May 4, 2023

Judy Mohr Peterson

Med-QUEST Division Administrator
State of Hawaii, Department of Human Services
601 Kamokila Blvd
Room 518 PO Box 700190
Kapolei, HI 96709-0190
Dear Ms. Peterson:
In accordance with 42 CFR 438.6(c), the Centers for Medicare \& Medicaid Services (CMS) has reviewed and is approving Hawaii's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on September 30, 2022 and a final, revised preprint on May 4, 2023. The proposal has a control name of HI_VBP.Fee_IPH.OPH_Renewal_20230101-20231231.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- Pay for performance arrangement established by the state for public and private hospitals as defined in the preprint for the rating period covering January 1, 2023 through December 31, 2023 incorporated in the capitation rates through a separate payment term of up to $\$ 46.22$ million;
- Uniform dollar increase established by the state for safety net hospitals owned and operated by a government agency for the rating period covering January 1, 2023 through December 31, 2023 incorporated in the capitation rates through a separate payment term of up to $\$ 78.1$ million;
- Uniform percentage increase established by the state for inpatient and outpatient hospital services within privately-owned hospital provider classes for the rating period covering January 1, 2023 to December 31, 2023 incorporated in the capitation rates through a separate payment term of up to an estimated computable $\$ 166.69$ million; and,
- Minimum and Maximum fee schedule established by the state for in-state general acute hospitals and children's hospital services within in-state general acute hospital provider classes for the rating period of January 1, 2023 to December 31, 2023 incorporated in the capitation rates through a risk-based adjustment.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period(s), or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement
described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Therefore, CMS strongly recommends that states share this approval letter and the final approved preprint with the certifying actuary. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

The total dollar amount approved for the separate payment term for this state directed payment is $\mathbf{\$ 2 9 1 . 3 1}$ million within the Quest Integration managed care program. If the total amount of the separate payment term is exceeded from what was approved under this preprint or, the payment methodology is changed from the approved preprint, CMS requires the state to submit a state directed payment preprint amendment. Please note that if the separate payment term amount documented within the rate certification exceeds the separate payment term amount approved under the preprint, then the state will be required to submit a rate certification amendment to address the inconsistencies between the rate certification and the approved preprint.

If you have questions concerning this approval or state directed payments in general, please contact StateDirectedPayment @.cms.hhs.gov.

Sincerely,
John F. Giles Jr -S Date: 2023.0504

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Department of Health and Human Services Centers for Medicare \& Medicaid Services

Section 42 C.F.R. § 438.6(c) Preprint - January 2021
STATE/TERRITORY ABBREVIATION: HI
CMS Provided State Directed Payment Identifier: A

## Section 438.6(c) Preprint

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

Submit all state directed payment preprints for prior approval to:

## StateDirectedPayment@cms.hhs.gov.

## SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
January 1, 2023 - December 31, 2023
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period. January 1, 2023
3. Identify the managed care program(s) to which this payment arrangement will apply:
4. Identify the estimated total dollar amount (federal and non-federal dollars) of this state directed payment: \$291.31M.
a. Identify the estimated federal share of this state directed payment: $\$ 206.49$ million
b. Identify the estimated non-federal share of this state directed payment: $\$ 84.81$ million

Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? $\square$ Yes $\square$ No
6. If this is not the initial submission for this state directed payment, please indicate if:
a. $\square$ The State is seeking approval of an amendment to an already approved state directed payment.
b. The State is seeking approval for a renewal of a state directed payment for a new rating period.
i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
$\square$ Payment Type Change
Provider Type Change
Quality Metric(s) / Benchmark(s) Change
$\square$ Other; please describe:
$\square$ No changes from previously approved preprint other than rating period(s).
7. $\square$ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

## SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

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

[^0]9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)
a. $\square$ Value-Based Payments / Delivery System Reform: In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.
b. $\square$ Fee Schedule Requirements: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. [Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]

If checked, please answer all questions in Subsection IIB.

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

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.
10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. Check all that apply; if none are checked, proceed to Section III.

Quality Payment/Pay for Performance (Category 2 APM, or similar)
$\square$ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
Multi-Payer Delivery System Reform
Medicaid-Specific Delivery System Reform
Performance Improvement Initiative
Other Value-Based Purchasing Model
11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).
Hospital Pay For Performance
In the CY2017 rate development, the State established a pay for performance pool for private hospitals. Since then, a second pay for performance pool has been established for public hospitals. The total size of the pool is up to $20 \%$ of the facility's Medicaid Managed Care Revenue for the private class and up to $10 \%$ for the public class. Both public and private hospitals are reimbursed at approximately the Medicare rate. The total reimbursement in aggregate is then $110 \%$ of Medicare, although based on performance, some hospitals will achieve more and others less than this amount. The final quality payment pool distribution will be based each facility's performance on various quality metrics, using the methodologies outlined in Table 1. The State will direct Medicaid managed care plans to distribute $100 \%$ of the payment pools for each class for the contract year. Any unearned dollars will be distributed among facilities that demonstrate additional improvements from baseline. The number of metrics are expected to mature and expand over time, transitioning from process to outcome measures as various efforts that advance the state's quality strategy goals are furthered through the pay for performance program.
12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

| Measure Name and NQF \# (if applicable) | Measure Steward/ Developer ${ }^{1}$ | $\begin{gathered} \text { Baseline }^{2} \\ \text { Year } \end{gathered}$ | Baseline ${ }^{2}$ <br> Statistic | Performance Measurement Period ${ }^{3}$ | Performance Target | Notes ${ }^{4}$ |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Example: Percent of High-Risk Residents with Pressure Ulcers Long Stay | CMS | CY 2018 | 9.23\% | Year 2 | 8\% | Example notes |
| a. Hospital Pay For Performance Readmissions collaborative | Hawai` ${ }^{\text {i }}$ | 2023 | N/A (Payout <br> based on meeting a set performance targets) targets) | 2023 | Completion of group goals and submission of required metrics |  |
| b. Hospital Pay For Performance: Reducing ED Visits for Patients with 4 or more Visits | Hawai i | 2018 | 24.6\% | 2023 | 24.11\% |  |
| c. Hospital Pay For Performance: SDOH Collaborative | Hawai'i | N/A (Payout based on meeting specific criteria) | N/A (Payout based on meeting specific criteria) | 2023 | Completion of group goals | Qualitative Measure based on participation and completion o group goals |
| d. Hospital Pay For Performance: Perinatal Collaborative | Hawai'i | N/A (Payout based on meeting specific criteria) | N/A (Payout based on meeting specific criteria) | 2023 | Completion of group goals | Qualitative Measure based on participation and completion of group goals |
| e. |  |  |  |  |  |  |
1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.
13. For the measures listed in Table 1 above, please provide the following information:
a. Please describe the methodology used to set the performance targets for each measure.
Hospital Pay For Performance
The performance targets for payout are set differently for each measure used in 2023.
1) Readmissions Collaborative

Hospitals will be paid based upon the completion of a set of group goals designed to support quality improvement to reduce avoidable readmissions. The measure will include a combination of attending learning collaborative sessions, developing a customized quality improvement plan utilizing best practices disseminated during the learning collaborative sessions, implementation of the plan, and completion of a report to describe lessons learned, challenges, and successes gleaned from the program. Additionally, hospitals will continue to collect and submit day on the 30 -day all cause readmissions measure to determine the impact of the quality improvement activity on the outcome variable. Payment will be based upon the satisfactory completion of the goals of the collaborative.
2) Reducing ED Visits for Patients with 4 or more Visits

CY2018 was used to develop baseline data for this measure; the state's performance in 2018 was used to develop a sliding scale to reward performance. Based on the historic target $(24.6 \%, 2018)$, an aggressive performance target of $14.99 \%$ was set for 2020 , and the same target is retained for 2023. Hospitals performing better than the target will receive the full payout for the measure along with bonuses in proportion to their actual performance, whereas those performing below the target will receive proportionally reduced payouts.

## 3) SDOH Collaborative

The objective of the collaborative is to design and implement a hospital program to build infrastructural capacity to intervene when members with social needs are identified through screening. Payout in 2023 will be based on the completion of collaborative activities to establish processes and protocols for the provision of interventions and referrals for any unmet social needs in a standardized manner.

## 4) Perinatal Collaborative

The objective of the collaborative is to improve the quality of care for mothers and babies. Payout in 2023 will be based on operationalization of data collection plans for the selected 3-5 metrics that will be affected by the improvement and demonstrated implementation of ongoing quality improvement efforts.
b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

## Hospital Pay For Performance

Yes, providers can receive a portion of the payment if they meet some but not all measures. The overall pool of funds available is parsed among the measures based on distribution determined at the outset of each program year. Then, hospitals independently work towards each of the measures. Hospitals also earn the allocated amounts for each measure independently of their performance on other measures.
c. For state-developed measures, please briefly describe how the measure was developed?
Hospital Pay For Performance
The state has several state-developed measures that include learning collaboratives. The state seeks extensive stakeholder feedback in developing its program, including but not limited to, hospitals and the state hospital association. Given the state's priorities (reducing avoidable readmissions, reducing avoidable emergency department visits, increasing referrals to support social needs, and improving maternal and child health outcomes), the hospitals collaborated with the state to identify potential strategies to improve upon these measures. Our hospitals have preferred a collaborative style approach where they work together to learn about best practices and apply these to their individual hospitals to advance quality improvement programs to support the state's initiatives. The intent of these collaboratives is to provide a shared environment for learning and sharing of best practices and lessons learned, so that the hospital community may work together to improve these goals. Further, the collaborative atmosphere reduces disparities across hospitals, and promotes shared progress. The collaboratives have been driven by prior performance in these areas that suggests that most, if not all, hospitals in the state struggle with some of the same quality improvement areas.
14. Is the State seeking a multi-year approval of the state directed payment arrangement?
$\square$ Yes $\square$ No
a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.
b. If this payment arrangement is designed to be a multi-year effort and the State is NOT requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.
Hospital Pay For Performance
The Hospital P4P program is still evolving, and at this time, the measures included in the program continue to undergo annual refinement. Hawaìi is currently evaluating hospital performance in the program in past years and identifying areas wher
changes may be neded. The agency began a process of redesigning the program in 2021 that was intended for implementation in 2022 ; however, given the public health emergency, the re-design is still ongoing and may take another year or two to changes may be needed. The agency began a process of redesigning the program in 2021 that was intended for implementation in 2022 ; however, given the public health emergency, the re-design is still ongoing and may take another year or two to

15. Use the checkboxes below to make the following assurances:
a. $\square$ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.
b. $\square$ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.
c. $\square$ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.
d. $\square$ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

## SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:

This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.
16. Please check the type of state directed payment for which the State is seeking prior approval. Check all that apply; if none are checked, proceed to Section III.
a. $\square$ Minimum Fee Schedule for providers that provide a particular service under the contract using rates other than State plan approved rates ${ }^{\mathbf{1}}$ (42 C.F.R. § 438.6(c)(1)(iii)(B))
b. $\square$ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))
c. $\square$ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[^1]17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):
a. Check the basis for the fee schedule selected above.
i. $\checkmark$ The State is proposing to use a fee schedule based on the State-plan approved rates as defined in 42 C.F.R. § 438.6(a). ${ }^{2}$
ii. $\square$ The State is proposing to use a fee schedule based on the Medicare or Medicare-equivalent rate.
iii. $\quad$ The State is proposing to use a fee schedule based on an alternative fee schedule established by the State.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., $80 \%$ of Medicaid State-plan approved rate)
b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

- DRG Fee Schedule Payment Arrangement
- Hospital Directed Access Payment Arrangement
- Hospital Dirccted Access Payment Arrangemen

Ithe directed Access payment percentage increases are based on the uniform target of
leHf maintaining access to services and achieving the state's goals and objectives.
o The directed uniform payment increases are based on the average loss per service
target reimbursement tevel. consisent with target reimbursement level, consistent with payments under Medicare principles.

- Hospital Pay Fc
- Not applicable.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:
a. $\square$ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.
b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.
DRG Fee Schedule Payment Arrangement
The plans and the providers must submit a request for exemption if they are under contractual obligations that result in the need to pay more than the maximum fee schedule, for special arrangements such pay-for-performance or other alternative payment models. The contract, and contractual provisions, show why a plan and the provider needs to pay more than the maximum fee schedule must be submitted to the State. Additionally, the plan and the providers must submit a justification for why there is a need to pay more than the maximum fee schedule. The State will review the materials submitted by the plans and providers to make an informed determination of whether the contractual obligations resulting in a need to pay more than the maximum fee schedule will be approved as an exemption.
c. Indicate the number of exemptions to the requirement:
i. Expected in this contract rating period (estimate) 0
ii. Granted in past years of this payment arrangement 0
d. Describe how such exemptions will be considered in rate development.

[^2]19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:
a. Will the state require plans to pay a $\square$ uniform dollar amount or a $\square$ uniform percentage increase? (Please select only one.)
b. What is the magnitude of the increase (e.g., $\$ 4$ per claim or $3 \%$ increase per claim?)
c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

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

MCO encounter data will be used to directly link each hospitals' payments to utilization of inpatient and outpatient services for managed care enrollees. Each month, Med-QUEST will calculate each hospital's allocation of the payments by taking the current year utilization multiplied by the payment increase amount per service separately for inpatient and outpatient. This amount will then be used to allocate the directed payment funding to each hospital.
d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

- DRG Fee Schedule Payment Arrangement
- Not applicable since payments were developed initially to be budget neutral
- Hospital Directed Access Payment Arrangement
- Consistent with 2022 , the 2023 Interim Directed Access Payment Increase Percentages for each eligible hospital are based on the gap between each hospital's estimated payments under Medicare (for Medicaid managed care services) and Medicaid
 Feimbursement levels. The State believes its composite statewide reimbursement level below $100 \%$ of Medicare is reasonable and necessary for achieving its goals and objectives for this directed payment arrangement.
- These directed uniform payment increases are each based on the average loss per service unit for Medicaid managed care services, separately for inpatient and outpatient, using the most recently available hospital patient acco
cost report data, inflated to CY 2023 based on changes in CMS hospital mark basket index levels. We believe a cost-based Upper Payment Limit for he directed payment increases is a reasonable target reimbursement level.


## SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:
a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):inpatient hospital service
outpatient hospital serviceprofessional services at an academic medical centerprimary care servicesspecialty physician servicesnursing facility services
$\square$ HCBS/personal care servicesbehavioral health inpatient services
behavioral health outpatient services
dental services
$\square$ Other:
b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

[^3]c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

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- DRG Fee Schedule Payment Arrangement
o The provider class is defined in the state's recent approved SPA found here:
https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/SPA_21-0011_Public_Notice_05-21-21_and_Attachment_4_19
-A_pg_1-4_CLEAN_Redline.pdf
- Hospital Directed Access Payment Arrangement
o Directed Access payments for private hospitals provides additional funding to maintain access to services, to complement the separate directed payment
arrangement for public hospitals. The exclusion for charitable hospitals is due to available funding separately from donations and other non-insurance
sources.
- HHSC
o The state plan that defines this provider class is found here:
https://humanservices.hawaii.gov/wp-content/uploads/2017/12/4.19-A-from-Attachment-4-Rev.-07.2017.pdf
- Hospital Pay For Performance
o The complete Hawai'i State Plan is found here: https://humanservices.hawaii.gov/reports/hawaii-medicaid-state-plan/(see section 3 and Attachment 3).
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21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

- DRG Fee Schedule Payment Arrangement
o The payment methodology does not vary by provider is and is predicated exclusively on utilization and delivery of services.
- Hospital Directed Access Payment Arrangement
o Under the hospital Directed Access payment program, each hospital is brought up to the same uniform benchmark of payments under Medicare, separately for inpatient and outpatient.
- HHSC
o Under the directed uniform payment increases, Hawai'i's MCOs will make uniform payment increases for each inpatient day and outpatient visit within the government-owned class of safety net hospitals. This program is predicated exclusively on utilization and delivery of services.
- Hospital Pay For Performance
o All Private Hospitals are evaluated using the same quality metrics; similarly, all Public Hospitals are evaluated using the same set of quality metrics. Where appropriate, the same measures are applied to both Private and Public Hospitals. Exceptions are made by hospital type for specific metrics. For example, in the Private Hospital program, hospitals with Obstetrics and Gynecology Departments have a measure in 2022 that does not apply to hospitals without these this department. Another exception is made for two specialty hospitals that are structured differently: the quality measures used are adapted to be applicable to these hospitals, as they exclusively serve individuals with behavioral health and rehabilitation needs respectively, and do not provide typical hospital services. A consistent set of measures are applied to Public Hospitals; one Public Hospital with behavioral health beds submits data on an additional measure.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:
a. $\square$ Replace the negotiated rate(s) between the plan(s) and provider(s).
b. $\square$ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).
c. $\square$ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).
23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).
This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. Ex: The average base payment level from plans to providers is $80 \%$ of Medicare and this SDP is expected to increase the total payment level from $80 \%$ to $100 \%$ of Medicare.

TABLE 2: Provider Payment Analysis

| Provider Class(es) | Average Base Payment Level from Plans to Providers (absent the SDP) | Effect on <br> Total <br> Payment Level of State <br> Directed <br> Payment (SDP) | Effect on Total Payment Level of Other SDPs | Effect on Total Payment Level of PassThrough Payments (PTPs) | Total Payment Level (after accounting for all SDPs and PTPs |
| :---: | :---: | :---: | :---: | :---: | :---: |
| Ex: Rural Inpatient Hospital Services | 80\% | 20\% | $N / A$ | $N / A$ | 100\% |
| a. Private Hospital Inpatient | 76.90\% | 31.80\% |  |  | 108.70\% |
| b. Private Hospital Outpatient | 92.80\% | 16.50\% |  |  | 109.20\% |
| c. Publicly owned hospitals - inpatient | 31.40\% | 72.30\% |  |  | 103.80\% |
| d. Publicly owned hospitals - outpatient | 50.30\% | 53.40\% |  |  | 103.70\% |
| e. | 0.00\% | 0.00\% |  |  | 0.00\% |
| f. | 0.00\% | 0.00\% |  |  | 0.00\% |
| g. | 0.00\% | 0.00\% |  |  | 0.00\% |

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:
a. $\square$ Medicare payment/cost
b. $\square$ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) (Please note, this rate cannot include supplemental payments.)
c. $\square$ Other; Please define:
25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? $\square$ Yes $\square$ No If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.
26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? $\square$ Yes $\square$ No
If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.
27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

- DRG Fee Schedule Payment Arrangement
o This directed payment arrangement is not a payment in addition to the standard fee schedule.
- Hospital Directed Access Payment Arrangement
o The comparison benchmark is based on the estimated payments under Medicare for Medicaid managed care services, calculated by multiplying Medicaid managed care billed charges from FYE 2020 Medicaid DSH survey data by Medicare pay-to-charge ratios from Medicare cost reports with fiscal reporting periods matching the DSH survey. Adjustments for utilization and service mix changes for 2023 have been applied to Medicaid base payments (including adjustments to reflect estimated payments impacts under the State's new APR DRG methodology).
- HHSC
o The comparison benchmark is based on the estimated costs of Medicaid managed care services, separately for inpatient and outpatient, using the most recently available hospital patient accounts data and FYE 2022 cost report data, inflated to CY 2023 based on changes in CMS hospital market basket index levels.
- Hospital Pay For Performance
o The private hospital Medicare benchmark is based on hospital FYE 2020 DSH survey data. The quality payment pool was calculated to be approximately $10 \%$ of participating hospital Medicaid managed care base payments, which the state has estimated to be approximately $100 \%$ of Medicare.
care base payments, which the state has estimated to be approximately $100 \%$ of Medicare. accounts data and FYE 2020 cost report data, inflated to CY 2023 based on changes in CMS hospital market basket index levels. The quality payment pool was calculated to be approximately $5 \%$ of Medicaid managed care payments.

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

- DRG Fee Schedule Payment Arrangement
o The State believes the proposed state directed payment is appropriate and reasonable because the minimum and maximum fee schedules ensure budget neutrality to current Medicaid managed care base payments.
- Hospital Directed Access Payment Arrangement
o As shown in the table above, the combined base payments and payments from this State Directed Payment are approximately $103 \%$ - $104 \%$ of payments under Medicare, and is estimated to be well below $100 \%$ of commercial rates. The State believes Medicare is reasonable and necessary for achieving its goals and objectives for this directed payment arrangement.
- HHSC

As shown in the table above, the combined base payments and payments from this State Directed Payment are approximately $100.0 \%$ of cost (as a proxy for payments under Medicare). Total payments including the separate quality pool payments are approximately 101-102\% of estimated costs, which is reasonably close to Medicare reimbursement levels and is generally below commercial reimbursement levels.

- Hospital Pay For Performance
o As shown in the table above, including the directed quality pool payments are reasonably close to Medicare and cost benchmarks and are generally below commercial reimbursement levels. The State believes the slight increases above the benchmark from this SDP are appropriate because they incentivize improved quality and are at risk based on reimbursement levels.


## SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? $\square$ Yes $\square$ No
a. If yes:
i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?
Hospital Pay For Performance: RFP-MQD-2021-008
ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).
b. If no, please estimate when the state will be submitting the contract actions for review.

## SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.
30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? $\square$ Yes $\square$ No
a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.
b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

| Control Name Provided by CMS <br> (List each actuarial rate <br> certification separately) | Date <br> Submitted <br> to CMS | Does the <br> certification <br> incorporate the <br> SDP? | If so, indicate where the <br> state directed payment is <br> captured in the <br> certification (page or <br> section) |
| :--- | :--- | :--- | :--- |
| i. Hospital Directed Access and DRG: <br> Hawaii_QuestIntegration_20231001-20231231 | $09 / 30 / 2022$ | Yes | In the section labeled <br> section I.4.D.ii |
| ii. |  |  |  |
| iii. |  |  |  |
| iv. |  |  |  |
| v. |  |  |  |

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)
c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. $\S 438.7$ (b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

All four of these directed payment arrangements are captured in the actuarial rate certification.
31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):
a. $\square$ An adjustment applied in the development of the monthly base capitation rates paid to plans.
b. $\square$ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
c. $\square$ Other, please describe: Both A and B apply; please see the attached appendix for a detailed response.
32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

- Hospital Directed Access Payment Arrangement
- The funds for this proposal are included as a separate payment term and are itemized for this purpose. The State believes a separate payment term is appropriate to ensure adequate precision in the distribution of the directed payments. Continued implementation of the directed payments as a separate payment term results in administrative effficiencies for all parties involved in the directed payment arrangement. Without the use of a separate payment term, additional administrative burdens would exist, such as the need for an additional monthly reconciliation processes to monitor and ensure that the aggregate interim directed payments made to providers are consistent with the target aggregate directed payment amounts. The State believes its proposed reconciliation process accomplishe
the appropriate allocation of directed payments across providers based on actual contract year utilization. - HHSC
- HHSC $\begin{aligned} & \text { - The funds for this proposal are included as a separate payment and are itemized for this purpose. The State believes a separate payment term is appropriate to ensure adequate precision in the distribution of the directed payments. Continued implementation of the }\end{aligned}$ directed payments as a separate payment term results in administrative efficiencies for all parties involved in the directed payment arrangement. Without the use of a separate payment term, additional administrative burdens would exist, such as the need for an additional monthly reconciliation processes to monitor and ensure that the aggregat interim directed payments made to providers are consistent with the target aggregate directed payment amounts. The State believes its proposed reconciliation process alread accomplishes the appropriate allocation of directed payments across providers based on actual contract year utilization.

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

## SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:
a. $\square$ State general revenue
b. $\square$ Intergovernmental transfers (IGTs) from a State or local government entity
c. $\square$ Health Care-Related Provider tax(es) / assessment(s)
d. $\square$ Provider donation(s)
e. $\square$ Other, specify:
35. For any payment funded by IGTs (option b in Question 34),
a. Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

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

b. $\square$ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.
36. For any state directed payments funded by provider taxes/assessments (option cin Question 34),
a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.
Table 5: Health Care-Related Provider Tax/Assessment(s)

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

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

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

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

37. For any state directed payments funded by provider donations (option din Question 34), please answer the following questions:
a. Is the donation bona-fide? $\square$ Yes $\quad \square$ No
b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
$\square$ Yes $\square$ No
38. $\square$ For all state directed payment arrangements, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

## SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. $\square$ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."
40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:
a. A hyperlink to State's most recent quality strategy: htps:/medquest.hawaii.gov/enresources/quality-strategy.html
b. The effective date of quality strategy. October 1, 2020
41. If the State is currently updating the quality strategy, please submit a draft version, and provide:
a. A target date for submission of the revised quality strategy (month and year):
b. Note any potential changes that might be made to the goals and objectives. No changes anticipated.
Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.
42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

| Goal(s) | Objective(s) | Quality <br> strategy page |
| :---: | :---: | :---: |
| Example: Improve care coordination for enrollees with behavioral health conditions | Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15\% | 5 |
| a. DRG: Align Payment Structures to Improve Health Outcomes | Objective 17, Align Payment Structures to Enhance Quality and Value of Care <br> Selected measures: Inpatient Utilization - Average lengths of stay in various inpatient settings (Total, Maternity, Medicine, Surgery) | 55 |
| b.DRG: Maintain Access to Appropriate Care | Objective 15, Increase Coordination of Care and Decrease Inappropriate Care <br> Selected measure: Plan All-Cause Readmissions | 53 |
| c. Hospital Directed Access: Maintain or Enhance Access to Care Align payment structures to improve health outcomes | Maintain Access to Appropriate Care <br> - Meet or exceed performance on the state aggregate CAHPS measure 'Getting Needed Care' measure over baseline (Adult and CHIP measures considered separately) <br> Increase the percent of hospitals that meet or exceed the national average Time from ED Admit to Discharge (OP-18 ED Throughput) | 51,55 |
|  $\qquad$ e. Hospital Pay For Performance: Invest in Primary Care, Prevention and Health Promotion $\qquad$ g. viii. Hospital Pay For Performance Align Payment Structures to Improve Health Outcomes Assess and address social determinants of health needs | Maintain Access to Appropriate Care <br> Meet or exceed performance on the state aggregate CAHPS measure 'Getting Needed Care' measure over baseline (Adult and CHIP measures <br> Increase the percent of hospitals that meet or exceed the national average Time from ED Admit to Discharge (OP-18 ED Throughput) <br> Reduce unintended pregnancies; Improve pregnancy-related care Enhance Adult Preventive Screenings in the Primary Care Setting <br> Measures: <br> - SDOH Collaborative <br> Increase coordination of care and decrease inappropriate care Measures: Readmiscione Collahorative | 51,55 <br> 39, 40, 48 <br> 51 <br> 48, 54 |

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

[^4]44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.
a. $\square$ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. $\S 438.340$, and that the evaluation conducted will be specific to this payment arrangement. Note: States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are specific to this payment arrangement and its impacts on health care quality and outcomes.
b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

| Measure Name and NQF \# (if applicable) | Baseline Year | Baseline Statistic | Performance Target | Notes ${ }^{1}$ |
| :---: | :---: | :---: | :---: | :---: |
| Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF \# 0039 | CY 2019 | 34\% | Increase the percentage of adults 18-64 years of age who report receiving an influenza vaccination by 1 percentage point per year | Example notes |
| ${ }^{\text {i. }}$ Hospital Directed Access: Inpatient Utilization (IPU) - Total Inpatient Days per 1000 Member-Months (Total Population) | 2021 | 34.62 | Between the 50th percentile and the 90th percentile of performance on the measure, based on the National HMO Average (26.71-48.10 per $1000 \mathrm{MM})$. | At baseline, Hawaii performed between the 66.67th and 75th percentile on this measure |
| ii. Hospital Directed Access: Inpatient Utilization (IPU) - Total Maternity Days per 1000 Member-Months (Total Population) | 2021 | 5.55 | Between the 5th percentile and below the 33.33th percentile of performance on the measure, based on the National HMO Average (0.39-6.56 per 1000 MM ). | At baseline, Hawaii performed between the 10th and 25th percentile on this measure |
| iii. Hospital Directed Access: Inpatient Utilization (IPU) - Total Medicine Days per 1000 Member-Months (Total Population) | 2021 | 14.65 | Between the 50th percentile and 90th percentile of performance on the measure, based on the National HMO Average (11.43-23.72 per $1000 \mathrm{MM})$. | At baseline, Hawaii performed between the 66.67th and 75th percentile on this measure |
| iv. $\qquad$ v. Hospital Directed Access: Ambulatory Care - ED Visits per 1000 member months (Total) $\qquad$ $\qquad$ vii. DRG: Inpatient (Total Population) $\qquad$ $\qquad$ Total Population) <br> x. DRG: Plan All-Cause Readmissions (O/E Ratio, Total) - NQF\# 1768 | 2021 <br> 2021 <br> 2021 <br> 2021 <br> 2021 <br> 2021 <br> 2021 <br> 2017 <br> 2018 <br> 2018 <br> 2022 |  | Between the 66.67 th percentile and 95 th perce HMO Average ( $12.27-30.83$ per 1000 MM ) Average ( $30.45-47.62$ per 1000 MM ). $\leq 5.40$ days $\leq 3.13$ days $\leq 4.28$ days $\leq 6.91$ days $\leq 0.8164$ $\qquad$ <br> Meet or exceeds baselin Meet or exceeds national average |  |

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.
c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.
DRG Fee Schedule Payment Arrangement

- This directed payment arrangement is currently under year 1, beginning July 2022

Hospital Directed Access Payment Arrangement

- This directed payment arrangement is currently under year 1, beginning July 2022

HHSC

- There was an attached document to this preprint.

Hospital Pay For Performance

- There was an attached document to this preprint.


[^0]:    - DRG Fee Schedule Payment Arrangement

    The state plan amendment authority that defines this provider class is found here
    https://medquest.hawaiii.gov/content/dam/formsanddocument//med-quest/hawaii-state-plan/SPA_21-0011_Public_Notice_05-21-21_and_Attachment_4_19-A_pg_1-4_CLEAN_Redline.pdf
    o The state plan authority that defines this provider class is found here: https://humanservices.hawaii.gov/wp-content/uploads/2017/12/4.19-A-from-Attachment-4-Rev.-07.2017.pdf
    o The 1115 waiver authority for these services can be found here:
    https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/hawaii_QUEST_Integration_1115_Demonstration_Extension_Approval_Package.pdf

    - Hospital Directed Access Payment Arrangement

    The 1115 waiver authority for these services can be found here:
    https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/hawaii_QUEST_Integration_1115_Demonstration_Extension_Approval_Package.pdf
    o The state plan authority that defines this provider class is found here: https://humanservices.hawaii.gov/wp-content/uploads/2017/12/4.19-A-from-Attachment-4-Rev.-07.2017.pdf o The 1115 waiver authority for these services can be found here.
    https://medquest.hawaii.gov/content/dam/formsanddocuments/med - Hospital Pay For Performance

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

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

[^3]:    - DRG Fee Schedule Payment Arangement
    o This applies to in-state general acute hospitals and children's hospitals as approved in in the State's recent SPA. Per the SPA, the APR DRG Payment methodology excludes Critical Access Hospitals, freestanding rehabilitation hospitals,
    
    - Hospital Directed Access Payment Arrangement
    o The cligibibe rovider class consists of Hawait in
    - The eligible provider class consists of Hawait i privately-owned hospitals, excluding charitable hospitals funded primarily through donations or other non-insurance sources of funding, and whose net patient revenue is less than $40 \%$ of operating
    - expense ,
    -     - HHSC
    o This payment arrangement pertains to Hawair i government-owned safety net hospitals for inpatient and outpatient services.
    - Hospital Pay For Performance

[^4]:    - DRG Fee Schedule Payment Arrangement
    - This payment arrangement allows Med-QUEST to continue to ensure adequate funding is available for hospitals to remain financially viable and to maintain participation in the Medicaid managed care program. The directed increases also ensure that enrollees receive medically necessary care in the most appropriate and cost-effective setting, meeting the e ools of the state's Suality Strategy. We anticipate that this will result in an increased extent to which our beneficiaries' "get needed care" from
    their health insurance plans. Additionally the State believes that continuing to provide funding to hopppals will ensure timely and efficient cre.
    - Hospital Directed Access Payment Arrangement
    o This payment arrangement allows Med-QUEST to continue to ensure adequate funding is available for private hospitals to remain financially viable and to maintain participation in the Medicaid managed care program. The directed increases also ensure
    that enrollees receive medically necessary care in the mole their health insurance plans, thereby contributing to beneficiary satisfaction, and resultivg in increases ing the goores of the state's Quality Strategy. We anticipate that this will result in an increased extent to which our beneficiaries' "get needed care" from ensure timely and efficient delivery of services.
    - HHSC
    - This payment arrangement allows Med-QUEST to continue to ensure adequate funding is available for the safety net hospitals to remain financially viable and to maintain participation in the Medicaid managed care program. The directed increases also ensure that enrollees receive medically necessary care in the most appropriate and cost-effective setting, meeting the goals of the state's Quality Strategy. We anticipate that this will result in an increased extent to which our beneficiaries' "get needed care" from their health insurance plans, thereby contributing to beneficiary satisfaction, and resulting in increases in the corresponding Getting Needed Care CAHPS measure. Additionally, we believe that continuing to provide funding to safety net hospitals will ensure timely and efficient delivery of emergency services, resulting in improvements in the Time from ED Admit to Discharge measure.


    ## - Hospital Pay For Performance

    beginning of the program is "30 bonuses for quality metrics incentivizes them to focus on quality improvement activities targeting the Medicaid populations they serve. One quality metric that has been applied consistently to private hospitals since the wrap-around supports to hospitals to continue to improve upon this measure. Continuing to incentivize this measure signals to hospitals the agency's intent to hold hospitals responsible for unnecessary re-admissions by properly transitioning care back to the community, assigning community care navigators to patients who need the support to navigate their transition successfully, and following up as necessary with the patient and the patient's care providers to prevent re-admissions. In turn, since hospital
    admissions are a key driver of costs, reducing re-admissions is expected to increase cost efficiency of health plan services by reducing the total number of re-admissions. All measures included in the P4P program directly support various goals of the admissions are a key driver of costs, reducing re-admissions is expected to increase cost efficiency of health plan services by reducing the total number of re-admissions. All measures included in the P4P program directly support various goals of the goals through the MCH collaborative remains in strong alignment with the program. In total, the Hospital P4P program supports four key goals of the Medicaid program.

