Financial Models to Support State Efforts to Coordinate Care for Medicare-Medicaid Enrollees

Demonstration Proposal

Hawaii

Summary: In July 2011, CMS released a State Medicaid Directors' letter regarding two new models CMS will test for States to better align the financing of the Medicare and Medicaid programs, and integrate primary, acute, behavioral health and long term supports and services for Medicare-Medicaid enrollees. These two models include:

- Capitated Model: A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- Managed Fee-for-Service Model: A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

To participate, States must demonstrate their ability to meet or exceed certain CMS established standards and conditions in either/both of these models. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for the selected financial model(s). The Hawaii Department of Human Services has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time, interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m. EDT, June 29, 2012. You may submit comments on this proposal to HI-MedicareMedicaidCoordination@cms.hhs.gov.

STATE OF HAWAII

DEMONSTRATION TO INTEGRATE CARE FOR MEDICARE-MEDICAID ENROLLEES

PROPOSAL

May 25, 2012

A. Executive Summary

The Hawaii Department of Human Services (the Department) is pleased to submit this proposal for a Capitated Financial Duals Alignment Model to integrate healthcare for individuals eligible for both Medicare and Medicaid. The Department looks forward to collaborating with the Center for Medicare and Medicaid Services (CMS) on this model and the clinical, operational and financial integration for Hawaii's Medicare and Medicaid Enrollee (MMEs).

Since 2009, Hawaii has been in the forefront of delivering comprehensive and coordinated care to Medicaid beneficiaries. Through a partnership with health plans selected via a competitive procurement process, Hawaii's QUEST Expanded Access (QExA) Program offers coordinated care across the continuum of preventive, acute and long term care to individuals eligible for Medicaid. Each of the QExA health plans is required to deliver member-centric care that meets strict access, quality and performance criteria. The Department expects to begin re-procurement of the QExA contracts by the end of calendar year 2012 for a target date of January 1, 2014 for the commencement of service provision under the new contracts. The QExA health plans contracted as of January 1, 2014 and as approved by CMS will be the participating health plans in the demonstration that offers QExA Integrated with Medicare (QExA-IM).

The current QExA health plans offer Medicare Advantage special needs plans for MMEs (MA MME-SNP, aka Dual-SNP). The combined enrollment in the health plans of MMEs as of February 2012 is approximately 27,000, of which about 9,500 or 35% are also enrolled in one of the QExA health plans' MA MME-SNP. Although Hawaii already has made progress on coordinating care for the MMEs by enrollment of such members within the same health plan, the complexities and inconsistencies between the current Medicare and Medicaid programs do not fully support and enable full integration. Hawaii proposes to use the QExA-IM Program Model to integrate the experience of both the Medicaid and Medicare programs in a new demonstration. The goal of an integrated program will be to provide better access to care, improved clinical coordination, as well as improved quality and service for the Medicare and Medicaid Enrollee. An additional goal will be to enable administrative simplification, efficiency and provide increased value to the State of Hawaii, CMS, the healthcare providers and the participating community members.

The Capitated Alignment Model the Department proposes would leverage the ability to create a statewide QExA-IM program covering all Hawaii Medicaid beneficiaries who are fully eligible to receive Medicare and Medicaid. To leverage the success of the QExA program and fully integrate care, the Department proposes to seamlessly enroll those individuals into the QExA-IM program offered by their existing QExA health plan. Individuals who are in Medicare fee-for-service would be passively enrolled into QExA-IM, but those who have already enrolled in a Medicare Advantage (MA) plan other than that offered by a contracted QExA health plan shall remain in their chosen MA plan and receive only their Medicaid services from their QExA health plan.

In keeping with CMS's guidance for the program, eligible members will have the opportunity to opt-out of the plan in which they are enrolled. Under Hawaii's model, enrollees will have sixty (60) days from enrollment in which to opt out or change QExA health plans. After the opt-out period, enrollees will have the opportunity to change QExA health plans annually, or for specific reasons as set forth by the Department (such as moving from one island to another, or primary care provider no longer with current health plan). As is the case today in the QExA program, Medicaid covered services for MMEs will

continue to be only available through the QExA health plans. If an individual does elect to opt-out of the QExA-IM program in which they are enrolled, they will have the following options for their Medicare coverage:

- Return to the Medicare fee for service program (with a stand-alone Part D plan); or,
- Enroll in another Medicare Advantage program (with Part D)

All current and future MME beneficiaries not enrolled in a Medicare Advantage plan will be enrolled in the QExA-IM program for their Medicare coverage. The current MME beneficiaries that are enrolled in one of the QExA health plan's MA MME-SNP will be moved into the QExA-IM program for their Medicare coverage. All MME members seamlessly enrolled into QExA-IM will be able to opt-out of the QExA-IM program for their Medicare coverage as outlined above.

The QExA-IM program will cover the full continuum of preventive, acute, behavioral, long term care, and pharmacy services as provided today through Medicare and Medicaid. The QExA health plans will be encouraged to offer value added services as may be appropriately funded within the capitation rate provided by the State and CMS, in order to provide beneficiaries with additional benefits and choice.

Each qualified member will be assigned to a primary care provider and have an assigned Service Coordinator to identify health care needs and assist with coordination of primary and acute care as well as home and community based and long term care services.

The QExA health plans will receive a capitation payment for the combined Medicare and Medicaid benefit package for members enrolled in the QExA-IM. The QExA health plans will receive different capitation rates for those individuals enrolled and those not enrolled in the QExA-IM demonstration; however, blended rates may be explored in the future. This will require that CMS transmit accurate enrollment files on a timely basis in order for the Department to know when an individual has chosen a different option for Medicare coverage.

The program will include the following beneficiary protections for each plan participant:

- An ability to opt-out of the program for their Medicare coverage
- A stakeholder advisory board for each plan
- A stakeholder advisory board or Ombudsman program at the State level
- Choice of providers within each plan's network
- A specifically-assigned member Service Coordinator
- Appeals and Grievance procedures consistent with Medicaid and Medicare established standards
- State of Hawaii DHS Fair Hearing process for appeals and grievances

By fully integrating Medicare and Medicaid services in this way, the Department and the QExA health plans will be able to deliver seamless care to MME beneficiaries in Hawaii. The Department expects that through the delivery of fully integrated care, the health care system will be more member-centric, easily accessible and intuitive, allowing beneficiaries to navigate through the health care system more efficiently, more effectively and at a lower cost.

Overview of the Hawaii Integrated Care Delivery System Demonstration

Target population	*Beneficiaries fully eligible to receive Medicare and Medicaid benefits*
Total Number of Full benefit Medicare-Medicaid Enrollees Statewide	*27,189 as of November 30, 2011*
Total Number of Beneficiaries eligible for the Demonstration	*24,189*
Geographic Service Area	*Statewide*
Summary of Covered Benefits	*Medicaid State plan, Medicaid Waiver, Medicare Parts A,B,D, Behavioral health, Community based Services*
Financing Model	*The capitated financial alignment model offered in the 7/8/11 State Medicaid Director Letter*
Summary of Stakeholder Engagement and Input Vision	*The first stakeholder meeting was held at the Medicaid Summit on October 7, 2011, and the second meeting was held as part of a legislative briefing on April 3, 2012. In addition, focus groups were held with community stakeholders, mostly consumers, throughout the State in March and April 2012.*
Proposed Implementation	*January 2014*

B. Background

i. Overall Vision and Barriers to Integration

The QExA-IM Program will leverage Hawaii's successful QExA program to implement a fully integrated system of care that provides comprehensive services to Medicare-Medicaid Enrollees across the full continuum of Medicare and Medicaid benefits, including long-term services and supports (LTSS).

Each QExA health plan will be required to provide the full continuum of Medicare and Medicaid covered preventive, acute and long-term services and supports. Each plan will be required to meet Medicare network adequacy standards for all Medicare covered services and Medicaid network adequacy standards for long term care services and supports.

Each member will be provided with person-centered care leveraging each plan's existing Service Coordination model, interdisciplinary care teams and providing each participant with individualized care planning and management. The QExA health plans will assure that each member has a primary care provider, work to expand the role of primary care providers, and support more progressive models such as person-centered medical homes or medical neighborhoods for the QExA-IM program. Expanding access to technological solutions such as electronic medical records and care coordination tools will be leveraged to assure coordinated care that is accessible to members, providers and caregivers. In addition, QExA health plans will develop and pilot value-based payments to primary care providers who choose to adopt a more progressive role in managing and supporting their patients.

ii. Detailed Description of Target Population

The demonstration will be open to the eligible MME portion of the existing QExA population that includes children and adults with disabilities and the elderly but excludes approximately 1,200 individuals enrolled in the DD/ID 1915(c) home & community-based services (HCBS) waiver program. The number of MMEs targeted for enrollment is 26,000. Adults with serious mental illness will be included in the demonstration, but the specialized behavioral health services will remain carved out. Individuals receiving HCBS under our approved 1115 waiver will be included.

The charts below represent the estimated number and/or proportion of MME individuals who are currently receiving their Medicare and Medicaid benefits through the following delivery systems:

Medicare

Original Medicare FFS	15,455
Medicare Advantage (non-SNP)- not part of QExA program	2,634
Medicare Advantage (QExA SNP)	9,356
PACE	0
Other- Medicare Advantage (Non- QExA SNP)	138
Total	27,189

Medicaid

Traditional FFS	0
Medicaid managed care- comprehensive	27,189
Medicaid managed care- limited (e.g. BH only)	0
PACE	0
Other (specify)	

As shown above nearly 9,400 or 34 percent of the current QExA MMEs are also enrolled in the QExA health plan's MA MME-SNP product.

C. Care Model Overview

i. Description of Proposed Delivery System

Hawaii's QExA-IM Program will be based upon the QExA program model to deliver the integrated care for the MMEs. The QExA re-procurement will be conducted with CMS input to ensure that selected health plans meet both the QExA and QExA-IM requirements. Having experience with operating a Medicare Advantage Plan, particularly a NCQA approved MA MME-SNP, is expected to be a key factor.

By applying NCQA approved MA MME-SNP Models of Care to the delivery of all Medicare and Medicaid covered demonstration benefits, eligible enrollees will receive uniform health risk assessments, uniform care management and coordinated care planning, and integrated care gap tracking and reporting across the entire continuum of preventative, acute, and long-term care services and supports.

Each QExA health plan will be required to meet Medicare network adequacy standards for all Medicare covered services and Medicaid network adequacy standards for all long term care services and supports. Medicare and Medicaid medical necessity criteria (as applicable) will apply; however, where there is a conflict between the two, the Medicare medical necessity criteria will be applied to primary and acute services.

In QExA-IM, each eligible participant (full MME) will have a choice of health plans that will provide each member with a designated primary care provider and a Service Coordinator. Care management will be delivered via a multi-disciplinary team and integration with the primary care provider and specialty providers as appropriate.

(a) Geographic Service Areas

The demonstration program will be implemented on a statewide basis. All participating plans may be expected to operate statewide.

(b) Enrollment Method

Eligible members will be sent a letter notifying them that they will be seamlessly enrolled into QExA-IM offered by their existing QExA health plan unless they choose to opt out of the program. The letter will include specific direction that if the member chooses to disenroll, they will continue to receive their Medicaid services from their QExA health plan, and will only be opting out of participation in QExA-IM. Additionally, the Department is proposing changing the annual open enrollment period for QExA to align with the Medicare annual enrollment period. This will align the Medicaid and Medicare programs' benefit year and annual enrollment processes thereby decreasing member confusion.

For those individuals who become newly eligible, they will be offered the opportunity to choose between the QExA health plans for QExA-IM. If they fail to choose, they will be auto-assigned to a plan consistent with existing QExA auto-assignment policy. They retain the opt-out provisions as previously mentioned, for example sixty (60) days from auto-assignment enrollment to opt-out.

All current and future MME beneficiaries not enrolled in a Medicare Advantage plan will be enrolled in the QExA-IM program for their Medicare coverage. New MMEs will be passively enrolled into QExA-IM following conclusion of the Medicare initial enrollment unless they selected a MA plan offered by a non-QExA health plan. The current MME beneficiaries that are enrolled in one of the QExA health plan's MA MME-SNP will be moved into the QExA-IM program of that health plan for their Medicare coverage. MME members will be able to opt-out of QExA-IM program for their Medicare coverage. Individuals who enrolled in a MA MME-SNP offered by a QExA health plan but change QExA health plans will be enrolled into the QExA-IM plan offered by their new QExA health plan.

The Department seeks to ensure member choice and understands the need to have a sufficient number of individuals participating in QExA-IM. Options to opt-out include during the sixty-day period following

initial enrollment and during the annual enrollment/plan change period, or monthly. The former is consistent with current QExA enrollment procedures and increases continuity; the latter is consistent with current Medicare procedures and increases choice.

In order to facilitate the integration of the individual's Medicare and Medicaid coverage, the State of Hawaii intends to coordinate Medicare and Medicaid enrollment through a single, simplified and integrated enrollment process. The process will include a combined eligibility process with the QExA health plans, consistent file usage, reduced administrative burden, operational simplification, and improved accuracy and reporting. MMEs will enroll in a QExA health plan on a single, coordinated enrollment effective date based on QExA health plan selection or through auto-assignment.

To accomplish this, Hawaii recognizes the need to coordinate with CMS to develop an efficient and reliable process. Hawaii proposes that enrollment files pass through the Department's existing Medicaid enrollment process. Based on CMS data regarding Medicare enrollment, individuals will be considered enrolled or not enrolled in QExA-IM. Disenrollment from QExA-IM without change in QExA health plan would occur through CMS, and CMS would exchange disenrollment data with the Department. Disenrollment from QExA-IM with a change in QExA health plan would be managed by the Department, which would transmit such information to CMS. The State anticipates additional discussion with CMS on the final method for enrollment/disenrollment. The goal is to facilitate the enrollment process into QExA-IM without disrupting continuity for those who selected a MA plan not offered by a QExA health plan.

(c) Available Medical and Supportive Service Providers

Because QExA health plans will offer both Medicare and Medicaid health plans, their provider networks would separately need to meet Medicare and Medicaid network adequacy requirements. The State of Hawaii does not anticipate any adverse changes in terms of availability of medical and supportive service providers under the demonstration. In addition, the State expects QExA-IM will positively impact medical and supportive service providers. As a result of the administrative efficiencies gained through integration, providers will be able to devote more time to service delivery and less to administrative duties under the demonstration.

In accordance with the CMS guidance, demonstration health plans will be required to credential to the applicable standard, Medicare for primary and acute care and Medicaid for long term services and supports.

The need to coordinate benefits and billing across Medicare and Medicaid will be minimized for QExA-IM enrollees. Providers will be able to make referrals to and consult with a network operating under a uniform set of clinical guidelines and authorization requirements. Medical necessity will be based on Medicare requirements and Hawaii statute. Alignment of medical necessity criteria that meet the requirements of both will be sought.

Because of the rural nature of most of Hawaii and our island geography, certain specialty services are only available on the island of Oahu. Further, certain procedures and services are not available in Hawaii and require referral to a mainland provider. Hawaii's QExA health plans will provide access to specialty providers on Oahu for neighbor island members as well as referrals to mainland-based providers. The QExA health plans will also provide access to out of network providers when needed for specific unique or difficult to access services. Beyond meeting Medicaid and Medicare network

adequacy requirements, the Department will require and monitor the QExA health plans to enable, when appropriate, out of network and out of state referrals. The Department will also monitor the cost of out of network services to assure that the QExA health plans are utilizing applicable Medicare or Medicaid reimbursement as required. The State will work with CMS to clearly define demonstration plan obligations with respect to crossover claims applying the "lesser of" standard for reimbursement as well as member protection from balance billing or other potential member liability issues with both participating and non-participating providers.

ii. Description of Proposed Benefit Design

Upon implementation of the demonstration, all Medicaid State Plan and 1115 QExA waiver services will be included with the exception of DD/ID services and additional behavioral health services (i.e. Medicaid Rehabilitation Option services) as previously described. The QExA program provides comprehensive services to individuals 65 years and older and with disabilities of all ages. This includes coverage of HCBS and personal care long-term supports and services as required under the QExA 1115 waiver. All Medicare Part A and Part B covered services will also be included, and QExA-IM health plans must comply with Part D requirements. This approach allows for QExA-IM to coordinate the full array of Medicare covered services, Medicaid long-term care and home and community-based services and supports, and those services that are generally either Medicare Advantage supplemental benefits or Medicaid covered services – such as dental, vision, hearing and transportation as appropriately funded in the capitation.

Services will be approved based upon medical necessity. QExA-IM will apply consistent medical necessity criteria. Medicare medical necessity criteria will apply to all Medicare covered services. Medicaid medical necessity criteria will apply to long-term services and support. Where there is overlap between Medicare and Medicaid guidelines, Medicare medical necessity criteria will be applied.
The following figure provides a summary of all services that will be included in the integrated Dual Alignment Demonstration benefit package.

Summary of Proposed Services in the Program

Medicare Services	**Medicaid Services**	**Additional Services**
Part A Hospital Insurance: helps cover inpatient care in hospitals, including critical success hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice and some home health care. **Part B Medical Insurance**: helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the	• Hospital services: emergency, inpatient and outpatient • PCP (Primary Care Provider), medical specialists and other providers • Lab tests and X-rays • Prescription drugs • Durable medical equipment and medical supplies • Home health services • Hospice services • Vision services	DHS will review the scope of additional services currently covered and/or proposed by MA MME-SNPs in Hawaii for possible inclusion based on available funding. Under QExA-IM, the QExA health plans can provide appropriately aligned enhanced benefits which are supportive of the Model of Care and as long as they are appropriately funded.

services of physical and occupational therapists and some home health care.

Part D Prescription Drug Coverage: helps cover prescription drugs. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium.

- Preventive care services
- Maternity and family planning services
- Rehabilitation services
- Transportation services
- Urgent care services
- Personal Assistance Services – Level I

Behavioral Health Services, including:

- Acute care for psychiatric illnesses
- Crisis services – 24 hours a day, 7 days a week
- Substance abuse treatment
- Psychiatric or psychological evaluation

Long-Term Services and Supports, including:

- Home and Community-Based Services (HCBS), such as adult day care, personal care attendants, and residential care
- Institutional Services, such as a nursing home

iii. Description of Supplemental Benefits and Ancillary Services

A single, integrated package of preventive, acute, pharmacy and long-term services and supports will be delivered by the QExA-IM Program. This includes supplemental benefits and ancillary services. The QExA health plans will have the opportunity to deliver additional supplemental or enhanced benefits to demonstration plan enrollees. DHS will evaluate and approve the enhanced benefits available through the MA MME-SNP products offered in Hawaii for appropriate inclusion to support the Model of Care. DHS hopes to decrease or eliminate cost sharing for dual eligible beneficiaries enrolled in the demonstration, specifically Part D prescription drug co-pays. No other cost-sharing exists or is proposed under QExA-IM, with the exception of spend-down obligations related to Medicaid eligibility which will remain. The value of the Medicare associated benefits in the QExA-IM program will be designed to meet or exceed the value in the current MA MME-SNPs in Hawaii. This will assure that the MMEs will not be disadvantaged by moving from a separate MA MME-SNP into the QExA-IM Program. Ultimately, the ability to fund value added benefits and services is dependent on the capitation rates and financial model as agreed to by all parties.

iv. Discussion of employment of evidence based practices

Based on the health care needs of the member population and any opportunities for improvement identified, clinical practice guidelines are adopted by participating health plans. These guidelines are reviewed, revised and approved on an annual basis, using nationally recognized evidenced-based literature. The guidelines are developed with input from community physicians via the Medical Advisory Council and then approved by the plan's Quality Management Committee(s). Member education material, benefit plans and coverage parameters are reviewed against the guidelines annually to ensure consistency. Annually, a random sample of provider records is reviewed by the health plan for compliance with clinical practice guidelines.

v. How the proposed care model fits with:

(a) Current Medicaid waivers and state plan services

All current Medicaid services for MMEs are offered through the QExA program. This program will be seamlessly transitioned into the new QExA-IM Program. Current Medicaid waiver services and State Plan services will be delivered via the QExA-IM Program, with the exception of the aforementioned excluded members and associated services (e.g. individuals served in the DD/ID HCBS waiver program and MRO services).

(b) Existing managed long-term care programs.

The QExA program will continue to serve those MME individuals who are excluded from or choose not to participate in the QExA-IM Program, as well as the non-MME individuals (Medicaid only) members in QExA. The current Money Follows the Person program, titled the Going Home Plus program, will continue to be offered to members in both the QExA-IM Program as well as all other QExA members.

(c) Existing Specialty Behavioral Health Plans

Upon implementation of the demonstration, all Medicaid State Plan and 1115 QExA waiver services will be included with the exception of certain specialty behavioral health services and the DD/ID HCBS waiver program as previously described. Medicare covered transplant services will be included. Medicaid dental benefits will not be included.

(d) Integrated Program via Medicare Advantage Special Needs Plans (SNPs) or PACE programs

As previously discussed, the QExA-IM Program will leverage the approved QExA health plans' experience with NCQA approved MA MME-SNP Models of Care. QExA-IM will overcome the current fragmented and non-coordinated Medicaid and Medicare delivery and care coordination systems to provide a proven platform for the delivery of a single, integrated care management system that includes the following elements for the demonstration program: a health risk assessment process, identified primary care provider, an interdisciplinary care team and person-centered care planning that manages member, caregiver, and providers involved in the care delivery process including closure of care gaps, medical home assignment and coordination, as well as medication management programs.

(e) Other state payment delivery efforts

Where possible, the Department and the QExA health plans will coordinate and collaborate with other State and Federal programs, including for example, the Hawaii Department of Health and State and County Offices on Aging.

(f) Other CMS payment/delivery initiatives or demonstrations

The State does not expect there to be any other State or CMS payment/delivery initiatives or shared savings demonstrations (e.g., MSSP ACOs, Pioneer ACOs, Comprehensive Primary Care Initiative) operating in the conjunction with QExA-IM. However, the State will concurrently be supporting the development of health homes and will encourage value based contracting between the health plans and providers. If identified, the State will coordinate with CMS and the QExA health plans to leverage existing or future payment/delivery initiatives with the QExA-IM program.

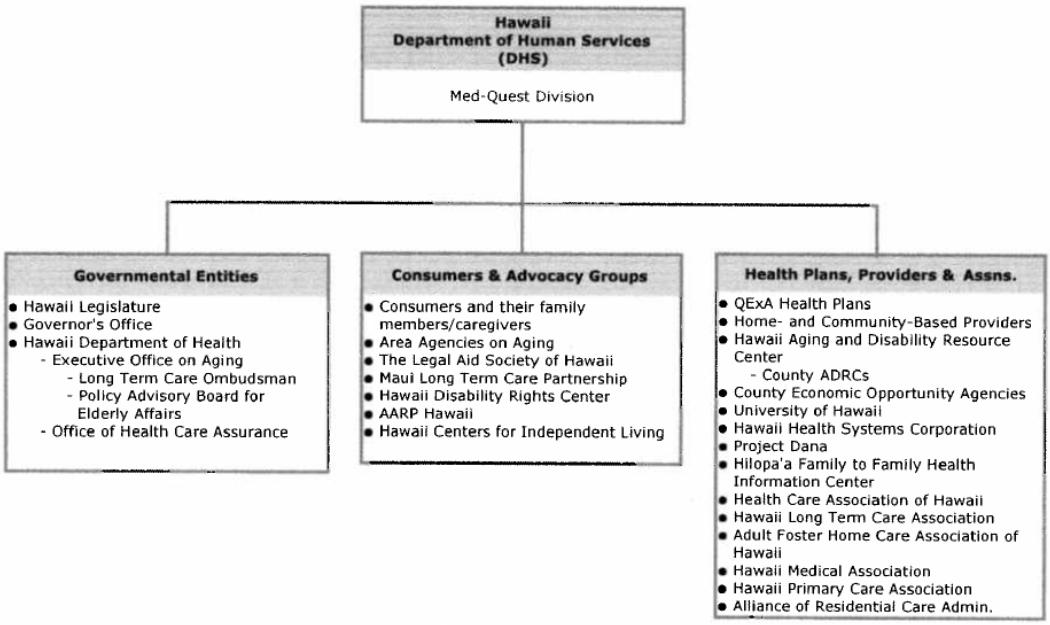
D. Stakeholder Engagement and Beneficiary Protections

i. Description of stakeholder engagement in planning.

In developing the QExA-IM Program, Hawaii continues a longstanding policy of including stakeholders in the development of publically funded health care programs. The State consulted with a wide array of stakeholders through both formal and informal mechanisms. Key stakeholder groups for development of this demonstration proposal include:

- Consumers and advocates;
- Government representatives; and
- Providers, health plans, and relevant associations.

Exhibit 3 – Demonstration Stakeholders



The State has consulted with stakeholder groups on a regular basis through a Medicaid Task Force established for this purpose, and successfully used the Task Force as a forum for soliciting input on the design of the Hawaii integrated care model. In addition, two meetings were held in which integration of care for MMEs was discussed. Finally, consumer focus groups were conducted throughout the state.

Consistent with the requirements of the Financial Alignment Model, this proposal will be open for public comment for thirty days from the time of its issuance to obtain feedback.

II. Themes from Stakeholder Engagement Activities

Stakeholders, notably consumers and providers, consistently support the concept of integrated care and decreasing the complexity of navigating the healthcare system. Comments received in response to the posting of the draft proposal include allowing Medicare beneficiaries to exhaust their full Medicare initial enrollment period before passively enrolling them into QExA-IM, clarifying that QExA-IM health plans must meet Part D requirements, utilizing pharmacists for medication therapy management services, and utilizing end-stage renal disease multidisciplinary care teams. In addition, questions were received from providers concerning reimbursement and shared-savings, and questions were received from a consumer group regarding assurance of beneficiary choice.

Eight consumer focus groups were conducted throughout the state. Consumers thought integration could be helpful for improving continuity of care, coordination of services, and user-friendly customer service, as well as decreasing the number of medical cards. However, consumers expressed concern that they will have to may receive a reduction in benefits or have to pay more for them. They were also concerned about their being enough participating providers available.

iii. How Stakeholder Input Was Incorporated into the Program Design

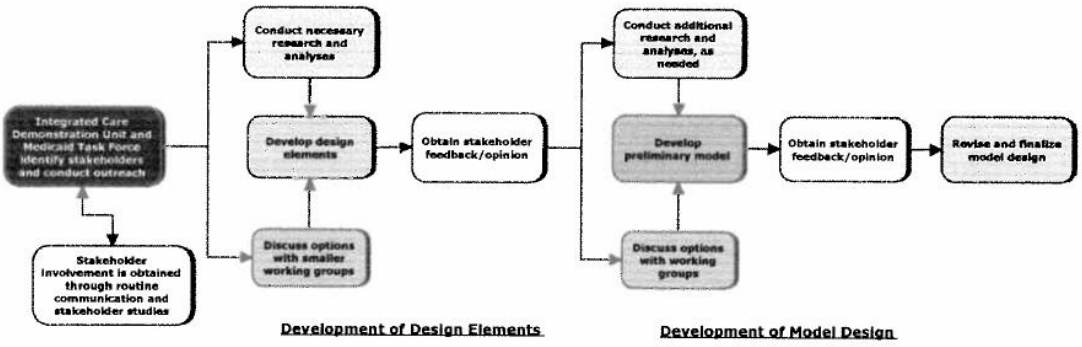
The State has directly incorporated stakeholder input into the design of the Hawaii integrated care model. Hawaii has developed this integrated care model through an iterative and inclusive process that incorporated continuous involvement of stakeholders.

This includes input received through meetings of the State's Medicaid Task Force, discussions with additional stakeholders, and coordination with health plans that currently operate an MA MME-SNP in Hawaii.

One specific item was the consumers' desire to have input during the process and to postpone implementation. As a result, we are postponing target implementation from January 1, 2013 to January 1, 2014.

Comments received were reviewed and incorporated as applicable into this revised version. We will continue to seek and incorporate additional public input throughout the refinement and implementation of the demonstration.

Exhibit 4 – Design and Implementation Milestones



iv. Beneficiary Protections

Beneficiary protections that are built into the program model include the following:

(a) Appeals

The QExA-IM Program will include the creation of a single, integrated appeals process. We particularly note that there are several substantial administrative efficiencies that could be achieved via a single appeals process. This process will utilize the Medicare filing standards (60 days to file an appeal) and will require participants to utilize the plans' internal appeals processes before going to the external appeals entity. The Medicare standards will apply to the continuation of benefits pending appeal. The Department will work with CMS to develop a template for the QExA health plans to use in order to inform beneficiaries of the single combined appeals process. All expedited appeals will be required to be

resolved within 72 hours. Standard pre-service Appeals will be required to be resolved in 30 days. Post-service appeals will be required to be resolved in 60 days.

(b) Provider Choice

Beneficiaries will have a choice of Medicare coverage, QExA-IM health plans, and providers within their plan's network for all services coordinated by and through their assigned primary care provider.

(c) Consumer Directed Care

The QExA program currently includes a robust consumer direction program for select personal care services delivered in the home. The program allows for member choice of providers including the ability to select family members or friends to be their paid caregiver. This program will be integrated into the QExA-IM Program.

(d) Disclosure of Rights and Responsibilities

In the QExA program each member has a designated Service Coordinator that must engage with the member at least annually. Members that meet nursing facility level of care or who are receiving home and community based services are seen at least quarterly. Members with multiple chronic conditions or severe episodic care can be seen more frequently. During these contacts with the members, in addition to assessments and plan of care activities, Service Coordinators are required to provide members with information on how to utilize their QExA health plan's appeals and grievance process as well as how to contact the Department and/or the State's QExA ombudsman (Hilopa'a).

In addition to Service Coordinator contacts, the QExA health plans are required to disclose Member Rights and Responsibilities via a variety of mediums. Quarterly member newsletters are mailed to each household that periodically include such disclosures. QExA health plans' websites shall have member specific pages that address both how to access benefits and member specific rights. Additionally, member rights and responsibilities are described in the member handbook, which is mailed annually. All printed materials include a language block with the information on how to obtain the information in alternative languages.

(e) Consumer Advisory Boards

Member Advisory Boards are a key component to the success of any demonstration. The QExA health plans will be required to have member advisory boards reflective of the MME members in the QExA-IM Program including neighbor island representation.

v. Integrated Member Communications

The member materials will leverage the best practices in the existing marketing and beneficiary information materials used by the current health plans, with enhancements to reflect the coordination and integration in the new program. All documents will allow for the presentation of the QExA-IM program to the member in a fully integrated fashion.

Members will be provided complete, integrated materials in an understandable format. The currently applicable Medicaid reading level (at or below 6.9 grade level), will apply to the QExA-IM Program. Translation requirements will also follow the Medicaid standards which are reflective of the culturally and ethnically diverse population in Hawaii.

In order to ensure that all materials are complete and that the materials relevant to this program are able to be produced in an efficient and effective manner, the Department and CMS will apply one set of rules regarding the creation, submission and approval of all member communication materials. The Department and CMS will develop and implement a concurrent review process for all member materials. Both CMS and the Department will approve or reject materials on a single timeline and use the same evaluation terminology. Materials will be submitted through the Medicare HPMS submission portal. CMS will then communicate those materials to the Department who will conduct a simultaneous review. In order to facilitate the approval process and meet timeline requirements, the Department and CMS will establish model operational letters (appeals, grievances, notices, etc.) specifically for use by the QExA health plans for this program.

As the Department begins to finalize certain procedures such as enrollment/disenrollment and appeals/grievances, additional stakeholder input will be sought. The Department expects to convene a stakeholder advisory group.

E. Financing and Payment

The participating QExA health plans will receive a single set of capitation rates for the combined Medicare and Medicaid benefit package. In general, these rates would be expected to be effective for the duration of a benefit period which is expected to be on a calendar year basis. The Department's actuaries (currently Milliman) will work with the CMS Office of the Actuary to establish actuarially sound rates for the QExA-IM Program that supports CMS and the Department's goals of seamless integration, improved quality of care and cost-effectiveness.

i. State-Level Payment Reforms

The existing QExA program is a relatively new program having been implemented in 2009. The QUEST program, which serves individuals younger than 65 years who are not disabled, has been in existence since the mid-1990's. We have recently implemented financial incentives for performance, quality-based auto-assignment, and required an increasing percentage of provider networks on value-based contacts. We anticipate incorporating these concepts into the QExA reprocurement.

From a long term care perspective, under the QExA program we have been successfully rebalancing by reducing the number of individuals in nursing facilities by 15% and more than doubling the number of individuals receiving home and community-based services. The State hopes to revise the acuity based methodology for nursing facility reimbursement and more appropriately align payment for resources required to care for complex patients.

ii. Payments to Demonstration Health Plans

Each QExA health plan will be paid an actuarially appropriate blended rate that is developed in a transparent manner. As part of this process, the QExA health plans will have the opportunity to examine current Medicare encounter data in order to participate meaningfully in the rate setting process. The blended rate will take into consideration the current funding rate for Medicare Advantage and the rate impacts of the implementation of the Affordable Care Act to ensure Medicare funding that does not establish an unnecessary and unintended competitive disadvantage for the QExA-IM Program as compared to "stand alone" MA MME-SNPs. Furthermore, Medicare rate setting should include allowances for inclusion of STAR quality payments for high performing plans to maintain a level playing field and accommodate for the quality withhold outlined above. Savings calculations should be based upon expected trend over the life of the demonstration rather than reduced from fee-for-service experience at the beginning of the program. Furthermore, the Medicaid portion of the blended rate should take into consideration managed care savings already achieved and assumed in the current QExA Medicaid capitation rates and account for a reduced overall savings opportunity commiserate with these established savings achieved and/or assumed. This includes the savings already achieved by decreasing the percentage of members in nursing facilities and increasing the percentage in home and community based settings.

In addition, as referenced above, given the significant portion of QExA members that have already chosen to participate in their plan's MA MME-SNP, rate setting must consider and mitigate for any negative impact to the plans resulting from transitioning to the new rate setting methodology. In addition, in order to seamlessly transition these members into QExA-IM, Medicare value added benefits must be included in QExA-IM to avoid negative member impact. In order to accomplish this, a two-year transition period may be appropriate to incorporate into the rate development.

The Department seeks to use the current QExA rate setting process to risk adjust for the population served in the QExA-IM Program. The Department will explore opportunities to refine and expand its risk profiling capabilities to implement an acuity adjusted rate process for the Medicaid component of the blended rate in the QExA-IM program. This will be critical to assuring that the blended rate is sufficient to meet all of the individuals' health and long term care needs.

Additional review will be required to ensure the rates for the QExA population not in the QExA-IM Program (e.g. Medicaid only members) will remain actuarially sound and financially viable for the continuation of the QExA Program for the Department, CMS and the participating QExA health plans. In addition, the QExA Medicaid rates for MMEs who choose to not participate in QExA-IM must be reviewed for actuarial soundness, since the risk of the members may vary significantly from the risk of the MME members who choose to participate in QExA-IM. Risk adjustments after the beginning of the play year may be needed to accommodate for any unintended adverse selection or risks not anticipated during initial rate development.

Key financial parameters such as QExA health plan provider reimbursement levels and administrative costs will need to be discussed and included in the tri-party agreements with the Department, CMS, and the QExA health plans. Rate setting will take into account the ACA requirements regarding primary care payments for Medicaid at the Medicare fee schedule and to adjust for the "doc fix" in Medicare rates. The QExA-IM Program will have a mandatory minimum medical loss ratio, and risk corridors will be established to assure that the QExA health plans and the State do not bear an unsustainable amount of risk.

In order to assure that care is delivered efficiently and effectively and that rates are appropriate to cover the cost of care, plans will be required to utilize the existing encounter data systems and currently applicable encounter reporting standards. Inbound encounters will continue to be received in an 837 X12 EDI format for Institutional, Professional and Dental Services and Pharmacy data will continue to be received in a CBT format. Outbound encounters will continue to be submitted to the states or CMS in an ANSI 837 X12 5010 format for Institutional, Professional and Ancillary services. For pharmacy encounters, plans will send encounters in the NCPDP D.0 format.

F. Expected Outcomes

i. Description of the ability of the State to monitor, collect and track data on key metrics related to the model's quality and cost outcomes for the target population, including beneficiary experience, access to care, utilization of services, etc., in order to ensure beneficiaries receive high quality care and for the purposes of the evaluation.

The Med-QUEST Division within the Hawaii Department of Human Services will oversee the implementation of the demonstration. This Division is currently responsible for monitoring, collecting, and tracking data on key metrics for the QExA program and has existing capacity and expertise to oversee these elements for the QExA-IM Program. The Med-QUEST Division currently monitors QExA Medicaid quality and cost outcomes for the MMEs that will be enrolled in this demonstration program. Based on historical data used to build the blended capitation rates and encounter data received for the demonstration period, the actuary will be able to compare projected to actual utilization and expenditures.

In addition, the State's ability to oversee the quality of services delivered and the performance of contractors will be improved by CMS agreement to use a single set of demonstration quality measures and quality improvement program standards in order to streamline administration and support the integration of care in all areas including quality measurement and improvement.

ii. List potential improvement targets for measures such as potentially avoidable hospitalizations, 30-day readmission rates, etc.

A list of Proposed Quality Measures for the QExA-IM Program can be found in Appendix A of this proposal.

The State of Hawaii recognizes that there is an evolving body of work that supports the unique characteristics of the MME population as well as the need to thoughtfully select quality measures for this population. Research has shown that these individuals are typically in poorer health, more likely to be disabled, and more likely to be racially and ethnically diverse than the overall Medicare population. The research indicates that low-income people are less likely than those with higher incomes to have a usual primary care provider or to receive pneumonia vaccines, mammograms, colorectal or osteoporosis screenings; and are more likely to have hospital admissions for short-term complications of diabetes, deaths for hospital admissions with acute myocardial infarction, and treatment for a major depressive disorder. The list of measures included in Appendix A leverage the measures currently in use in the QExA program and combine them with measures which assess the delivery of high quality health services while allowing for the health disparities and socio-economic challenges of the MME population.

iii. Discussion of the expected impact of the proposed demonstration on Medicare and Medicaid costs, including specific mention of any effect on cost-shifting occurring today between the two programs and detailed financial projections over the next three years for Medicare, Medicaid, and total combined expenditures, including estimates of how much savings are anticipated.

Hawaii continues to be on the leading edge of integrated care delivery for Medicaid beneficiaries. By allowing for the full integration of care for Medicare-Medicaid Enrollees, the Department expects the QExA-IM Program to generate positive results similar to those seen in QExA for individuals eligible only for Medicaid. The Department expects that the QExA-IM Program will enhance care coordination, reduce cost shifting incentives between Medicare and Medicaid, reduce inappropriate hospital, ER and nursing facility utilization, further enable members to move from institutional to home and community based care, improve the quality of care, and enhance member satisfaction and self-determination. The blended funding will allow better alignment and value-based contracting between health plans and providers. Improved case management/care coordination will be able to seamlessly span the continuum of care. Savings are expected and will need to be shared between the State and CMS; however, some of the savings will need to fund the increased administrative cost for the State.

G. Infrastructure and Implementation

i. State capacity to implement and oversee the proposed demonstration

The Med-QUEST Division within the Hawaii Department of Human Services will oversee the implementation of the demonstration. The Division is responsible for the administration of Hawaii's Section 1115 Medicaid demonstration waiver and QExA program and has existing capacity and expertise related to health plan oversight and contracting. The Department already oversees the full continuum of care provided to non-MME QExA recipients. Alignment in operational requirements, as is expected to be achieved through development of the next QExA RFP in collaboration with CMS, will further facilitate and increase efficiency of health plan oversight.

The Administrator of the Med-QUEST Division will have ultimate oversight responsibility for the demonstration. Demonstration staff will continue to be located within the Med-QUEST Division, Health Services Branch, and the State will leverage the existing Med-QUEST management and staff to support implementation and oversight of the demonstration program.

The participating plans will have the existing capacity to provide a strong foundation for fully integrating the financing and delivery of care to MME members in the QExA-IM Program. As a result, the State anticipates working closely with CMS to develop a fully integrated and administratively efficient approach to oversight, monitoring, auditing, and program integrity for this demonstration program. Wherever possible, oversight standards should be led by the State of Hawaii, fully coordinating with CMS. This will assure that oversight is consistent and not duplicative. The State intends to work with CMS to develop reporting requirements that are clearly and explicitly defined to assure QExA health plan compliance, enable the State to carry out complete oversight functions as well as provide CMS with line of sight into the demonstration program and further oversight capabilities. The State proposes a collaborative auditing of the demonstration program with a single audit approach of the program and the QExA health plans using a common set of standards and tools.

ii. Implementation strategy and anticipated timeline

The following figure presents the State of Hawaii's implementation strategy and timeline.

Design and Implementation Timeframe

Activity	Start date	Target Date for Completion
Begin public stakeholder dialogue	November 2011	Ongoing
State specific modeling	December 2011	January 2012
State development of initial proposal	December 2011	April 2012
State submission of proposal to CMS	May 2012	Same as start date
State submission of any necessary 1115 amendments	TBD	TBD
CMS public notice of State proposal	April 2012	May 2012
CMS/State review of public comments, revisions to proposal	May 2012	May 2012
MOU finalization	May 2013	May 2013
Strategize with State on contract certification/migration (will use this approach given QExA procurement processes)	January 2013	June 2013
Three-way agreement finalized	May 2013	July 2013
Three-way agreement signed contingent upon readiness requirement	July 2013	Same as start date
Readiness reviews	July 2013	September 2013
Beneficiary notification (aligns with Medicare open enrollment)	October 2013	Same as start date
Enrollment/implementation effective date	January 2014	Same as start date

iii. Initial Enrollment of Medicare-Medicaid Enrollees into the Program

The Department proposes a statewide program covering all Hawaii Medicaid beneficiaries who are fully eligible to receive Medicare and Medicaid benefits in the QExA-IM Program. The Department proposes to seamlessly enroll those individuals into the QExA-IM Program with their existing QExA health plan. For those individuals who become newly eligible, they will be offered the opportunity to choose between the QExA-IM health plans. If they do not select a QExA health plan, they will be auto-assigned to a QExA health plan consistent with the Department's auto-assignment policy. They retain the opt-out provisions as previously mentioned, for example, sixty (60) days from auto-assignment enrollment to opt-out.

All current and future MME beneficiaries not enrolled in a Medicare Advantage plan will be enrolled in the QExA-IM program for their Medicare coverage. The current MME beneficiaries that are enrolled in one of the QExA health plan's MA MME-SNP will be moved into the QExA-IM program for their Medicare coverage effective January 1, 2014. MME members will be able to opt-out of the QExA-IM

program for their Medicare coverage as outlined above. Individuals who enrolled in a MA MME-SNP offered by a QExA health plan but change QExA health plans will be enrolled into the QExA-IM plan offered by their new QExA health plan.

Currently, all Medicaid beneficiaries who will participate in the QExA-IM Program currently participate in or are eligible for the QExA Medicaid managed care program. It is anticipated that the Department will require future QExA health plans to have experience operating an MA MME-SNP. As a result, the QExA health plans will have experience providing Medicare services to MMEs, and the Department intends to utilize the QExA health plans to deliver the QExA-IM Program.

H. Feasibility and Sustainability

i. Potential Barriers and Challenges

Because the QExA-IM Program leverages the existing QExA program and QExA health plans for a full array of medical, pharmacy, behavioral, long term care and other covered services for both Medicare and Medicaid benefits and will utilize the State's existing infrastructure including QExA health plan oversight, The Department anticipates no significant barriers to implementation.

ii. Remaining Statutory or Regulatory Challenges

The State does not anticipate needing any additional legislative authority or budgetary approval to implement the demonstration program.

iii. Funding Commitments or Contracting Processes Needed

Implementing QExA-IM based on the QExA health plans following re-procurement allows for incorporation of the QExA-IM requirements into the new contracts from their commencement. The Department will incorporate CMS input into the development of the RFP and will follow State requirements for procuring the contracts. The Department will need guidance from CMS regarding receipt of federal funds for administrative expenses related to the Medicare aspect of QExA-IM.

iv. Scalability and Ability to Replicate

The program is being launched statewide and will serve nearly all MMEs, being able to include additional individuals that become newly eligible. Replication in other states would depend on their having Medicaid managed care that includes long term services and supports.

I. Additional Documentation

Not Applicable

J. Interaction with Other HHS/CMS Initiatives

Hawaii's Money Follows the Person program has already been integrated into QExA and will be incorporated into QExA-IM as well. By the inclusion of LTSS, the QExA program itself is already rebalancing by reducing nursing facility census and increasing the number of members receiving home and community based services. Like the QUEST contracts, the new QExA contracts will be expected to have value-driven requirements.

APPENDIX A

Examples of Potential Quality Measures for Hawaii Dual Alignment Demonstration

Number	*Measure*	*Source*
1	***Behavioral Health***	HEDIS©
	a) Enrollees with new evidence of alcohol or other drug dependence (AOD) who received initiation and engagement of AOD treatment	HEDIS©
	b) Follow up after hospitalization for mental illness (excluding individuals with SMI) in 7 days	HEDIS©
	c) Proportion of members who had a positive BH screen with referral to BH	HEDIS©
2	***Diabetes Care***	
	a) % of individuals with HgbA1c >9	HEDIS©
	b) *% of individuals with LDL <100*	HEDIS©
	c) *% of individuals with blood pressure < 140/90*	HEDIS©
	d) *Retinal examination*	HEDIS©
	e) *Microalbuminuria screening*	HEDIS©
3	***Cardiovascular Risk/Disease***	
	a) Beta Blocker Post MI for 6 months following MI	HEDIS©
	b) Cholesterol management	HEDIS©
	c) Blood pressure control	HEDIS©
	d) Aspirin use and discussion	HEDIS©
4	***Care Transitions***	
	a) Medication reconciliation post hospital discharge	HEDIS©
	b) Members identified for HCBS and assessed within 30 days	
	c) Community reintegration 6 months or > from institutional setting	
	d) 30 day readmission following inpatient discharge	HEDIS©
5	***Utilization***	
	a) Emergency Department visits per 1,000 Enrollees	HEDIS©
	b) Services for Population in HCBS waiver – Emergency Department visits per 1,000	
	c) General Hospital Inpatient Utilization Admits per 1,000 Enrollees	HEDIS©
	d) Mental Health services utilization per 1,000 Enrollees (excluding individuals with SMI)	HEDIS©
6	***Preventive Services***	

Number	*Measure*	*Source*
	a) Colorectal Cancer Screening	HEDIS©
	b) Breast Cancer Screening	HEDIS©
	c) Members with fall history who have a Falls Assessment completed and interventions in Plan of Care within 90 days	HEDIS©
	d) Proportion of members who received a flu shot	HEDIS©
	e) Discussion and documentation of advanced directives	HEDIS©