



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington DC 20201

JAN 31 2006

Lillian B. Koller, Esquire  
Director  
Department of Human Services  
Med-QUEST Division  
Policy and Program Development Office  
P O Box 700190  
Kapolei, HI 96709-0190

Dear Ms. Koller:

We are pleased to inform you that the Hawaii Medicaid section 1115 demonstration extension, QUEST Expanded (11-W-0000179), is approved in accordance with section 1115(a) of the Social Security Act (the Act), through June 30, 2008, upon which date, unless reauthorized, all waivers and authorities granted to operate this demonstration will expire.

Our approval of this extension is subject to the limitations specified in the list of approved waivers and expenditure authorities. The State may deviate from Medicaid State plan requirements to the extent those requirements have been specifically waived or (with respect to expenditure authorities) listed as inapplicable to expenditures for demonstration expansion populations and to other expenditures for services not covered under the State plan. The approval is also conditioned upon compliance with the enclosed Special Terms and Conditions (STCs), and is subject to our receiving your acknowledgement of the award and the acceptance of the STCs, waiver list, and expenditure authorities within 30 days of the date of this letter.

Your project officer is Lane Terwilliger, Esquire. She is available to answer questions concerning this demonstration project. Ms Terwilliger's contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and State Operations  
7500 Security Boulevard, S2 01 16  
Baltimore, MD 21244-1850  
Telephone: (410) 786-2059  
Facsimile: (410) 786-5883  
E-mail: Lane.Terwilliger@cms.hhs.gov

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Official communications regarding program matters should be submitted simultaneously to the project officer and to Ms. Linda Minamoto, Associate Regional Administrator in our San Francisco Regional Office. Ms. Minamoto's address is:

Centers for Medicare & Medicaid Services  
Division of Medicaid & Children's Health  
75 Hawthorne Street, Suite 408  
San Francisco, CA 94105

If you have additional concerns regarding CMS oversight of this demonstration or additional questions, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

Sincerely,



Mark B. McClellan, M.D., Ph.D.

Enclosures

**EXPENDITURE AUTHORITY  
FOR HAWAII'S SECTION 1115(a) DEMONSTRATION**

**NUMBERS:** 11-W-00001/9 (Title XIX)  
21-W-00020/9 (Title XXI)

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

**AWARDEE:** Hawaii Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 shall, for the period of this demonstration extension be regarded as expenditures under the State's Title XIX plan.

The following costs not otherwise matchable expenditure authorities shall enable the State to implement the approved Special Terms and Conditions (STCs) for the Hawaii QUEST Expanded Medicaid Section 1115 Demonstration.

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

a) Expenditures for capitation payments provided to managed care organizations (MCOs) in which the State restricts enrollees' right to 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) of the Act. Enrollees may disenroll for cause at any time and may disenroll without cause during the annual open enrollment period, 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.

2. Expenditures to provide coverage to the following populations that are not otherwise covered under the Medicaid State plan.

a) **Children Not SCHIP Eligible.** Children with family incomes above 200 percent but below 300 percent of the Federal poverty level (FPL) who are not otherwise eligible under the Medicaid State plan but who are not within the definition of optional targeted low income children (QUEST - Not children for whom the State is claiming title XIX funding); and

b) **Demonstration Eligible Enrolled in QUEST Expanded:**

- Adults who are TANF cash recipients but are not otherwise eligible under the Medicaid State plan;
- Childless adults who are GA cash recipients but are not otherwise eligible under the Medicaid State plan;

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- Adults who have lost QUEST or Medicaid Fee-for-Service eligibility (QUEST-Net adults), and
  - Adults with incomes at or below 100 percent of the FPL and who meet Medicaid asset limits, including those previously enrolled in the former fully State-funded SHIP program, but who are not otherwise Medicaid-eligible (QUEST-Adult-Coverage-Expansion).
3. **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.
  4. **SCHIP-Related Demonstration Eligibles.** Expenditures to provide coverage to children not otherwise eligible under the approved State Medicaid plan who meet the definition of optional targeted low income children and have family incomes above 200 percent but less than or equal to 300 percent of the FPL.

Requirements Not Applicable to the Demonstration Eligible Populations:

**Cost Sharing**

**Section 1902(a)(14)**

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

**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-Adult-Coverage-Expansion beneficiaries.

**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.

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**CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL TERMS AND CONDITIONS**

**NUMBERS:** 11 W-00001/9 (Title XIX)  
21-W-00030/9 (Title XXI)

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

**AWARDED:** Hawaii Department of Human Services

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for Hawaii's QUEST Expanded (QEx) section 1115 (a) Medicaid demonstration excursion (hereinafter "Demonstration"). The parties to this agreement are the Hawaii Department of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective February 1, 2006 unless otherwise specified. Demonstration year 12 is the period from July 1, 2005 through June 30, 2006. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through June 30, 2008.

The STCs have been arranged into the following subject areas: Program Description and Objectives, General Program Requirements, General Reporting Requirements, Eligibility, Benefits, and Enrollment, Cost Sharing, Delivery Systems, Hospital Uncompensated Care, General Reporting Requirements, General Financial Requirements under title XIX and XXI, Accounting Procedure, Monitoring Budget Neutrality, Evaluation, and Schedule of State Deliverables During the Demonstration.

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

The QUEST Expanded section 1115 (a) Demonstration is designed to use a managed care delivery system to create efficiencies in the Medicaid program and enable the extension of coverage to certain individuals who would otherwise be without health insurance. Through the enactment of the Hawaii Prepaid Health Care Act (HPHCA), the State requires employers to provide health insurance to any employee who works 20 or more hours a week. The initial QUEST demonstration project was approved in 1993 to help provide coverage to adults and children not covered under HPHCA. Currently the QUEST demonstration project has approximately 160,000 enrollees, 93,000 of whom are children. As part of this QUEST Expanded demonstration project, Hawaii seeks to continue the QUEST initiative and expand coverage to approximately 9,000 children and up to 20,000 adults. Through this Demonstration and the HPHCA, Hawaii expects to reduce its rate of uninsurance and improve quality and efficiency while stabilizing cost.

Under this Demonstration Hawaii expects to achieve the following objectives:

- Improve health outcomes and reduce inappropriate utilization.

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- That by continuing to serve recipients in a coordinated care-managed environment, the overall health of Hawaii's most vulnerable citizens will continue to improve.
- Decrease the percentage of uninsured individuals in the State.
- Expand coverage to Children from 200 percent through 300 percent of the Federal Poverty Level (FPL) using title XXI funding.

**III. GENERAL PROGRAM REQUIREMENTS**

- 1. Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.
- 3. Changes in Law.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid and SCHIP programs that occur after the approval date of this Demonstration, unless the provision being changed is explicitly waived.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this SIC. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The State shall not be required to submit Title XIX State plan amendments for changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required except as otherwise noted in these special terms and conditions.
- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget and allotment neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The state must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration is not retroactive and FFP may not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

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7. **Amendment Process:** Amendment requests must be submitted to CMS for approval no later than 120 days prior to the date of implementation and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:
  - a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
  - b) A current assessment including the necessary expenditure data, of the impact the requested amendment shall have on budget and allotment neutrality;
  - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
  - d) A description of how the evaluation design shall be modified to incorporate the amendment provisions.
  
8. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted herein the State is responsible for reviewing, complying and adhering to the timeframes and reporting requirements as set forth in Section 1115 (e) of the Social Security Act (Act) and the STCs. During the six-month period ending one year before the date this extension is scheduled to expire (June 30, 2007), the State must submit to CMS written notice of the State's intent to extend the Demonstration. Regardless of the authority for the extension, the State must submit to CMS no later than January 30, 2008, a complete extension application, including any proposed Demonstration modifications and complete budget neutrality data.
  
9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State shall submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FRP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
  
10. **Enrollment Limitation During Demonstration Phase-Out.** During the last six months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current Medicaid State plan shall not be permitted unless the Demonstration is extended by CMS.

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11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
12. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS's finding that the State materially failed to comply.
13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Titles XIX or XXI. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
14. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
15. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) when any program changes to the Demonstration, including, but not limited to, those referenced in section III, paragraph 6, are proposed by the State.
16. **Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR Section 438 et. seq., except as expressly waived or referenced in the expenditure authorities incorporated into the STCs. Capitation rates, must be developed and certified as actuarially sound in accordance with 42 CFR Section 438.6.
17. **Federal Funds Participation.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

#### IV. QUEST Expanded ELIGIBILITY, BENEFITS, AND ENROLLMENT

"QUEST Expanded" (QEx) is a continuation of the State's current demonstration "QUEST," which is funded through Title XIX and Title XXI. QEx will increase the State's SCHIP (Title XXI) program for children and increase coverage for low-income uninsured adults. QEx will continue the QUEST program, which provides Medicaid State Plan benefits through comprehensive managed care plans to families and children covered by the state plan, as well as to childless adults with income up to the specified federal poverty level (FPL), subject to an enrollment cap. The QUEST-Net program currently provides coverage to children (who receive all state plan benefits) and adults (who receive a limited package of benefits) previously enrolled in QUEST or Medicaid fee-for-service but who have income in excess of the Medicaid limits, up to 300% of the FPL. Under QEx, all children up to 300% FPL will be eligible for QUEST-Net; the requirement that the child have been previously enrolled in QUEST will be eliminated, and the premium contribution will be eliminated or reduced for most children. The State is also instituting a QUEST Adult-

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Coverage Expansion program, which provides the same benefits as the QUEST-Net coverage for adults, to all adults under 100% of the FPL, who are unable to enroll in QUEST due to the enrollment cap.

18. **Eligibility:** Mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the S/Cs and waiver and expenditure authorities for this Demonstration. The criteria for QLEx eligibility groups is as follows:

<b>QUEST</b>	
<b>Mandatory State Plan Groups</b>	<b>FPL Level and/or other qualifying criteria</b>
Pregnant women and infants under age 1	Up to 185% FPL
Children 1-5	Up to 133% FPL
Children 6-18	Up to 100% FPL
Adult AFDC related family members covered by Section 1931	Up to 100% FPL
Transitional Medicaid (Section 1925)	Coverage is for two six-month or one four-month periods due to increased earnings or child support, respectively, make an individual ineligible for continued coverage under Section 1931. In the second six month period, family income may not exceed 185% FPL.
<b>Optional State Plan Groups</b>	
Children through the S-C.H.H.P. Medicaid expansion	101 - 200% FPL and for whom the State is claiming Title XXI funding
Medically Needy	Up to 300% FPL. If individuals otherwise eligible under State Plan groups described above spend down to Medicaid income limits.
<b>Demonstration Eligible Groups</b>	
Adult AFDC related family members who are TANF cash recipients who are otherwise ineligible for Medicaid.	Up to 100% FPL (using TANF methodology)
Childless adults who are General Assistance (GA) cash recipients but are otherwise ineligible for Medicaid.	Up to 100% FPL (using GA methodology)
Childless adults who meet Medicaid asset limits.	Up to 100% FPL (subject to an enrollment cap presently set at 125,000)

<b>QUEST-Net-Children</b>	
<b>Demonstration Eligible Groups</b>	<b>FPL Level and/or other qualifying Criteria</b>
Children who could be eligible for SCHIP	201-300% FPL for whom the State is claiming Title XXI funding
Children who are not eligible for SCHIP	201-300% FPL - who could be eligible through 1912 (+) (2) and for whom the State is claiming Title XXI funding  Eligibility criteria requiring prior enrollment in QUEST or Medicaid for service is eliminated in QUEST-Net Expanded.

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**QUEST-Net-Adults**

Demonstration Eligible Groups	FPL Level and/or other qualifying Criteria
Adults	Up to 300% FPL but exceed QUEST asset and/or income rules. Must meet QUEST-Net-Adult asset limit
Adults	Eligible to enroll in QUEST subject to a premium share, but who have elected to participate in QUEST-Net-Adult.

**QUEST-Adult-Coverage-Expansion**

Demonstration Eligible Groups	FPL Level and/or other qualifying Criteria
Childless Adults	Up to 100% FPL and meet the Medicaid asset limits but who are unable to enroll in QUEST due to enrollment cap.

19. **Financial Responsibility/Deeming.** The State shall determine eligibility using the income of household members whose income may be taken into account under the AFDC-income rules. If the household income so calculated exceeds QUEST limits, the State shall determine eligibility using Medicaid financial responsibility and deeming rules.
20. **Quality Review of Eligibility.** The State will continue to follow Medicaid Eligibility Quality Control (MEQC) plan procedures approved by CMS on October 11, 1996, when reviewing eligibility determinations for Demonstration enrollees. The State remains relieved of any liability from disallowance for errors that exceed the three (3) percent tolerance. Any changes to the MEQC plan procedures related to the Demonstration must be submitted to CMS as an amendment pursuant to the procedures set forth in paragraph 7.
21. **QUEST Expanded Benefits:** Benefits provided through this Demonstration for QUEST, QUEST-Net-Children, QUEST-Net-Adults, and QUEST-Adult-Coverage-Expansion are as follows:
  - a) **QUEST.** QUEST benefits are State Plan benefits delivered through mandatory managed care. Through this Demonstration extension, QUEST Expanded, the State is adding a preventive and restorative dental benefit for adults. The costs of such services are capped at \$500 annually for each individual. Covered services are listed in Attachment B.
  - b) **QUEST-Net-Children.** QUEST-Net-Children benefits are State Plan benefits delivered through mandatory managed care for non-blind or disabled children and through fee-for-service for blind and disabled children.
  - c) **QUEST-Net-Adults and QUEST-Adult-Coverage-Expansion:** The following benefits are delivered through mandatory managed care to QUEST-Net-Adults and QUEST-Adult-Coverage-Expansion groups:
    - Emergency Visits (including ground ambulance) (as defined in State Plan)
    - 10 Inpatient Hospital Days (no benefit for maternity, surgery, rehabilitation, or skilled nursing level of care) (as defined in State Plan)
    - 12 Outpatient medical visits (as defined in State Plan)

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- 6 Mental health outpatient visits (as defined in State Plan)
- 3 Ambulatory Surgeries (as defined in State Plan)
- Diagnostic tests associated with the 12 outpatient medical visits (as defined in State Plan)
- Immunizations for diphtheria and tetanus (as defined in State Plan)
- Family planning services (as defined in the State Plan) consultation, counseling, or examination subject to the limitation on outpatient visits; and voluntary sterilization subject to the limitation on surgeries)
- Limited Prescription Drugs (over-the-counter and prescription drugs limited by a strict formulary defined by the State and the MCO)
- Language/Interpreter Services QUEST-Net enrollees receive language interpretation services when receiving a covered benefit, if necessary
- The 12 outpatient medical visits benefit may include alcohol and substance abuse outpatient visits (as defined in State Plan)
- 6 of the 12 outpatient medical visits may be substituted for 6 mental health outpatient visits (as defined in State Plan)

22. **Plan Selection Process.** The State must provide all Demonstration applicants with brochures on the available health plans, and will ask each applicant to select a health plan when he or she submits the application. If Demonstration applicants do not make a selection within ten days, they are automatically assigned to a plan within a reasonable geographical radius of their home. If more than one plan is available and meets the needs of the applicant, the assignment process provides preferential treatment to the plan with the lowest expiration rate. A QUEST-Net-Adult applicant who is required to pay a premium and who does not choose a plan is not eligible to participate.

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

24. **Enrollment Cap and Priority Enrollment:** Adult applicants with incomes below 100 percent of the FPL who do not meet the qualifications for any other eligibility category are subject to an enrollment cap for enrollment into the QUEST coverage group. The cap is set at 125,000 individuals.

a) An adult applicant is not subject to the enrollment cap if:

- His or her countable family income is less than 62.5 percent of the FPL for 1993 and the individual meets the criteria for the former General Assistance (GA) program. The GA program covers single adults, childless couples, and adults in 2-parent families ages 18-64 who must be either temporarily disabled or meet work search requirements;

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- AFDC related family members covered by section 1931;
  - Adults, his or her countable family income is less than 62.5 percent of the FPL for 1993;
  - The individual has been covered by employer-sponsored insurance and has applied for QUEST benefits within 45 days of losing such coverage; and
  - The individual has been covered under COBRA and has applied for QUEST benefits within 45 days of losing COBRA coverage.
- b) The State will continue to accept applications and determine whether an eligible individual is exempt from the enrollment cap.
- c) Individuals who are not subject to the enrollment cap will be enrolled. All others will be denied or, if eligible, enrolled into QUEST-Adult-Coverage Expansion.
- d) When on the last day of the previous calendar year the statewide enrollment for the population subject to the enrollment cap is at least 120,000, or earlier when determined to be in the best interest of the State, the State must open enrollment and take applications. If applications received during the open application period exceed the number of available number of slots, the State will give priority to applicants who are enrolled in QUEST-Adult-Coverage-Expansion.

**V. COST SHARING**

25. Premiums are charged to individuals who are not otherwise eligible for Medicaid as follows:

Population	Premiums
Self-employed QUEST Expanded adults and spouses, with the exception of an enrollee who is pregnant, a recipient of cash assistance received through General Assistance or TANF, or a recipient of Section 1931.	50% of cost per person per month
QUEST-Net adults with family income greater than 100% FPL, with the exception of TANF recipients	\$60 per person per month
Self-employed QUEST Net adults and spouses with family income less than or equal to 100% FPL, with the exception of TANF recipients	\$30 per person per month
QUEST-Net children (both title XIX- and title XXI-eligible) with family income greater than 250% FPL and less than or equal to 300% FPL	Up to \$60 per person per month on a sliding scale based on income (not to exceed 5 percent of the family's total annual income)

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**VI. DELIVERY SYSTEMS**

26. **Contracts.** Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation.
27. **Contracting with Federally Qualified Health Centers (FQHCs).** The State must require health plans to contract with FQHCs. If an MCO can demonstrate to CMS and to the Hawaii Department of Human Services that both adequate capacity and appropriate range of services for vulnerable populations exist to serve the expected enrollment in all service areas without contracting with FQHCs, the plan may, with CMS Regional Office approval, be relieved of this requirement.

**VII. HOSPITAL UNCOMPENSATED CARE**

- Federal statute at 42 USC Section 1923 currently prevents Hawaii from receiving an allotment for payment adjustments for inpatient hospital services furnished by disproportionate share hospitals, known as a "DSH" program. Federal financial participation for hospital uncompensated care (UCC) payments described in this section will be provided as set forth below.
28. **Available Federal Financial Participation for UCC:** Annually, Federal financial participation (FFP) is authorized to pay for hospital UCC during this extension period. The State shall be limited to no more than the total of actual UCC incurred in any given year, up to \$15 million FFP. Expenditures may be made for hospital uncompensated care costs (UCC) in private hospitals as well as governmentally owned and operated hospitals provided the benchmarks set forth in paragraphs 31, 32, 33, and 34 are met. Unexpended FFP may be carried forward into subsequent Demonstration years.
29. **Availability of UCC Funds.** Under the authority granted in these Special Terms and Conditions, the availability of Demonstration funding the State may use to pay uncompensated care costs to hospitals will begin February 1, 2006 for costs incurred on and after July 1, 2005, through June 30, 2008, unless payments for costs incurred after June 30, 2008 are specifically reauthorized in a subsequent extension to this demonstration by CMS.
30. **Coverage of Uncompensated Care Costs:** The State will be permitted to make payments to governmentally-operated and private hospitals to cover uncompensated care costs (UCCs) of furnishing hospital services as follows:

- a) **Governmentally-operated Hospitals:** The costs are limited to the following:
- The costs of providing hospital services to the uninsured, reduced by any applicable uninsured hospital inpatient and outpatient revenues, and any payments made by or on behalf of the uninsured for the provision of said services to this population (Uninsured shortfall);
  - The costs of providing inpatient and outpatient hospital services to QUEST Expanded enrollees, reduced by any applicable Medicaid managed care revenues for the provision of said services to this population (QUEST Expanded shortfall);

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- The costs of providing outpatient hospital services to Medicaid fee-for-services (FFS) beneficiaries, reduced by any applicable Medicaid outpatient revenues for the provision of said services to this population (FFS Outpatient shortfall); and
- b) **For Governmentally-operated Hospitals: UCCs Must Not Include:**
- Inpatient FFS shortfall, as public hospitals already receive inpatient payments only up to cost;
  - The costs of providing non-emergency care to unqualified aliens, including those from countries which have entered into a Compact of Free Association with the U.S; and
  - The costs of providing drugs to individuals eligible for Medicare Part D.
- c) **For Governmentally-operated Hospitals:** Certified public expenditure reimbursement methods shall comply with the approved State plan for the populations and services set forth in this paragraph. CMS must approve any alternative method. In the event that CMS issues national guidance and/or policy governing CPE methodology, the State will comply with such guidance.
- d) **Privately-operated Hospitals:** For private hospitals, direct payments may cover UCCs up to the amount of funds made available by the State for this purpose. UCCs for private hospitals will include the following:
- The Uninsured shortfall;
  - QUEST Expanded shortfall;
  - FFS outpatient shortfall; and
  - The costs of providing inpatient services to Medicaid FFS enrollees reduced by the amount of payments received from Med-QUEST for the provision of said services to this population (FFS inpatient shortfall).
- e) **For Privately-operated Hospitals: UCCs Must Not Include:**
- The costs of providing non-emergency care to unqualified aliens, including those from countries which have entered into a Compact of Free Association with the U.S; and
  - The costs of providing drugs to individuals eligible for Medicare Part D.
- f) **Governmentally-operated Hospitals.** The State may pay Governmentally-operated hospitals listed in Attachment A UCC payments. Any changes to Attachment A must be approved by CMS. The State must report to CMS any changes to the ownership and/or operational status of any hospital listed in Attachment A.

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g) **Reporting UCC Payments to Hospitals.** The State will report all expenditures for UCC payments to hospitals under this Demonstration on the Forms CMS-64.9 Waiver and/or 64.9F Waiver under the appropriate waiver name, as well as on the appropriate forms CMS-64.9I and CMS 64.9PI.

h) **DSH Legislation.** Should legislation pass authorizing a DSH allotment for Hawaii, the LICC and Budget Neutrality provisions will be brought into compliance with the authorizing provisions. The State must submit budget neutrality information requested by CMS.

31. **Benchmarks:** The State must accomplish the benchmarks specified in paragraphs 32, 33, and 34 in Demonstration years 12, 13, and 14, respectively.

32. **Demonstration Year 12.**

a) **Implementation QUEST- Adult-Coverage-Expansion:** The State will submit and secure approval from CMS of its implementation plan for the QUEST-Adult-Coverage-Expansion no later than July 1, 2006. The implementation plan must include the following components:

- Outreach efforts;
- Program readiness;
- Enrollment and eligibility training; and
- **Assurances of Enrollment and Coverage Start Dates.** Enrollment must begin no later than October 1, 2006 and coverage will begin on January 1, 2007.

b) **Reporting Cumulative Success QUEST-Adult-Coverage Expansion.** Beginning with the Annual Report due for Demonstration year 12, and continuing in subsequent Demonstration years, the State must provide annual qualitative and quantitative data that describes the impact the QUEST-Adult-Coverage Expansion has on the rate of uninsurance and emergency room utilization in Hawaii. Year 12 results must include but not be limited to development of baseline data and process information. Future years will also include case studies and outcome measures to evaluate the shifting of care away from the emergency room and inpatient place of treatment and the impact on the rate of insurance

33. **Demonstration Year 13 Enrollment Requirements.** The State will enroll at least 4,500 individuals into QUEST-Adult-Coverage Expansion group by the end of Demonstration year 13. In the event the State has not enrolled at least 4,500 individuals into QUEST-Adult-Coverage Expansion group at the end of Demonstration year 13, the State will submit a plan to CMS detailing the actions it will undertake to increase enrollment, including modifying the income and asset enrollment requirements.

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- 34. **Demonstration Year 14 Enrollment Requirements.** The State will enroll 7,500 of the State's uninsured into QUEST-Adult-Coverage Expansion group by the end of Demonstration year 14. In the event the State has not enrolled at least 7,500 individuals into QUEST Adult Coverage Expansion group at the end of Demonstration year 14, the State will submit a plan to CMS detailing the actions it will take to increase enrollment, including modifying the income and asset enrollment requirements.

**VIII. GENERAL REPORTING REQUIREMENTS**

- 35. **General Financial Requirements.** The State must comply with all general financial requirements under Title XIX and Title XXI set forth in section IX.
- 36. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in section VIII.
- 37. **Corrected Budget Neutrality Information.** The State must submit corrected budget neutrality data upon request.
- 38. **Compliance With Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR Section 418 et. seq. except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.
- 39. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate verifications), health care delivery, enrollment, including the State's progress on enrolling individuals into the QUEST-Adult-Coverage Expansion group, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, MCO financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.
- 40. **Monthly Enrollment Data.** The State must provide monthly enrollment data for each eligibility group specified in paragraph 18.
- 41. **Quarterly Reports:** The State must submit progress reports in a format specified by CMS and no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:
  - a) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to approval and contracting with new plans, progress on implementation and/or enrollment progress of the QUEST-Adult-Coverage-Expansion group; populations served, and benefits, enrollment, grievances; quality of care;

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access; health plan financial performance that is relevant to the Demonstration, and other operational issues;

- b) Action plans for addressing any policy and administrative issues identified;
- c) State efforts related to the collection and verification of encounter data and enrollment data;
- d) The quarterly reports must also include various kinds of data, such as enrollment data, member month data, budget neutrality monitoring tables;
- e) Progress toward demonstration goals, in particular, updates on all milestones contained in section VIII; and
- f) Evaluation activities.

42. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State must submit the draft annual report no later than March 1, 2007. Within 30 days of receipt of comments from CMS, a final annual report must be submitted. The annual report must include the expenditures for uncompensated care costs and expenditures made for the QUEST-Adult-Coverage Expansion group.

43. **Title XIX Enrollment Reporting.** Each month the State will provide CMS with enrollment figures by Demonstration populations. In addition each quarter the State will provide CMS with an enrollment report by demonstration population showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.

#### **IX. GENERAL FINANCIAL REPORTING REQUIREMENTS FOR DEFINED AUTHORIZED EXPENDITURES**

##### **General Financial Requirements under Title XIX**

44. **Quarterly Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X.

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

- a) In order to track expenditures under this Demonstration, Hawaii must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions

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outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures must be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

- b) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, the QUEST Expanded premium collections (both total computable and Federal share) should also be reported on the Form CMS-64 Narrative.
- c) Corrections for any incorrectly reported demonstration expenditures for previous demonstration years must be input within three months of the beginning of the extension. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual.
- d) For each Demonstration year at least eight (8) separate waiver forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed reporting expenditures for individuals enrolled in the Demonstration and for hospital uncompensated care payments as follows:
  - 1) Mandatory Title XIX Children (State Plan Children) (CMS-64.9 Waiver and/or 64.9P Waiver);
  - 2) Optional Title XIX Children (Optional State Plan Children), including title XXI children if title XXI allotment is exhausted (CMS-64.9 Waiver and/or 64.9P Waiver)
  - 3) Mandatory Adults (State Plan Adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
  - 4) QUEST Adults (Demonstration eligible adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
  - 5) QUEST-Net Adults (Demonstration eligible adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
  - 6) QUEST-Adult-Coverage-Expansion (QUEST ACE, Demonstration eligible adults) (CMS 64.9 Waiver and/or CMS 64.9P Waiver);
  - 7) Hospital payments to governmentally-operated hospitals (UCC-Governmental)
  - 8) Hospital payments to private hospitals (UCC-Private) (CMS 64.9 Waiver and/or CMS 64.9P Waiver).

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9) SCHIP children up to 200 percent of the FPL covered through the Medicaid expansion (CMS 21 P)

- 46 **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration and for hospital uncompensated care payments as described in paragraph 45 (d) (1-8). All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS 64.9 Waiver and /or 64.9P Waiver.
- 47 **Premium Collection Adjustment.** The State must include 1115 premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.
- 48 **Administrative Costs.** Administrative costs must not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.
- 49 **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the Demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- 50 **Reporting Member Months:** The following describes the reporting of member months for Demonstration populations:
- a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member months for all Medicaid and Demonstration Eligibility Groups (EGs) defined in section IV paragraph 18. This information must be provided to CMS 30 days after the end of each quarter as part of the CMS-64 submission, either under the narrative section of the MBES/CBS or as a stand-alone report. To permit full recognition of "in-process" eligibility, reported counts of member months must be subject to minor revisions for an additional 180 days after the end of each quarter. For example, the counts for the quarter ending September 30, 2005, due to be reported by November 30, 2005, are permitted to be revised until June 30, 2006.
  - b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

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c) For the purposes of this Demonstration, the term "Demonstration eligibles" refers to the eligibility groups described in Section IV paragraph 18. The term "Demonstration eligibles" specifically excludes unqualified aliens, including aliens from the Compact of Free Association countries.

51. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. Hawaii must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
52. **Extent of Federal Financial Participation:** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide Federal Financial Participation (FFP) at the applicable Federal matching rates for the following, subject to the limits described in section X.
- a) Administrative costs, including those associated with the administration of the Demonstration;
  - b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and
  - c) Net expenditures made with dates of service during the operation of the Demonstration.
53. **State Certification of Funding Conditions.** The State certifies that matching funds for the Demonstration are State/local appropriations. The State further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding and distribution of monies involving Federal match are subject to CMS approval.
- a) CMS may review the sources of the non-Federal share of funding and distribution methods for Demonstration funding at any time. All funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
  - b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
54. **MSIS Data Submission.** The State must submit its Medicaid Statistical Information System (MSIS) data electronically to CMS in accordance with CMS requirements and timeliness standards. The State must ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

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

**General Financial Requirements under Title XXI**

56. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided to Title XXI children that are Demonstration eligible between 201-300% FPL. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide enhanced FFP only for allowable expenditures that do not exceed the State's available Title XXI funding.

57. **Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES):** In order to track Title XXI expenditures under this Demonstration, the State must report Demonstration expenditures through the MBES/CBES, following routine CMS 21 reporting instructions as outlined in section 2113 of the State Medicaid Manual. Title XXI Demonstration expenditures must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made) Once the appropriate waiver form is selected for reporting expenditures, the State must be required to identify the program code and coverage (children or adults).

a) All claims for expenditures related to the Demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the Demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS 21;

b) The standard SCHIP funding process must be used during the Demonstration. Hawaii must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State must provide updated estimates of expenditures for the Demonstration population. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS shall reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State, and

c) The State will certify that State/local monies are used as matching funds for the Demonstration. The State further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding

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sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

58. **Limitation on Title XXI Funding.** Hawaii shall be subject to a limit on the amount of Federal Title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal Title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available Title XXI Federal funds for the claiming period, no further enhanced Federal matching funds shall be available for costs of the Demonstration until the next allotment becomes available.
59. **Exhaustion of Title XXI Funds.** In order to continue operation of the Demonstration if the State exhausts the available Title XXI Federal funds for the claiming period, the State will continue to provide the same coverage to its approved Title XXI State plan population and the Demonstration population with Title XIX funds until further Title XXI Federal funds become available. The State may close enrollment or institute a waiting list with respect to Title XXI populations. Before closing enrollment or instituting a waiting list, the State must provide 60-day notice to CMS. The State and CMS will negotiate an allotment neutrality agreement once further Title XXI funds become available.
60. **Priority of Title XXI Expenditures.** The State will use title XXI funds to cover services for the SCHIP State plan and Title XXI-eligible Demonstration children in the following priority order:
- a) Individuals eligible under the title XXI State plan;
  - b) Beginning February 1, 2006, children with family income above 200 percent of the FPL, and less than or equal to 300 percent of the FPL who are Title XXI-eligible;
  - c) If the State determines that title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population. The State will not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI State plan while the Demonstration is in effect;
  - d) The State may also, for the Title XXI-eligible children enrolled in the Demonstration: lower the FPL used to determine eligibility, and/or; suspend eligibility determination and/or intake into the program, or, discontinue coverage, institute cost sharing up to the Title XXI limits; and
  - e) Before taking any of the above actions related to the priority system, Hawaii must provide 60-day notice to CMS.

**X. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION**

61. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the Approval Period February 1, 2006, Through June 30, 2008

period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration.

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

63. **Eligibility Groups (EG) Subject to the Budget Neutrality Agreement.** The two EGs under this budget neutrality agreement are:

EG 1	Income Level
Infants under 1	Up to 185 % FPL
Children 1-5	Up to 133% FPL
Children 6-18	Up to 100% FPL
Children who could be eligible for Medicaid through the implementation of section 1902(r)(2) provisions (QUEST-Net children for whom the State is claiming Title XIX funding)	Up to 300% FPL
EG 2	
Pregnant women	Up to 185 % FPL
Section 1931 Adults	Up to 100% FPL

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

For each year of the budget neutrality agreement an annual limit is calculated for the EGs described above. The annual limit for the Demonstration is the sum of the projected annual limits for the two EGs, plus a Disproportionate Share Hospital (DSH) adjustment for that year described in (c) below.

- a) Each EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 50 (a) for that EG, times the appropriate estimated per member per month (PMPM) cost from the table in (f) below.
- b) The PMPM limits are determined by applying the growth rate of 7.64 percent for each EG.

(c) The budget neutrality ceiling is the sum of the annual PM/PM limits for the Demonstration period plus the sum of the annual DSH adjustments, plus the amount of unused budget authority carried over from prior Demonstration years. The Federal share of the budget neutrality ceiling represents the maximum amount of Federal Financial Participation (FFP)

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that the State may receive for expenditures on behalf of eligibles described in paragraph 50 (c) during the Demonstration period

- d) The Disproportionate Share (DSH) adjustment is based upon Hawaii's DSH allotment for 1993 and calculated in accordance with current law. The total computable DSH adjustment for July 1, 2005 through June 30, 2006 is \$80,364,047. The DSH adjustment for each subsequent year shall be the previous Demonstration year's adjustment trended by the policy contained in current law. In this manner, Hawaii will have available funding for DSH adjustments similar to other states. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation that impacts the calculation of DSH allotments.
- e) The following are the ceiling PM/PM costs for the calculation of the budget neutrality expenditure ceiling for the Demonstration enrollees under this section 1115 Demonstration
- f) The PM/PM costs below must be net of premiums paid by QUEST Expanded eligibles

SFY	All Children	State Plan Adults
2006	\$261.16	\$458.35
2007	\$281.11	\$493.37
2008	\$302.59	\$531.07

- 65. **Reporting Actual Member Months.** For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the State must provide a report to CMS, in the format provided by CMS, identifying the State's actual member months for each EG and corresponding actual expenditures for each EG, less the amount of premiums paid by QUEST eligibles.
- 66. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
Year 12	Budget neutrality cap plus	2 percent
Years 12 and 13	combined budget neutrality caps plus	1 percent
Years 12 through 14	combined budget neutrality caps plus	0 percent

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

**XI. EVALUATION**

- 68. **State Must Evaluate the Demonstration.** The State must submit to CMS for approval a draft evaluation design no later than May 1, 2006. At a minimum, the draft design must include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design must

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**ATTACHMENT A  
HOSPITALS THAT MAY RECEIVE PAYMENTS FOR UNCOMPENSATED CARE COSTS**

**Public Hospitals**

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

**Private Hospitals**

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

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**ATTACHMENT D  
 QUEST ADULT DENTAL BENEFIT**

Code	Description	Limits
	<b>Diagnostics</b>	
D0120	Periodic oral examination	1/year
D0270	Single bitewing	
D0272	Bitewings--2films	
D0220	Periapical, first film	
D0230	Periapical, additional film	
	<b>Preventive</b>	
D1110	Prophylaxis--adult	1/year
	<b>Restorative</b>	
D2140	Amalgam --1 surface	
D2150	Amalgam--2 surfaces	
D2160	Amalgam--3 surfaces	
D2161	Amalgam--4 or more surfaces	
D2330	Composite--1 surface anterior	
D2331	Composite--2 surfaces anterior	
D2332	Composite 3 surfaces anterior	
D2335	Composite--4 or more surfaces anterior	
D2931	Stainless Steel Crown	

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**CENTERS FOR MEDICARE & MEDICAID SERVICES  
WAIVER LIST**

**NUMBERS:** 11-W-00001/9 (Title XIX)  
21-W-00020/9 (Title XXI)  
**TITLE:** QUEST Expanded Medicaid Section 1115 Demonstration  
**AWARDEE:** Hawaii Department of Human Services

**Title XIX Waivers**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning February 1, 2006, through June 30, 2008. In addition, these waivers may only be implemented consistently with the approved Special Terms and Conditions (STCs).

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

To enable the State to limit medically needy spend-down eligibility for QUEST to those individuals whose gross incomes, before any spenddown calculation, are at or below 300 percent 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 permit managed care organizations (MCO) providing QUEST, QUEST-Net and QUEST-ACE coverage to provide additional benefits that may not be available to enrollees in other plans or to Medicaid recipients not enrolled in an MCO.
3. **Financial Responsibility/Deeming** **Section 1902(a)(17)(D)**  

To allow the State to determine eligibility using the income of household members whose income may be taken into account under the AFDC-income rules. If the household income so calculated exceeds QUEST Expanded limits, the State shall determine eligibility using Medicaid financial responsibility and deeming rules.

To also 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.

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**3. Three Month Retroactive Eligibility Section 1902(a)(34)**

To enable the State to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made because QUEST Expanded eligibility begins on the date of the application.

**5. Quality Review of Eligibility Section 1902(a)(4)**

To enable the State to be exempt from the current administrative procedure of reviewing the eligibility process and to allow the State to continue to follow Medicaid Eligibility Quality Control (MEQC) plan procedures approved by CMS on October 11, 1996, when reviewing eligibility determinations for Demonstration enrollees. The State remains relieved of any liability from disallowance for errors that exceed the three (3) percent tolerance.

**6. Freedom of Choice Section 1902(a)(23)**

To enable Hawaii to restrict the freedom of choice of providers.

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