

STATE OF HAWAII
“QUEST EXPANDED” SECTION 1115 DEMONSTRATION
(11-W-00001/9)

DRAFT EXTENSION APPLICATION
May 29, 2012

The State of Hawaii, Department of Human Services (DHS), is seeking a three-year extension of the QUEST Expanded Section 1115 demonstration project (the Demonstration) from the Centers for Medicare & Medicaid Services (CMS). Absent an extension, the Demonstration will expire on June 30, 2013.

I. Historical Narrative Summary of the QUEST Expanded Program

Originally implemented as the QUEST program in 1994, QUEST Expanded is the current version of Hawaii’s demonstration project to provide comprehensive benefits to its Medicaid enrollees through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. The State combined its Medicaid program with its then General Medical Assistance Program and its State Children’s Health Insurance Program. Low-income women, children, and adults who had been covered by the two “state-only” programs were enrolled into fully capitated managed care plans throughout the State. This program contributed substantially to closing the coverage gap in the State for low-income individuals.

QUEST includes three primary programs: QUEST, QUEST-Net, and QUEST-ACE. In 2008, the State added QUEST Expanded Access (QExA) for Medicaid clients who are 65 years or older or disabled of all ages, who were previously receiving services through a fee-for-service (FFS) system. Together, the four components are known as QUEST Expanded.

The goals of QUEST Expanded are to:

- Improve the health care status of the member population;
- Maintain a managed care delivery system that assures access to high quality, cost-effective care;
- Establish a “provider home” for members through the use of assigned primary care providers (PCPs);
- Establish contractual accountability among the state health plans and health care providers;
- Continue the predictable and slower rate of expenditure growth associated with managed care; and
- Expand and strengthen a sense of member responsibility that leads to more appropriate utilization of the health care system.

More specifically, for the Aged, Blind and Disabled (ABD) population, the goals of the QExA program are to:

- Maintain a managed care delivery system for the ABD population that assures access to high quality, cost-effective care;
- Coordinate care for the ABD population across the care continuum (from primary care through long-term care);
- Expand access to home- and community-based services, and allow beneficiaries meeting the institutional level of care to have a choice between institutional services and home- and community-based services.

Since its implementation, the State has made several changes to the current QUEST Expanded program.

- 1) The first amendment, approved July 11, 1995, allowed the State to deem parental income for tax dependents up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing for expansion populations, impose a premium for self-employed individuals, and change the fee-for-service window from the date of coverage to the date of enrollment.
- 2) The second amendment, approved on September 14, 1995 allowed the State to cap QUEST enrollment at 125,000 expansion eligibles.
- 3) The third amendment, approved on May 10, 1996, allowed the State to reinstate the asset test, establish the QUEST-Net program, and require participants to pay a premium.
- 4) The fourth amendment, approved on March 14, 1997, lowered the income thresholds to the mandatory coverage groups and allowed the State to implement its medically needy option for the AFDC-related coverage groups for individuals who become ineligible for QUEST and QUEST-Net.
- 5) The fifth amendment, approved on July 29, 2001, allowed the State to expand the QUEST-Net program to children who were previously enrolled in SCHIP when their family income exceeds the Title XXI income eligibility limit of 200% FPL.
- 6) In January 2006 (with a retroactive start date of July 1, 2005), the federal government approved an extension of the Section 1115 waiver for Hawaii, QUEST programs which incorporated the existing QUEST program with some significant changes including:
 - Extension of coverage to all Medicaid-eligible children in the child welfare system;
 - Extension of coverage to adults up to 100% of the FPL who meet Medicaid asset limits through QUEST-ACE;
 - Elimination of premium contributions for children with income at or below 250% of FPL;

- Elimination of the requirement that children have prior QUEST coverage as a condition to qualifying for QUEST-Net; and
 - Increased SCHIP eligibility from 200% of FPL to 300% of FPL.
- 7) In February 2008, the waiver was amended to implement the QUEST Expanded Access (QExA) program and to increase the eligibility level for QUEST-ACE from 100% to 200% of the FPL.
- 8) In April 2012, CMS approved the State’s request to cap eligibility for non-pregnant, non-disabled adults not otherwise Medicaid eligible at 133% of the FPL.

As described in more detail below, the State currently has an amendment pending that seeks to align the QUEST-Net and QUEST-ACE benefits with the QUEST benefit package, and to add certain benefits to the QExA benefit package.

II. Description of the QUEST Expanded Demonstration

Delivery System

The State seeks an extension of the Demonstration in order to continue to provide most benefits through capitated managed care programs. Fee-for-service shall continue to be provided for long-term care services for individuals with developmental disabilities, applicants eligible for retroactive coverage only, and medical services under the State of Hawaii Organ and Tissue Transplant (SHOTT) program, as well as for certain other benefits.

Eligibility Requirements

The QUEST program provides Medicaid State Plan benefits through comprehensive managed care plans to the following children and adults:

- Families with dependent children covered by the State Plan up to 300% FPL for children and 100% for adults;
- Pregnant women with a family income not exceeding 185% of FPL;
- Adults who are Temporary Assistance for Needy Families (TANF) cash recipients but are otherwise not eligible for Medicaid;
- Low-income adults covered under Section 1931 of the Social Security Act;
- Individuals qualifying for transitional medical assistance under Section 1925 of the Social Security Act;
- Participants in the State General Assistance Program; and
- Childless adults with income up to 100% of the FPL, subject to an enrollment cap.

QUEST-Net provides more limited coverage to adult recipients previously enrolled in QUEST, QUEST Expanded Access (QExA) or Medicaid Fee-For-Service who have income in excess of the Medicaid limits up to 133% of the FPL or assets exceeding QUEST limits. QUEST-Net provides State Plan benefits to children.

The QUEST-ACE program provides the same benefits as QUEST-Net for adult applicants with income in excess of the Medicaid limits up to 133% of the FPL and for childless adults with income up to 100% who are unable to enroll in the QUEST program due to the enrollment cap.

QExA provides State plan benefits, plus long-term care services, including nursing facility and home- and community-based services, for the following individuals:

- Aged, blind, or disabled individuals who meet the SSI standards.
- Individuals with breast or cervical cancer with income at or below 250% FPL.
- Aged or disabled adults whose SSI-related net income is at or below 100% FPL.
- Medically needy aged, blind, or disabled individuals who meet the medically needy household income standard using SSI income methodology.
- Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules.
- Individuals who would otherwise be eligible under the State plan or another QExA demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of the QExA capitation payment, subject to an enrollment fee equal to the spend-down liability

Eligibility for all 4 programs will continue as described above, until January 1, 2014, when the Medicaid changes enacted in the Affordable Care Act (ACA) take effect. In this extension application, the State is not currently proposing any amendments related to the January 1, 2014 changes. That will be done by separate amendment, subject to a separate notice and comment process.

Benefit Coverage

The Demonstration currently offers three benefit packages:

- 1) Full Medicaid State plan benefits for QUEST children and adults and for QUEST-Net children.
- 2) The QExA benefit package through which aged, blind, and disabled individuals may receive State plan primary, acute, and long-term (*i.e.*, nursing facility) care services in addition to the waiver home- and community-based services.
- 3) A limited benefit plan for adults in QUEST-Net and QUEST-ACE, which includes: emergency visits; 10 inpatient hospital days (no benefit for maternity, nursery, rehabilitation, or skilled nursing level of care); 12 outpatient medical visits; 6 mental health outpatient visits; 3 ambulatory surgery procedures; diagnostic tests associated with the outpatient medical visits; certain immunizations; family planning services; limited prescription drugs; language interpretation services; and preventive and restorative dental.

Once CMS approves the pending amendments, the Demonstration will offer two benefit packages:

- 1) Full Medicaid State plan benefits for QUEST, QUEST-Net, and QUEST-ACE beneficiaries.
- 2) The QExA benefit package through which aged, blind, and disabled individuals may receive State plan primary, acute, and long-term (i.e., nursing facility) care services in addition to the waiver home and community based services. The QExA benefit package will include primary and acute care beyond that which is offered in the State plan, including inpatient services without limitation, optometry services, hospice services for children without limitation, and rehabilitation services.

Cost Sharing

The State will continue to allow copayments as set forth in the Medicaid State plan, and will continue to have the authority to charge up to 5% in annual family income for cost sharing. Additionally, medically-needy individuals with a spend-down will be required to pay an enrollment fee equal to the spend down obligation or, where applicable, the amount of patient income applied to the cost of long-term care.

III. Pending Amendments Included in the Extension Application

Hawaii requests an extension of the Demonstration under the same terms and conditions as the current waiver and any approved pending amendments. DHS is aware that it will need to amend the Demonstration to reflect new requirements in the ACA that take effect January 1, 2014, and it plans to submit a separate proposed amendment, with a separate notice and opportunity for comment, to do so.

The pending amendments include the following:

- Align benefits for non-aged, -blind, or -disabled adults. Currently, the Demonstration offers three different benefit packages: QUEST (State plan benefits); QExA (State plan benefits plus additional long-term care services); and QUEST-ACE/QUEST-Net benefits (less comprehensive benefits package). This amendment will change the QUEST-ACE/QUEST-NET benefit package to mirror State plan benefits. These changes will facilitate preparation for expansion under the ACA and a future program merger.
- Consolidate all non-categorically needy recipient adults—i.e., non-pregnant childless adults age 19 and older—under QUEST-Net or, for applicants, QUEST-ACE. The consolidation of all non-Medicaid eligibles, who will eventually be the new ACA mandatory group, under QUEST-ACE/QUEST-Net promotes efficiency and streamlines operations without any negative impact on recipients. This amendment will distinguish the QUEST program as the program that serves the categorically needy populations, thereby effectively eliminating the need for the QUEST enrollment cap.
- Consolidate all eligible CHIP children under QUEST, or QExA for those who are blind or disabled. Currently, CHIP children with income up to and including 200% FPL are

placed in QUEST, or QExA if they are blind or disabled, and those with income above 200% FPL but not exceeding 300% FPL are placed in QUEST-Net. Despite enrollment in different programs, all children below 19 years of age receive identical benefits. Consolidating CHIP children under one program is more efficient with no negative impact on recipients.

- Allow retroactive enrollment in QUEST, QUEST-Net, and QUEST-ACE health plans as already exists in QExA plans.
- Expand QExA benefits. The QExA benefit package currently includes State plan primary and acute care. Under the pending amendment, QExA plans will include primary and acute care beyond that which is offered in the State plan. These expanded services will include inpatient services without limitation, optometry services, hospice services for children without limitation, and rehabilitation services.
- Enroll medically needy individuals who are expected to prospectively incur expenses from the date of eligibility sufficient to satisfy their spend-down obligation in a QExA plan.
- Make the QUEST-ACE assets limit the same as the assets limit in QUEST-Net
- Repeal the Hawaii Premium Plus Program due to absence of legislative appropriation.
- Make technical changes, as detailed in the State's amendment application.

IV. Waivers and Expenditure Authorities

The State requests the same waiver and expenditure authorities as those approved in the current demonstration, as well as those requested in the State's pending amendments to the current demonstration. This waiver and expenditure authority is described below. (Language that the pending amendments would add is underlined; language that the pending amendments would remove is in brackets.)

Waiver Authority

1. Medically Needy Section - 1902(a)(10)(C); Section 1902(a)(17)

To enable the State to limit medically needy spend-down eligibility except those enrolled in QUEST Expanded Access (QExA) to those individuals whose gross incomes, before any spend-down calculation, are at or below 300% of the Federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, which have no gross income limit.

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

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

3. Financial Responsibility/Deeming - Section 1902(a)(17)(D)

To allow the State to determine eligibility for QUEST, QUEST-ACE, and QUEST-Net [Children] using the income of household members whose income may be taken into account under the income rules of the related cash assistance program. If the household income so exceeds the program's limits, the State shall determine eligibility using standard Medicaid financial responsibility and deeming rules.

To allow the State to deem financial support from parents and legal guardians when determining eligibility for adults who are age 18 or older, but under age 21, and who are claimed as tax dependents by their parents or legal guardians.

4. Three-Month Retroactive Eligibility - Section 1902(a)(34)

To enable the State to limit retroactive eligibility to a five (5) day period prior to application, or [ninety (90) days] up to three months for [transitional home and community-based services] individuals requesting long-term care services.

5. Freedom of Choice Section 1902(a)(23)

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

Expenditure Authority

1. Managed Care Payments.

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

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

Expenditures for capitation payments to MCOs in non-rural areas that do not provide enrollees with a choice of two or more plans, as required under section 1903(m)(2)(A)(xii), section

1932(a)(3) and Federal regulations at 42 CFR section 438.52, to the extent necessary if a plan exceeds its enrollment cap.

2. Quality Review of Eligibility.

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

3. Demonstration Eligibility. Expenditures to provide coverage to the following populations:

- a. Demonstration Eligibles Enrolled in QEx Eligibility Components other than Quest Expanded Access (QExA).
 - i. TANF cash recipients, whose income is up to 100 percent FPL (using the TANF methodology), but are not otherwise eligible under the Medicaid State plan or enrolled in QUEST;
 - ii. Adults including General Assistance (GA) cash recipients, whose income is up to 100 percent FPL (using the GA methodology), but are not otherwise eligible under the Medicaid State plan or enrolled in QUEST, subject to an enrollment cap;
 - iii. Adults who have lost QUEST or Medicaid Fee-for-Service eligibility because they have income or assets in excess of the Medicaid limits (QUEST-Net Adults):
 1. Effective through June 30, 2012: With income up to 200 percent of the FPL or, for individuals continuously enrolled since January 1, 2008, incomes up to 300 percent FPL;
 2. Effective July 1, 2012 through June 30, 2013: With income up to 133 percent of the FPL; and
 - iv. Adults with incomes or assets in excess of the Medicaid limits, but who are not otherwise Medicaid eligible (QUEST-ACE):
 1. Effective through June 30, 2012: With income up to 200 percent of the FPL;
 2. Effective July 1, 2012 through June 30, 2013: With income up to 133 percent of the FPL.
- b. Demonstration Eligibles Enrolled in the QExA eligibility component.
 - i. Persons who would be eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR section 435.217 if the home and community-based services that they are receiving from a QExA plan were provided under a waiver that was granted to the State under section 1915(c) as of the initial approval date of the QExA component of this demonstration. This includes the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.
 - ii. Non-institutionalized persons who meet the institutional level of care but live in the community, and who would be eligible under the approved

State plan if the same financial eligibility standards were applied that apply to institutionalized individuals, including the application of spousal impoverishment eligibility rules. Allowable expenditures shall be limited to those consistent with the regular post eligibility rules and spousal impoverishment rules.

- iii. Individuals who would otherwise be eligible under the State plan or another QExA demonstration population only upon incurring medical expenses (spend-down liability) that is estimated to exceed the amount of the QExA capitation payment, subject to an enrollment fee equal to the spend-down liability.

4. Hospital Uncompensated Care Costs.

Expenditures to reimburse certain hospital providers for provider costs of hospital services to the uninsured, and or underinsured, subject to the restrictions placed on hospital uncompensated care costs, as defined in the STCs.

5. QExA Home and Community-Based Services (HCBS) and Personal Care Services.

Expenditures to provide HCBS and personal care services not included in the Medicaid State plan and furnished to QExA enrollees, as follows:

- a. Expenditures for the continued provision of services provided to individuals enrolled during the transition from fee-for-service to QExA in the State's Nursing Home Without Walls (NHWW), Residential Alternatives Community Care Program (RAACP), Medically Fragile Community Care Program (MFCCP) and HIV Community Care Program (HCCP) HCBS waiver programs as fee-for-service expenditures for the period beginning with the effective date of these authorities until QExA plan coverage (under the authority of subparagraphs band c below) is operational;
- b. Expenditures for the provision of services, through QExA plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement;
- c. Expenditures for the provision of personal care services, through QExA plans, to individuals with less than a need for an institutional level of care, including personal care assistance services provided by a family member.

6. [Hawaii Premium Plus (HPP) Subsidy Program.

Expenditures to provide of a premium subsidy to eligible HPP employers, as defined within the May 1, 2010 amended special terms and conditions, Section XI, in the provision of employer sponsored health insurance (ESI) coverage.]

Title XIX Requirements Not Applicable to Demonstration Populations

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

[To enable the State to modify the Medicaid benefit package to provide a more limited package to eligible QUEST-Net Adult and QUEST ACE beneficiaries.]

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

2. Cost Sharing - Section 1902(a)(14) and 1916

To the extent necessary to enable the State to impose cost-sharing that is above the limits that would apply under the State Plan. A qualifying Hawaii Prepaid Health Care Act employer must limit the employee's premium costs to no more than 1.5 percent of the employee's salary for employer sponsored insurance coverage. Co-payments and other cost-sharing will be consistent with the enrollee's specific health plan.

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

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

To enable the State to charge an enrollment fee to QExA enrollees whose spend-down liability or cost share obligation is estimated to exceed the QExA capitation rate (Demonstration Population 3.b.iii.), in the amount equal to the estimated spend-down or cost share amount.

4. Expenditures for MCO Contracts - Section 1903(m)(2)(A)(vi)

To enable the State to restrict an enrollees' right to disenroll without cause within 90 days of enrollment in a new MCO.

V. Summaries of EQRO Reports, MCO and State Quality Assurance Monitoring, and Other Documentation of the Quality of and Access to Care Provided Under the Demonstration

DHS hired Health Services Advisory Group, Inc. (HSAG) as its external quality review organization (EQRO) to monitor the Demonstration's managed care health plans. The 2011 External Quality Review Report of Results for the QUEST and QUEST Expanded Access Health Plans (hereafter "2011 EQR Report"), which provides more detail about the EQRO's activities, is available at <http://www.med-quest.us/PDFs/Consumer%20Guides/2011%20External%20Quality%20Review%20Report.pdf>

In 2011, HSAG performed the three federally mandated activities set forth in 42 C.F.R. § 438.358: a review and evaluation of compliance with the federal managed care standards and

associated State contract requirements; validation of performance measures/Healthcare Effectiveness Data and Information Set (HEDIS®) compliance audits; and validation of performance improvement projects. HSAG also performed two optional external quality review activities: a survey of child members (*i.e.*, parents/caregivers) using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and a survey of health care providers (primary care providers and specialists) contracted with QUEST Expanded health plans. The chart below summarizes these external quality review activities:

External Quality Review Activity	Description	Findings, Conclusions, and/or Recommendations
<p>Review and Evaluation of Compliance with Federal Managed Care Standards and State Contract Requirements</p>	<p>HSAG developed a monitoring tool to document pertinent findings and calculate performance scores in five areas or standards—delegation, member information, grievance system, provider selection, and credentialing—related to the health plans’ structure and operations, as described in the managed care regulations at 42 C.F.R. §§ 438.214-230. This review included approximately half of the managed care regulations and associated State standards to be reviewed within a three-year period, as the other half had been reviewed in 2010.</p>	<p>The plans received individual scores for each of the five areas reviewed for compliance. These scores can be viewed in the 2011 EQR Report linked to above. Two areas of strong health plan performance statewide emerged: member information and provider selection. Following issuance of the final reports, the health plans were required by the Med-QUEST Division to submit corrective action plans for any standards scored “Partially Met” or “Not Met”. HSAG collaborated with the Med-QUEST Division to review and approve the health plans’ corrective action plans. The results of the corrective activity and reevaluation of compliance will be reported in next year’s EQR Report.</p>
<p>Validation of Performance Measures/HEDIS®</p>	<p>HSAG performed independent audits of the HEDIS data. Each HEDIS Compliance Audit incorporated a detailed assessment of the health plans’ information systems capabilities for collecting, analyzing, and reporting HEDIS information. During the HEDIS audits, HSAG reviewed the performance of the health plans on six State-selected HEDIS performance measures: Childhood Immunization Status, Comprehensive Diabetes Care, Ambulatory Care, Cholesterol Management for Patients With Cardiovascular Conditions, Breast Cancer Screening, and Chlamydia Screening in Women.</p>	<p>All plans were compliant with the National Committee for Quality Assurance’s (NCQA) information systems standards. Plans varied in how they compared to the national Medicaid HEDIS 2010 averages. Those comparisons can be viewed in the 2011 EQR Report linked to above. Recommendations varied across the indicators. HSAG recommended that each plan target the lower-performing measures for improvement.</p>

<p>Validation of Performance Improvement Projects</p>	<p>The QUEST plans were required to conduct performance improvement projects on “Access to Care” and “Assessing the Documentation of Body Mass Index or Height and Weight Using the EPSDT Form.” The QExA plans were required to conduct one project on improving the results of a HEDIS measure, and a second on a topic of the plan’s choice, approved by the Med-QUEST Division. Both QExA plans conducted performance improvement projects related to the HEDIS measure on diabetes care. For their second project, both QExA plans focused on an aspect of obesity care.</p>	<p>HSAG validated each plan’s performance improvement project by following standardized validation procedures to assess the degree to which the projects were designed, conducted, and reported in a methodologically sound manner. Following the review and validation of the plans’ 2011 projects, HSAG arrived at a handful of specific conclusions, which can be viewed in the 2011 EQR Report linked to above. All plans’ projects achieved a “Met” validation status, with one exception. The health plans received various recommendations.</p>
<p>CAHPS®</p>	<p>The CAHPS health plan surveys are standardized survey instruments that measure members’ satisfaction levels with their health care. For 2011, HSAG administered a CAHPS survey for plan enrollees under 18 years of age.</p>	<p>The results of nine measures of satisfaction were reported. These measures included four global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often) and five composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Shared Decision Making). The QUEST plans’ aggregate score was above the NCQA national child Medicaid average on five measures: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, How Well Doctors Communicate, and Shared Decision Making. The QExA plan aggregate score was above the NCQA national child Medicaid average on one measure: Shared Decision Making. More details about the CAHPS findings can be found in the 2011 EQR Report linked to above.</p>
<p>Provider Survey</p>	<p>HSAG administered a survey to health care providers serving Demonstration enrollees. The goal of the provider survey was to supply feedback as it relates to providers’ perceptions of the Demonstration health plans and the QUEST Expanded program. The survey covered topics for primary care and specialty providers, including the impact of the plans’ utilization management on the providers’ abilities to provide quality care, satisfaction with reimbursement, and adequacy of the formulary.</p>	<p>The provider survey revealed that there was an opportunity to improve provider satisfaction with the Demonstration plans, and HSAG provided recommendations for improving provider satisfaction within the domains evaluated. Recommendations for the Med-QUEST Division related to the survey results were also offered. More details about the survey’s results can be found in the 2011 EQR Report linked to above.</p>

In addition to the EQRO activities, in 2010, the Med-QUEST Division finalized a new Quality Strategy in compliance with 42 C.F.R. § 438.202. The Quality Strategy was developed in part by following the CMS toolkit and checklist for State Quality Strategies, and by using the CMS-approved Delaware Quality Strategy as a template. A copy of the Quality Strategy is available at <http://www.med-quest.us/ManagedCare/qualitystrategy.html>

Under the Quality Strategy, the Health Care Services Branch in the Med-Quest Division receives and reviews all monitoring and quality reports from the MCOs, the DD/ID waiver, the State of Hawaii Organ and Tissue Transplant (SHOTT) program, and the EQRO. Findings from the reports are presented to various Quality Strategy Committees on a monthly rotation. The Committees are composed of representatives from the Quality Strategy Leadership Team, technical experts from the programs being reviewed, as well as the Health Care Services Branch reviewers. The Committee meetings represent a formal process for the analysis of data received, root causes, barriers, and improvement interventions. The Committees recommend feedback to the MCOs and programs, and corrective action is requested if needed.

The Med-QUEST Division also began implementing CMS's Quality Framework for home- and community-based services (HCBS) in state fiscal year 2011. The quality grid included measures that span the six assurances and sub-assurances of level of care, service plans, qualified providers, health and welfare, financial accountability, and administrative authority. The State will use this template for HCBS monitoring.

Like all States, Hawaii compiles data for the CMS-Form 416, Annual EPSDT Participation Report. Form 416 includes, among other things, the number of individuals eligible for EPSDT, the number receiving screening, the number referred for medical treatment, and the number provided dental services. Hawaii's 2011 Form 416 shows a screening ratio of .98, and a participation ratio of .78. The Form 416 from 2010 and from 2011 will be included as Attachment A in the final application to CMS.

VI. Waiver-Related Financial Data

In the last full demonstration year, July 1, 2010 to June 30, 2011, state and federal expenditures totaled approximately \$1.35 billion. During the requested extension period, aggregate expenditures for each year are anticipated to total approximately \$1.42 billion (DY 20), \$1.50 billion (DY 21), and \$1.60 billion (DY 22), with a federal share of \$717 million (DY 20), \$762 million (DY 21), and \$810 million (DY 22). Neither these figures nor the State's budget neutrality analysis referenced below account for the changes to the Demonstration that will be required by ACA starting on January 1, 2014. When the State submits its separate proposed amendment to address those requirements, it will also include financial data and projections, and a budget neutrality analysis, to account for the ACA-mandated changes.

The State's budget neutrality calculations can be viewed in the charts in Attachment A, which include detailed data about the Demonstration's historic, cumulative, and projected expenditures. No changes are being requested to the State's current demonstration, with approval of the pending amendment.

VII. Evaluation Report of the QUEST Expanded Waiver

Hawaii is testing the following research hypotheses through the current Demonstration:

- 1) The Demonstration will improve health outcomes and reduce inappropriate utilization.
- 2) The Demonstration will improve the overall health of Hawaii's most vulnerable citizens under a coordinated care management environment.
- 3) The Demonstration will decrease the percentage of uninsured individuals in the State.
- 4) The Demonstration will expand access to home- and community-based services.

The Med-QUEST Division (MQD), Health Care Services Branch (HCSB) is in the process of developing its Demonstration Evaluation for the current 1115(a) waiver. The previous evaluation was submitted in April 2007 prior to renewal of the current waiver on February 1, 2008. In completing the previous evaluation, MQD/HCSB utilized a document from CMS that was produced in August 2006 called "Evaluating Demonstrations: A Technical Assistance Guide for States."

MQD/HCSB requested technical assistance (TA) to ensure that it is developing the Demonstration Evaluation report consistent with any new requirements that CMS may have imposed since August 2006. MQD's Medical Director, Dr. Curtis Toma, contacted Mr. Gary Jackson from CMS about TA on Demonstration Evaluations. Mr. Jackson referred MQD to a CMS project officer, Ms. Alexis Gibson. On April 12, 2012, MQD/HCSB requested TA from Ms. Alexis Gibson on development of the Demonstration Evaluation report. As of the date of this application, MQD/HCSB has not yet received TA.

Once TA is received, MQD/HCSB will complete development of the Demonstration Evaluation report for submittal to CMS. The State will use the same evaluation parameters during the three-year extension period.

VIII. Documentation of the State's Compliance with the Public Notice Process

A. The State's Public Notice and Input Efforts

The State has taken multiple steps to inform the public and solicit public input about its Demonstration extension application. These public notice and public input procedures comply with 42 C.F.R. § 431.408.

The State's public notice and comment period begins on May 29, 2012 and runs for 30 days, until June 28, 2012. During that time, the State is accepting public comments sent to Noreen Moon-Ng by mail to P.O. Box 700190, Kapolei HI 96709-0190 or by email to nmoon-ng@medicaid.dhs.state.hi.us.

On May 23, 2012, the State issued a public notice document with a comprehensive description of the proposed Demonstration extension. This notice includes the location and internet address where copies of the Demonstration extension application are available for review and comment; the dates of the public comment period; postal and e-mail addresses where written comments may be sent; and the locations, dates, and times of the two public hearings convened by the State to seek public input about the extension application. This public notice document describes the public notice and input processes, includes a link to the relevant Medicaid demonstration page on the CMS web site, and will be maintained for the entire public comment period in a prominent location at <http://www.med-quest.us/> and http://hawaii.gov/dhs/main/har/proposed_rules?.

On May 25, 2012, the State published an abbreviated public notice in the newspapers of widest circulation in each city with a population of 100,000 or more, which included a description of the demonstration extension; the locations, dates, and times of two public hearings convened to seek public input about the extension application; and an active link to the full public notice document on the State's web page.

Also on May 29, 2012, the State notified, via e-mail, a list of potentially interested parties (the e-mail included a link to the public notice document). This e-mail list was gathered from individuals who attended one of two community forums or provided comments as part of the public input process for the pending amendment. Copies of the public notice, the abbreviated public notice, and the e-mail notification will be included in the final Demonstration application submitted to CMS as Attachment B, Attachment C, and Attachment D, respectively.

The State will hold two public hearings to solicit public input and comment about the Demonstration extension application:

1. May 31, 2012: 9:00 a.m.:

- | | |
|--------|--|
| Oahu | Keoni Ana Videoconference Center
Keoni Ana Building
1177 Alakea Street, Room 302
Honolulu, Hawaii |
| Hawaii | Hilo Videoconference Center
Hilo State Office Building
75 Aupuni Street, Basement
Hilo, Hawaii |
| Kauai | Lihue Videoconference Center
Lihue State Office Building
3060 Eiwa Street, Basement
Lihue, Hawaii |

Maui Wailuky Videoconference Center
 Wailuku Judiciary Building
 2145 Main Street, First Floor
 Wailuky, Hawaii

2. June 6, 2012: 9:00 a.m.:

Med-QUEST Division
Kakuhihewa State Office Building
601 Kamokila Blvd., Room 577 A & B
Kapolei, Hawaii

In its public notice, the State provided contact information for State staff to assist individuals who require special assistance or auxiliary aids and/or services to participate in the public hearings (*e.g.*, sign or foreign language or wheelchair accessibility).

Below is a chart detailing the State’s public notice and input procedures:

Date	Public Notice and/or Public Input Opportunity
May 17, 2012	Tribal notice issued
May 23, 2012	Public notice issued and available on websites
May 25, 2012	Abbreviated public notice published in newspapers
May 29, 2012	E-mail to potentially interested parties
May 29, 2012	1115(e) Extension Application posted on Department and Division websites and available for public distribution
May 29, 2012	Public comment period begins
May 31, 2012	Public meeting via videoconference
June 6, 2012	Public meeting at the Med-QUEST Division

In addition to steps taken specific to this extension request, Med-QUEST recently solicited public input regarding its recently-approved and pending Demonstration amendments, which afforded the public the opportunity to comment on proposed changes to the Demonstration. As part of this public input process, Dr. Kenneth Fink, Administrator of the Med-QUEST Division, held six public forums to discuss the changes to QUEST Expanded.

B. Issues Raised by the Public and the State’s Consideration of Those Issues

As of this writing, the State’s public notice period has just begun. In the final application it submits to CMS, the State will report on the issues raised by the public and how the State considered them.

C. Tribal Consultation

In compliance with 42 C.F.R. § 431.408(b), the State is consulting and seeking advice from Indian Health programs and urban Indian health organizations prior to submission of the extension application to CMS. On May 17, 2012, the State mailed its tribal notification letter consistent with the requirements in its State plan, and the State's tribal consultation process will continue in accordance with the State's formal tribal consultation agreement/process and it will be conducted as outlined in the State Medicaid plan.

The final extension application will describe the tribal notification process, the entities involved in the consultation, the issues raised through the consultation, and the potential resolution of the issues raised. Copies of the tribal notice will be included as Attachment F in the final Demonstration application submitted to CMS.

D. The Post-Award Public Input Process

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

IX. Affordable Care Act Amendment

DHS recognizes that it will need to amend the Demonstration to reflect the new requirements in the ACA that take effect January 1, 2014, but is awaiting CMS approval of the pending amendment before undertaking that process. The State plans to develop, in the fall of 2012, a separate proposed amendment to address those requirements, and will offer a separate notice and opportunity for comment on that proposal. The State expects to submit the proposed amendment to CMS no later than February 1, 2013.