY 2018</i>	<i>9.23%</i>	<i>Year 2</i>	<i>8%</i>	<i>Example notes</i>
a. NF Quality Pool: Long Stay Urinary Tract Infections (UTI)	Included in CMS 5-star ratings	2018	2.24%	Will collect new data annually	2.20%	Based on percentage of long stay residents who had a UTI in the past 30 days. Target unchanged from prior year
b. NF Quality Pool: Long Stay Antipsychotic Medications	Included in CMS 5-star ratings	2018	7.24%	Will collect new data annually	7.10%	Based on percentage of long stay residents who are receiving antipsychotic drugs. Target unchanged from prior year.
c. NF Quality Pool: Long Stay Pressure Ulcers	Included in CMS 5-star ratings	2018	5.15%	Will collect new data annually	5.05%	Based on percentage of high-risk long stay residents who have developed a pressure ulcer . Target unchanged from prior year.
d. NF Quality Pool: PointRight Pro 30 – Rehospitalizations	PointRight	2017	9.31%	Will collect new data annually	9.12%	Based on 30 day risk-adjusted hospital readmission rates. Target unchanged from prior year.
e. NF Quality Pool: PointRight Pro Long Stay Hospitalizations	PointRight	2017	8.27%	Will collect new data annually	8.10%	Based on risk-adjusted hospitalization rate for residents in the facility more than 100 days. Target unchanged 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.**

○ Nursing Facility Quality Pool

- For measures a-f in Table1, quintile thresholds for each measure are based on the national distribution of the quality measure. The quintiles are assigned 20 points for the lowest performing quintile, 100 points for the highest performing quintile, and 40, 60 or 80 points for the second, third and fourth quintiles respectively.
- For bonus measure f, a different number of points will be awarded based on whether the facility received a bronze (30 points), silver (60 points), or gold (100 points) award under the American Health Care Association/ National Center for Assisted Living National Quality Award Program. The total number of points earned by a facility (numerator) across all measures will be added together, and facilities will be assigned to one of four tiers based on total score: Tier 1, score of 450 points or higher; Tier 2, score of 400-449; Tier 3, score of 350-399; Tier 4, score below 350. The facility's payment pool distribution will be based on the Quality Tier percentage (ranging from 75% for Quality Tier 4 to 100% for Quality Tier 1). Quality Tier 1 and 2 facilities also receive a bonus payment based on the distribution of the unearned portion of the initial facility allocation for Quality Tier 3 and 4 facilities.

- 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?**

○ Nursing Facility Quality Pool

- Yes, providers can receive a portion of the payment if they meet some but not all measures. That said, the total earned amounts is based on the tier within which a provider is placed based on the total score the provider attains across all measures included in the program. Additionally, providers in the top two tiers will receive a distribution of the remaining pool based on their earned distribution relative to the total distribution of all facilities in the top two tiers.

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

○ Nursing Facility Quality Pool

- N/A - there are no state-developed measures for this program.

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.**

Nursing Facility Quality Pool

The Nursing Facility P4P program is in its initial stages of evolution, and at this time, the measures included in the program will need to undergo annual refinement. Hawaii is currently evaluating nursing facility performance in the program in past years and identifying areas where changes may be needed. Changes implemented may range from new or additional quality measures to alternative payment methodologies. Given substantive changes underway, the timing is still inappropriate for Hawaii to treat this preprint as a multi-year effort. Therefore, we are seeking a 1-year approval from CMS at this time.

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))

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).

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

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.
- c. Indicate the number of exemptions to the requirement:
 - i. Expected in this contract rating period (estimate)
 - ii. Granted in past years of this payment arrangement
- 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?)

The Med-QUEST program will provide uniform per diem payment increases for Medicaid managed care services at long term care nursing facilities. There will be separate directed payment increase per diem amounts for each regional class, as follows:

- Island of Oahu class: \$215.99 per day increase
- Island of Hawai'i class: \$389.07 per day increase

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).

- 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).

LTC Access Payments

MCO encounter data will be used to directly link each facility's payments to utilization of nursing facility services for managed care enrollees. Each quarter, Med-QUEST will calculate each facility's allocation of the payments by taking the current year utilization multiplied by the payment increase amount per day. This amount will then be used to allocate the directed payment funding to each nursing facility services within each class.

- 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

LTC Access Payments

These directed payment increases are each based on the average loss per day for Medicaid managed care nursing facility services using the most recently available nursing facility accounts data and FYE 2025 cost report data, capped at CY 2025 directed payment levels. We believe a cost-based Upper Payment Limit for the directed payment increases is a reasonable target reimbursement level.

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).

• **LTC Access Payments**

- This payment arrangement pertains to Hawai'i government-owned safety net providers that are not Critical Access Hospitals (CAHs). There will be separate regional classes for providers on the island of Oahu and providers on the island of Hawaii.

• **Nursing Facility Quality Pool**

- There are two provider classes: 1) Public nursing facilities with Medicaid managed care utilization, and 2) Private nursing facilities with Medicaid managed care utilization. Facilities with no full-time nursing facility beds (i.e. only swing beds) are excluded.

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.

○ LTC Access Payments

- The proposed public provider classes are consistent with the public hospital-based or freestanding nursing facility supplemental payments in attachment 4.19-D in the Hawai'i state plan:
 - <https://humanservices.hawaii.gov/wp-content/uploads/2021/06/Attachment-4.19-CDE-Rev.-01.2021.pdf>
- The proposed regional classes for the islands of Oahu and Hawaii reflect the different levels of uncompensated costs and maintains access to care in each region.

○ Nursing Facility Quality Pool

- 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.

• LTC Access Payments

- Under the directed uniform payment increases, Hawai'i's MCOs will make uniform payment increases for each nursing facility day within each regional provider class. This program is predicated exclusively on utilization and delivery of services.

• Nursing Facility Quality Pool

- All nursing facilities, for both the private and public (CAH and non-CAH) classes, are evaluated using the same quality metrics, same scoring basis, and same Quality Tier thresholds.

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)
<i>Ex: Rural Inpatient Hospital Services</i>	80%	20%	N/A	N/A	100%
a. Critical Access Hospitals (CAH)	73.16%	0.73%			73.89%
b. HHSC (Non-CAH) on Island of O'ahu	50.32%	23.77%			74.09%
c. HHSC (Non-CAH) on Island of Hawai'i	48.93%	42.59%			91.53%
d. Private Nursing Facilities	90.20%	0.70%			90.90%
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.

Please see the ‘MQD CY2026 LTC Preprint Exhibits – 20251002.xlsb’ for a detailed development of ACR levels, including explanation of data sources and methodology

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

- **LTC Access Payments**

- The combined base payments and payments from this State Directed Payment are capped at 100.0% of cost (as a proxy for payments under Medicare). Total payments including the separate quality pool payments are within 101% of estimated costs, which is effectively at Medicare reimbursement levels and is estimated to be significantly below commercial reimbursement levels.

- **Nursing Facility Quality Pool**

- Total directed payments including the directed quality pool payments are reasonably close to cost benchmarks and are significantly below commercial reimbursement levels. The State believes the slight increases above the cost benchmark from this SDP are appropriate because they incentivize improved quality and are at risk based on facility performance.

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?

RFP-MQD-2021-008.

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

The contractual obligations are described in Section 7.2.C.1.e.2 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 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.

Both 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:

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.

- **LTC Access Payments**

- 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 processes 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.

- **Nursing Facility Quality Pool**

- 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 processes 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 broad-based?	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. Nursing Facility Sustainability Fee	nursing facility 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. Nursing Facility Sustainability Fee	9/27/2019	Approved	03/09/2020
ii.			
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.

Page numbers may change, but the relevant goals and objectives have not changed in the new draft Quality Strategy.

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. LTC Access Payment and NF Quality Pool: Maintain or Enhance Access to Care Align payment structures to improve health outcomes	Quality Strategy Objective 17: Align payment structures to enhance quality and value of care	55
b. LTC Access Payment and NF Quality Pool: Enhance care in LTSS settings	Quality Strategy Objective 13: Enhance nursing facility and Home and Community Based Services (HCBS); prevent delay of progression to nursing facility level of care	50
c.		
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.

As of September 2025, Hawai'i has one of the highest overall nursing facility quality scores in the nation (3.4 as compared to a national average of 2.9), tied for third among all 53 states and territories. This payment arrangement is intended to continue to support nursing facilities in ensuring the availability of high-quality care.

- **LTC Access Payments**

- This payment arrangement allows Med-QUEST to continue to ensure adequate funding is available for public nursing facilities 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.

- **Nursing Facility Quality Pool**

- The nursing facility quality payment pool program is a part of a broader MQD initiative to enhance the quality and value of care rendered across various settings, and is intended to advance MQD's Quality Strategy Objective 17 "Align payment structures to enhance quality and value of care." This program is alignment with other pay-for-performance programs for providers (for example, for hospitals), as well as value-based purchasing programs for Managed Care Organizations. Paying nursing facilities performance bonuses for quality metrics incentivizes them to focus on quality improvement activities targeting the Medicaid populations they serve.
- The quality metrics selected for this program, as described later in this Preprint, are intended to advance MQD's Quality Strategy Objective 13 "Enhance nursing facility services". Linking the quality payment pool to these metrics will supplement the existing acuity-based claim payment methodology and tie more payment to quality outcomes.
- Metrics for the program were carefully chosen, in collaboration with the Healthcare Association of Hawai'i (HAH), to reflect the primary goals of care for the nursing facility population. MQD tentatively plans to use the Quality Tiers and metrics described in this Preprint for 3 years although year 3 performance may warrant future adjustments to the program. In the long-term, nursing facility performance will be monitored and metrics will be adjusted as needed.

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. Long Stay Antipsychotic Medications	2021	9.03%	Meet or exceed that national average	
ii. Long Stay Pressure Ulcers	2021	4.89%	Meet or exceed the national average	
iii. PointRight – Pro 30 Rehospitalizations	2021	11.26%	Statistically significant maintenance of baseline rate	
iv. PointRight Pro Long Stay – Hospitalizations	2021	8.15%	Statistically significant maintenance of baseline rate	

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 for 2024 are being submitted along with this preprint.

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

Directions 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.

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)
		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.	HHSC - CAH	73.2%	0.7%	N/A	N/A	73.9%
b.	Non-CAH HHSC - Oahu	50.3%	23.8%	N/A	N/A	74.1%
c.	Non-CAH HHSC - Hawai'i	48.9%	42.6%	N/A	N/A	91.5%
d.	Private Facilities	90.2%	0.7%	N/A	N/A	90.9%
e.						
f.						
g.						
h.						
i.						
j.						
k.						
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