DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

May 15, 2026

Meredith Nichols
Med-QUEST Division Administrator
Hawaii Department of Human Services
601 Kamokila Blvd, Room 518, PO Box 700190
Kapolei, HI 96709-0190

Dear Administrator Nichols:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically, STC #17.5 "Evaluation Design Approval and Updates" of Hawaii's section 1115 demonstration, "Hawaii QUEST Integration" (Project No: 11-W-00001/9), effective through December 31, 2029. CMS has determined that the Evaluation Design, which was submitted on July 4, 2025, February 11, 2026, and May 14, 2026, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's Evaluation Design.

CMS has added the approved Evaluation Design to the demonstration's STCs as Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Hawaii QUEST Integration section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2026.05.15 08:51:02 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Sasha Zolynas, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITIES

NUMBER: **11-W-00001/9**

TITLE: **Hawaii QUEST Integration Section 1115(a) Demonstration**

AWARDEE: **Hawaii Department of Human Services**

Under the authority of Section 1115(a)(1) of the Social Security Act ("the Act"), the following waivers are granted to enable Hawaii (referred to herein as the state or the State) to operate the Hawaii QUEST Integration demonstration. These waivers are effective beginning January 8, 2025 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) as set forth in the accompanying document.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that the Hawaii QUEST Integration demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation and policy document, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 8, 2025, through December 31, 2029.

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

   To enable the state to limit medically needy spend-down eligibility in the case of those individuals who are not aged, blind, or disabled to those individuals whose gross incomes, before any spend-down calculation, are at or below 300 percent of the federal poverty level. This is not comparable to spend-down eligibility for the aged, blind, and disabled eligibility groups, for whom there is no gross income limit.

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

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

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

   To the extent necessary to enable the state to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. To enable Hawaii to restrict the freedom of choice of providers to populations that could not otherwise be mandated into managed care under section 1932. No waiver of freedom of choice is authorized for family planning providers.

4. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release**

Section 1902(a)(84)(D)

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE AND MEDICAID SERVICES
EXPENDITURE AUTHORITIES

NUMBER: **11-W-00001/9**

TITLE: **Hawaii QUEST Integration Section 1115(a) Demonstration**

AWARDEE: **Hawaii Department of Human Services**

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Hawaii for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from January 8, 2025 through December 31, 2029, unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Hawaii to operate the above-identified section 1115(a) demonstration.

1. **Demonstration Expansion Eligibility.** Expenditures to provide coverage to the following demonstration expansion populations:

    a. Demonstration Population 1. Parents and caretaker relatives (as defined in 42 C.F.R. 435.4) who are living with an 18-year-old who would be a dependent child (as defined in 435.4) but for the fact that the 18-year-old has reached the age of 18, if such parents would be eligible if the child was under 18 years of age.

    b. Demonstration Population 2. Aged, blind, and disabled individuals in the 42 C.F.R. § 435.217 like group who are receiving home- and community-based services (HCBS), with income up to and including 100 percent of the federal poverty level using the institutional income rules, including the application of regular post-eligibility rules and spousal impoverishment eligibility rules.

    c. Demonstration Population 3. Aged, blind, and disabled medically needy individuals receiving HCBS, who would otherwise be eligible under the state plan or another QUEST Integration demonstration population only upon incurring medical expenses (spend-down liability) that is expected to exceed the amount of the QUEST Integration health plan capitation payment. Eligibility will be determined using the medically needy income standard for household size, using institutional rules for income and assets, and subject to post-eligibility treatment of income.

    d. Demonstration Population 4. Individuals ages 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance, who would not otherwise be eligible under the state plan,

with the same income limit that is applied for Foster Children (19-20 years old) receiving foster care maintenance payments or under an adoption assistance or kinship guardianship agreement under the state plan.

e. Demonstration Population 5. Individuals under age 26, who aged out of an adoption assistance or kinship guardianship assistance agreement with any state (either Title IV-E or non-Title IV-E), and were enrolled in Medicaid under such agreement.

~~f.~~ Demonstration Population 6. Individuals under age 26, who turned 18 on or before December 31, 2022, who were in foster care (either Title IV-E or non-Title IV-E) under the responsibility of a state (or tribe) other than Hawaii on the date of attaining age 18 or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act, were enrolled in Medicaid on the date of aging out of foster care, and are now applying for Medicaid in Hawaii.

2. **Home and Community-Based Services (HCBS) and Personal Care Services.** Expenditures to provide HCBS not otherwise covered by the Medicaid state plan and furnished to QUEST Integration enrollees, as follows:

    a. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, that could be provided under the authority of section 1915(c) waivers, to individuals who meet an institutional level of care requirement;

    b. Expenditures for the provision of services, through QUEST or QUEST Integration health plans, to individuals who are assessed to be at risk of deteriorating to the institutional level of care, *i.e.*, the "at risk" population.

    c. The state may impose an hour or budget limit on HCBS provided to individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "at risk" population), as long as such limits are sufficient to meet the assessed needs of the individual.

    d. Expenditures for personal assistance Level I and personal assistance Level II services provided by relatives, legal guardians, or legally responsible individuals.

    e. Expenditures for the remote delivery of specific HCBS services outlined in STC 10.5.

3. **Additional Benefits.** Expenditures to provide the following additional benefits:

    a. **Specialized Behavioral Health Services:** The services listed below (and further described in Attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
        i. Supportive employment.

ii. Financial management services.

b. **Cognitive Rehabilitation Services:** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability, and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical, occupational or speech therapist. Services must be medically necessary and prior approved.

c. **Habilitation Services.** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.

4. **Continuous Eligibility.** Expenditures for continued state plan benefits for individuals who have been determined eligible as specified in Table 5 of STC 4.5, who are not otherwise excluded under STC 4.6 for the applicable continuous eligibility period, and who would otherwise lose coverage during an eligibility redetermination, except as noted in STC 4.7**.**

5. **Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 8 of the STCs. This expenditure authority is contingent upon compliance with Section 13 of the STCs, as well as all other applicable STCs.

6. **Expenditures for HRSN Services Infrastructure.** Expenditures for allowable HRSN administrative and infrastructure costs not otherwise covered under section 1903 of the Act, as described in Section 8 of the STCs.

7. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, described in these STCs (Section 12), which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. This authority is contingent upon adherence to the requirements with STC Section 13, Provider Rate Increase Requirements, as well as all other applicable STCs.

8. **Expenditures Related to Contingency Management.** Expenditures for contingency management services provided to qualifying beneficiaries from a provider that has been approved by the Hawaii Department of Human Services (DHS) to deliver the Contingency Management benefit.

9. **Expenditures for Pre-Release Services**. Expenditures for pre-release services, as described in these special terms and conditions (STCs), provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the reentry demonstration initiative.

10. **Expenditures for Pre-Release Administrative Costs**. Capped expenditures for payments for allowable administrative costs, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 15.12, which may not be recognized as medical

assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the reentry demonstration initiative.

11. **Expenditures for Non-Medical Transportation.** Expenditures for non-medical transportation described in STC 9.1 and STC 9.2.

12. **Expenditures for Cooking Supplies.** Expenditures for cooking supplies outside of HRSN services that are not otherwise covered under title XIX of the Act for qualifying individuals, as described in STC 8.2.

All requirements of the Medicaid program expressed in law, regulation, and policy statement shall apply to the demonstration expansion populations, except those expressly identified on the waiver list or listed below as not applicable.

Title XIX Requirements Not Applicable to the HCBS and Personal Care Services Expenditure Authority.

Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary the state may maintain a waiting list for HCBS (including personal care services) benefits denoted in STC 6.1(g) and Section 10 of the STCs. Hawaii may not delegate the authority to establish policies for the selection of individuals to receive HCBS coverage to local/regional non-state entities or other types of entities. No waiting list is permissible for other services for QUEST Integration enrollees.

Title XIX Requirements Not Applicable to HRSN Expenditure Authority #5.

Comparability; Amount, Duration and Scope **Section 1902(a)(10)(B) and Section 1902(a)(17)**

To the extent necessary to allow the state to offer HRSN services and to vary the amount, duration, and scope of HRSN services covered for a subset of beneficiaries, depending on beneficiary needs as determined by the application of qualifying criteria, as specified in Section 8 of the STCs.

Statewideness **Section 1902(a)(1*)***

To enable the state to provide HRSN with limited geographical coverage only in certain geographic areas of the state, subject to the state's phase-in of HRSN services discussed in the HRSN Implementation Plan.

Title XIX Requirements Not Applicable to the Contingency Management Expenditure Authority.

Comparability; Amount, Duration, and Scope **Section 1902(a)(10)(B) and Section**

1902(a)(17)

To enable the state to provide contingency management services through approved providers to eligible individuals with stimulant use disorders and/or opioid use disorders, that are not otherwise available to other beneficiaries in the same eligibility group.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services.

Statewideness **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00001/9**

TITLE: **Hawaii QUEST Integration Section 1115(a) Demonstration**

AWARDEE: **Hawaii Department of Human Services**

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Hawaii QUEST Integration" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Hawaii Department of Human Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902 of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from January 8, 2025 through December 31, 2029, unless otherwise specified.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description, Objectives, and Historical Context
3. General Program Requirements
4. Eligibility for the Demonstration
5. Enrollment
6. Benefits
7. Cost Sharing
8. Health-Related Social Needs (HRSN)
9. Non-Medical Transportation (NMT)
10. Home and Community Based Services (HCBS)
11. Delivery System
12. Designated State Health Programs (DSHP)
13. Provider Rate Increase Requirements
14. Contingency Management
15. Reentry Demonstration Initiative
16. Monitoring and Reporting Requirements

17. Evaluation of the Demonstration
18. General Financial Requirements
19. Monitoring Budget Neutrality for the Demonstration
20. Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A:	Developing the Evaluation Design
Attachment B:	Preparing the Interim and Summative Evaluation Reports
Attachment C:	Evaluation Design [Reserved]
Attachment D:	Home and Community-Based Services (HCBS) and Long-Term Care Provider Guidelines and Service Definitions
Attachment E:	Behavioral Health Services Protocol
Attachment F:	Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services Protocol
Attachment G:	HRSN Implementation Plan [Reserved]
Attachment H:	HRSN Infrastructure Protocol
Attachment I:	Approved DSHP List
Attachment J:	DSHP Claiming Protocol [Reserved]
Attachment K:	Contingency Management Protocol [Reserved]
Attachment L:	Reentry Demonstration Initiative Services
Attachment M:	Reentry Demonstration Initiative Implementation Plan [Reserved]
Attachment N:	Reentry Demonstration Initiative Reinvestment Plan [Reserved]
Attachment O:	Monitoring Protocol [Reserved]
Attachment P:	Provider Rate Increase Attestation Table
Attachment Q:	HRSN Services Matrix

2. PROGRAM DESCRIPTION, OBJECTIVES, AND HISTORICAL CONTEXT

QUEST Integration is a continuation of the state's ongoing demonstration, which is funded through Title XIX, Title XXI, and the state. QUEST Integration uses capitated managed care as a delivery system unless otherwise noted below. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term-services and supports) based on medical necessity and clinical criteria to beneficiaries eligible under the state plan and to the demonstration populations described in STC 4.1.

The state of Hawaii implemented QUEST on August 1, 1994. QUEST is a statewide section 1115 demonstration project that initially provided medical, dental, and behavioral health services through competitive managed care delivery systems. The QUEST program was designed to increase access to health care and control the rate of annual increases in health care expenditures. It has also served as a mechanism for delivery system innovation, enabling Hawaii to advance its policy goals and improve the health and well-being of Hawaii residents.

QUEST stands for:

Quality care;
Universal access;
Efficient utilization ;
Stabilizing costs; and
Transforming the way healthcare is provided to QUEST beneficiaries.

Since its implementation, CMS has renewed the QUEST demonstration eight times. Over the years, the state has made significant changes to the demonstration, as described in Table 1 below, which describes the primary goals and accomplishments of each extension or renewal.

Table 1. Hawaii QUEST Integration Program Changes

Approval Date	Summary of Program Changes
July 1995	CMS approved an amendment that allowed the state to deem parental income for tax dependents up to 21 years of age, prohibit QUEST eligibility for individuals qualifying for employer-sponsored coverage, require some premium sharing for expansion populations, impose a premium for self-employed individuals, and change the fee-for-service (FFS) window from the date of coverage to the date of enrollment.
September 1995	CMS approved an amendment to cap QUEST enrollment at 125,000 expansion eligibles.
May 1996	CMS approved an amendment to reinstate the asset test, establish the QUEST-Net program, require participants to pay a premium, and extend demonstration eligibility to State Children's Health Insurance Program (SCHIP) children with family incomes from 101 to 200 percent of the federal poverty level (FPL).
March 1997	CMS approved an amendment to lower the income thresholds to the mandatory coverage groups and allowed the state to implement its medically needy option for the Aid to Families with Dependent Children (AFDC)-related coverage groups for individuals who become ineligible for QUEST and QUEST-Net.
May 2001	CMS approved an amendment to transition Hawaii's aged, blind, and disabled populations into mandatory managed care.
June 2001	CMS approved an amendment to allow the state to expand the QUEST-Net program to children who were previously enrolled in the SCHIP, when their family income exceeds the Title XXI income eligibility limit of 200 percent FPL.
October 2004	CMS approved an amendment to permanently align the demonstration month with the state fiscal reporting month.
June 2005	CMS approved an amendment to pay uncompensated care costs to hospitals.
July 2005	In January 2006, CMS approved a third extension (with a retroactive start date of July 1, 2005) of the 1115 demonstration, which incorporated the existing program with some significant changes, including: • Extension of coverage to all Medicaid eligible children in the child

	welfare system; • Extension of coverage to adults up to 100 percent FPL who meet Medicaid asset limits through the QUEST Adult Coverage Expansion (QUEST-ACE); • Elimination of premium contributions for children with income at or below 250 percent FPL; • Elimination of the requirement that children have prior QUEST coverage as a condition to qualifying for QUEST-Net; and • Increase SCHIP eligibility from 200 percent FPL to 300 percent FPL.
February 2008	The demonstration was renewed a fourth time, and as part of the renewal, the state implemented the QUEST Expanded Access (QExA) program and increased the eligibility level for QUEST-ACE from 100 percent to 200 percent FPL.
May 2010	CMS approved an amendment to implement a premium assistance program for employer-sponsored insurance.
October 2010	CMS approved an amendment to change eligibility requirements for the HPP program, including pneumonia vaccine, updated CHIP reporting, and clarifying the enrollment cap.
April 2012	CMS approved the state's request to limit eligibility for non-pregnant, nondisabled adults in QUEST-Net and QUEST-ACE from 200 to 133 percent of the FPL. Also eliminated the "grandfathered" QUEST-NET population with income from 200 to 300 percent FPL. This amendment was permissible under the Affordable Care Act's nonapplication of MPE provision because the state certified a budget deficit.
June 2012	CMS approved an amendment to: • Align QUEST-Net and QUEST-ACE benefits with Medicaid state plan benefits; • Redefined QUEST Expended demonstration programs to more clearly align with populations and eliminate the QUEST enrollment limit for childless adults; • Allowed retroactive eligibility for QUEST, QUEST-Net, and QUEST-ACE programs; • Added primary and acute care benefits beyond those included in the state plan to the QExA benefit package; • Removed the HPP program for employer-sponsored insurance; • Allowed uncompensated cost of care (UCC) payments to be made to nursing facilities; and • Made assorted technical corrections.
December 2012	CMS approved a fifth demonstration extension under the same terms and conditions that were in effect at the time.
March 2013	CMS approved an amendment to expand coverage to certain former foster children in advance of 2014 when that group becomes Medicaid eligible under changes in the Affordable Care Act (ACA).
September 2013	CMS approved a sixth demonstration extension, effective October 1, 2013,

	that: • Consolidated the four QUEST programs (QUEST Expanded, QUEST-ACE, QExA, and QUEST-Net) into a single QUEST Integration demonstration program which, beginning on January 1, 2014, provided the full Medicaid state plan benefit package to all beneficiaries in the demonstration; • Transitioned childless adults and former foster care children to the new adult group in the Medicaid state plan; • Expanded covered benefits to include cognitive rehabilitation, habilitation, and specialized behavioral health services to comply with federal requirements; • Increased the retroactive eligibility period from five to 10 days; • Eliminated state enrollment limits; • Removed QUEST ACE enrollment benchmark for uncompensated care (UCC) pool; and • Added evaluation requirements and a June 2016 sunset date for UCC authority.
October 2018	CMS approved an amendment to the demonstration to provide supportive housing services, called Community Integration Services (CIS), to certain eligible individuals who are homeless or at risk of homelessness and who also have a behavioral health need or a complex physical health need.
July 2019	CMS approved a seventh extension of the demonstration, which authorized Hawaii to continue providing benefits through its managed care delivery system, continue providing HCBS to certain populations, and expand access to and supportive housing benefits through a new program called the Community Transition Services Pilot program, which is a subset of CIS, for beneficiaries who meet specified needs-based criteria.
April 2020	CMS approved Attachment K, which granted certain flexibilities during the COVID-19 public health emergency (PHE).
December 2021	CMS approved a temporary authority that permitted Hawaii to add or modify risk sharing mechanisms such as reinsurance, risk corridors, or stop-loss limits after the start of a rating period, provided that the contract and rating period(s) begin or end during the COVID-19 PHE.
June 2024	CMS approved a temporary extension of the demonstration and a temporary extension of Hawaii's existing COVID-19 Attachment K authorities under the state's demonstration. These temporary extensions allowed the state and CMS to continue negotiations over two recent requests: (1) the state's demonstration extension application submitted on January 17, 2024; and (2) the state's request to make certain Attachment K authorities long-term components of the demonstration submitted on October 27, 2023.
November 2024	CMS approved an amendment to the demonstration to provide continuous eligibility to Medicaid children up to age six and 24 months of continuous eligibility to Medicaid children age six up to age 19.

Hawaii submitted a request to extend the demonstration in January 2024 for a period beginning on January 8, 2025 and ending on December 31, 2029. The 2025 extension made the following changes to the demonstration:

- Addition of new services, which include:
    - New health-related social needs (HRSN) housing supports such as housing supports without room and board (i.e., pre-tenancy navigation services, one-time transition and moving costs other than rent, and tenancy and sustaining services), utility assistance, home remediations that are medically necessary, home/environmental accessibility modifications, episodic housing interventions with clinical services with room and board (i.e., short-term pre-procedure housing, short-term recuperative care, and short-term post-transition housing), and room and board-only supports (i.e., first month's rent as a transitional service and short-term rental assistance). All of Hawaii's housing supports will be offered through a program called CIS+.
    - HRSN nutrition supports, such as coverage of nutrition instruction, home delivered meals or pantry stocking, medically tailored meals, and nutrition prescriptions
    - Cooking supplies that are necessary for meal preparation and nutritional welfare of a beneficiary when not available through other programs
    - Pre-release services for eligible incarcerated individuals.
    - Non-medical transportation.
    - A contingency management program for individuals with stimulant use disorder or opioid use disorder.
    - Assisted living facility services for the "at risk" population.
- Extension of coverage to individuals under age 26 who (1) were in foster care under the responsibility of a state other than Hawaii and who turned age 18 before January 1, 2023, or (2) who aged out of an adoption assistance or kinship guardianship assistance agreement with any state.
- Transition of certain HCBS from COVID-19 Attachment K authority to section 1115 authority.
- Authority for infrastructure funding to support implementation and maintenance of HRSN services.
- Authority for funding to support Designated State Health Programs (DSHP)-funded demonstration initiatives.

The objectives for the 2025-2029 demonstration approval period are:

- Improve health outcomes for Medicaid-enrolled individuals covered under the demonstration;
- Maintain a managed care delivery system that leads to more appropriate utilization of the healthcare system and a slower rate of expenditure growth; and
- Address social drivers of health to improve health outcomes and lower healthcare costs.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely

through the demonstration. If a population eligible through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures: The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility

as required under 42 CFR 435.916(d)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR part 431 subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must

also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY FOR THE DEMONSTRATION

4.1. **Eligibility Groups Affected by the Demonstration.** Hawaii includes in the demonstration almost all the mandatory and optional populations under age 65 eligible under the Medicaid State Plan. This demonstration affects mandatory and optional Medicaid State Plan populations as well as populations eligible for benefits only through the demonstration. Mandatory and optional state plan groups derive their eligibility through the Medicaid State Plan, and benefits are described in the Medicaid State Plan and these STCs. Coverage for mandatory and optional state plan groups are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived under authority granted by this demonstration or as described in these STCs, or as made inapplicable to the expenditure authorities for this demonstration that may provide demonstration-only benefits to state plan groups. Any

Medicaid State Plan Amendments modifying the eligibility standards and methodologies for these eligibility groups will apply to this demonstration.

The eligibility groups described below who are made eligible for QUEST Integration by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid and/or CHIP laws, regulations, and policies unless otherwise specified in the not applicable expenditure authorities for this demonstration.

The general categories of populations affected, or made eligible, by the demonstration are described in Tables 2 – 4.

Table 2. QUEST Integration Medicaid State Plan Mandatory Groups

Mandatory State Plan Groups		
Eligibility Group Name	**Qualifying Criteria**	**Medicaid Expenditure Group (MEG) Reporting**
Parents or caretaker relatives	Up to and including 100% FPL	Adults
Pregnant Individuals	Up to and including 191% FPL	Adults
	Extended and continuous eligibility for pregnant individuals	Adults
Infants	Infants up to age 1, up to and including 191% FPL	Children
	Deemed newborn children	Children
	Continuous eligibility for hospitalized infants	Children
Children	Children ages 1 through 5, up to and including 139% FPL; and 6 through 18, up to and including 133% FPL	Children
	Continuous eligibility for hospitalized children	Children
Low Income Adults Age 19 Through 64 Group	Not pregnant, not eligible for or enrolled in Medicare, not otherwise eligible for another mandatory eligibility group; up to and including 133% FPL	Group VIII Combined

Mandatory State Plan Groups		
Eligibility Group Name	**Qualifying Criteria**	**Medicaid Expenditure Group (MEG) Reporting**
Children with adoption assistance, foster care, or guardianship care under title IV-E.	No income limit; An adoption assistance agreement is in effect under title IV-E of the Act; or Foster care or kinship guardianship assistance maintenance payments are being made by a State under title IV-E.	Children
Former Foster Children under age 26	No income limit; aged out of foster care and enrolled in Medicaid at age 18 or a higher age, as elected by the state Includes individuals who turned age 18 on or after January 1, 2023, and who aged out of the foster care program under the responsibility of another state (or tribe) other than Hawaii on the date of attaining age 18 or such higher age as the former state has elected	Adults
State Plan Mandatory Aged, Blind, or Disabled Groups	ABD individuals who meet more restrictive requirements for Medicaid than the SSI requirements. Uses SSI payment standard.	Aged or Blind/Disabled
	Qualified severely impaired blind and disabled individuals under age 65	Blind/Disabled
	Other ABD groups as described in the State Plan	Aged or Blind/Disabled
Transitional Medical Assistance	Coverage for one 12-month period due to increased earnings that would otherwise make the family ineligible under Section 1931	Adults
Extended Medicaid due to Spousal Support Collection	Coverage for four months due to receipt of spousal support that would otherwise make the family ineligible under Section 1931	Adults
Qualified Medicare beneficiaries*	Standard eligibility provisions for this population as described in the State Plan.	Aged or Blind/Disabled

Mandatory State Plan Groups		
Eligibility Group Name	**Qualifying Criteria**	**Medicaid Expenditure Group (MEG) Reporting**
Specified low-income Medicare beneficiaries*	Standard eligibility provisions for this population as described in the State Plan.	Aged or Blind/Disabled

*Dual eligibles are included as those with full Medicaid benefits are served under QI health plans and QI health plans pay Part B co-payments and coordinate Medicare services.

Table 3. QUEST Integration Medicaid State Plan Optional Groups

Optional State Plan Groups		
Eligibility Group Name	**Qualifying Criteria**	**Medicaid Expenditure Group (MEG) Reporting**
Optional Coverage of Families and Children and the Aged, Blind, or Disabled	ABD individuals who do not receive cash assistance but meet income and resource requirements	Aged or Blind/Disabled
	Individuals eligible for assistance but for being in a medical institution	Children, Adults, Aged or Blind/Disabled
	Individuals who would be eligible for Medicaid if they were in a medical institution, who are terminally ill, and who receive hospice care	Children, Adults, Aged or Blind/Disabled
	ABD individuals in domiciliary facilities or other group living arrangements	Aged or Blind/Disabled
	Aged or disabled individuals with income up to and including 100% FPL	Aged or Blind/Disabled
Optional Coverage of Parents and Other Caretaker Relatives	Individuals qualifying as parent or other caretaker relative who are not mandatorily eligible and have income up to 105% FPL	Adult
Optional Targeted Low-Income Children	Uninsured children, up to and including 308% FPL, for whom the state is claiming Title XXI funding	Children

Optional State Plan Groups		
Eligibility Group Name	**Qualifying Criteria**	**Medicaid Expenditure Group (MEG) Reporting**
Certain Individuals Needing Treatment for Breast or Cervical Cancer	No income limit; under age 65; must have been detected through NBCCEDP; and not have creditable coverage	Blind/Disabled
Medically Needy Non-Aged, Blind, or Disabled Children and Adults	Up to and including 300% FPL, if spend down to medically needy income standard for household size	Blind/Disabled
Medically Needy Aged, Blind, or Disabled Children and Adults	Medically needy income standard for household size using SSI methodology	Aged or Blind/Disabled
State Adoption Assistance	Individuals under age 21 with non-Title IV-E adoption assistance	Children or Adults

Table 4. QUEST Integration Demonstration Expansion Population Groups

Expansion Groups		
Eligibility Group Name	**Qualifying Criteria**	**Medicaid Expenditure Group (MEG) Reporting**
Parents or caretaker relatives with an 18-year-old dependent child	Parents or caretaker relatives who (i) are living with an 18-year-old who would be a dependent child but for the fact that s/he has reached the age of 18 and (ii) would be eligible if the 18-year-old was under 18 years of age	Adults
Individuals in the 42 C.F.R. § 435.217-like group receiving HCBS	Income up to and including 100% FPL	Aged or Blind/Disabled
Medically needy ABD individuals whose spend-down exceeds the plans' capitation payment	Medically needy ABD individuals whose spend-down liability is expected to exceed the health plans' monthly capitation payment	Aged or Blind/Disabled
Individuals Age 19 and 20 with Adoption Assistance, Foster Care Maintenance Payments, or Kinship Guardianship Assistance	No income limit	Adults

Individuals Formerly Receiving Adoption Assistance or Kinship Guardianship Assistance – Any State	Under age 26; aged out of adoption assistance or kinship guardianship assistance agreement with any state (either Title IV-E assistance or non-Title IV-E assistance);and were enrolled in Medicaid while receiving assistance payments under such agreement	Adults
Out of State Former Foster Care Youth	Under age 26; turned age 18 on or before December 31, 2022; aged out of foster care (either Title IV-E or non-Title IV-E) under the responsibility of a state (or tribe) other than Hawaii on the date of attaining age 18 or such higher age as the former state has elected for termination of federal foster care assistance under title IV-E of the Act; were enrolled in Medicaid on the date of aging out of foster care; are now applying for Medicaid in Hawaii; and are not otherwise eligible for Medicaid.	N/A

4.2. **Post-Eligibility Treatment of Income and Resources.** All individuals receiving nursing facility long-term care services must be subject to the post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 C.F.R. section 435.733. Available income after appropriate deductions, such as for a personal needs allowance, allowances for a spouse and/or family members, and incurred medical expenses, shall be the amount by which Medicaid's payment is reduced for the relevant long-term services and supports. Individuals receiving HCBS must be subject to the post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 C.F.R. section 435.735 if they are medically needy, with or without spend-down, or individuals who would be eligible for Medicaid if institutionalized as set forth in 42 C.F.R. section 435.217.

4.3. **Financial Responsibility/Deeming.** The state must determine eligibility using the income of household members whose income may be taken into account under the Medicaid financial responsibility and deeming rules, including institutional deeming for aged, blind, and disabled individuals.

4.4. **Continuous Eligibility:** Eligible populations, identified in STC 4.5, will receive continuous eligibility through the demonstration. The state is authorized to provide continuous eligibility for the populations for the durations specified in Table 5 below, regardless of the delivery system through which these populations receive Medicaid benefits.

a. For individuals who qualify for continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915, or the effective date of the most recent redetermination.

b. Because individuals are continuously eligible regardless of changes in circumstances, the state does not need to conduct renewals or redeterminations of eligibility consistent with 42 CFR 435.916 and 435.919 for individuals who qualify for continuous eligibility until the end of the individual's continuous eligibility period, except in the limited circumstances of a beneficiary meeting one of the exceptions outlined in STC 4.7**.**

c. At the end of the continuous eligibility period, Hawaii must conduct a renewal of Medicaid eligibility and consider eligibility on all bases consistent with 42 CFR 435.916(d)(1) prior to terminating coverage. Individuals determined eligible on another basis at the end of the continuous eligibility period will be moved to the appropriate group at that time. Individuals determined eligible on another basis resulting in a reduction of Medicaid eligibility or services or increase in cost sharing or premiums will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 CR 435.917 and 42 CFR 431, Subpart E and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(d)(2).

4.5. **Populations and Duration:** The state is authorized to provide continuous eligibility for the following populations for the associated durations.

a. Children up to age six. Except as provided in STC 4.7**,** individuals age zero through the end of the month of their sixth birthday, who enroll in Medicaid shall qualify for continuous eligibility until the end of the month in which their sixth birthday falls.

b. Children aged six up to age 19. Except as provided in STC 4.7, the state is authorized to provide 24 months of continuous eligibility for children who enroll in Medicaid aged six until the end of the month in which their 19th birthday falls.

Table 5. Eligible Populations and Associated Duration for Continuous Eligibility (CE)

Population	Duration of CE
Children up to age six	Until the end of the month of their sixth birthday
Children aged six up to age 19	24 months

4.6. **Eligibility Exclusions:** The following children are excluded from receiving continuous eligibility:

a. Have only established Medicaid eligibility as medically needy (as set forth in section 1902(a)(10)(C) of the Act),

b. Have been determined presumptively eligible for Medicaid but have not yet received an eligibility determination based on a regular application, or

c. Upon the adult and child's renewal are determined to only be eligible for Medicaid based on transitional medical assistance (as set forth in section 1925 of the Act).

4.7. **Exceptions to Continuous Eligibility:** Notwithstanding STC 4.5, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be redetermined or terminated:

a. The beneficiary attains the age limit of the continuous eligibility period or eligibility group (if applicable);

b. The beneficiary is no longer a Hawaii resident;

c. The beneficiary or their representative requests termination of eligibility;

d. The beneficiary dies; or

e. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

4.8. **Beneficiary-Reported Information and Periodic Data Checks:**

a. The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their continuous eligibility as outlined STC 4.7 (such as a change in state residency) and are able to report other information relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

b. For individuals who qualify for a continuous eligibility period that exceeds 12 months, the state must continue to attempt to verify residency at least once every 12 months. The state should follow its typical processes that it would otherwise use to verify continued residency at renewal if continuous eligibility was not available for these individuals.

c. Additionally, at least once every 12 months, the state must follow its typical processes to attempt to confirm the individual is not deceased, consistent with the data sources outlined in the state's verification plan(s) and/or confirmed by the household per 42 CFR 435.952(d). The state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual

is deceased, verifying the change consistent with 42 CFR 435.919 and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j)**.**

d. Because individuals are receiving continuous eligibility beyond their eligibility period, the state does not need to complete the individual's annual renewal or act on changes in circumstances that would otherwise affect eligibility, except as detailed in STC 4.7, until the end of the individual's continuous eligibility period. Additionally, if the state obtains information about changes that may affect eligibility (e.g., change in income), they are not permitted to use the information related to the change to end the continuous eligibility period early and terminate coverage, unless the change relates to one or more of the exceptions detailed in STC 4.7.

4.9. **Annual Updates to Beneficiary Contact Information:** For all continuous eligibility periods longer than 12 months, the state must have procedures and processes in place to accept and update beneficiary contact information and must attempt to update beneficiary contact information on an annual basis, which may include examining data sources annually and partnering with managed care organizations to encourage beneficiaries to update their contact information. The state is reminded that updated contact information obtained from third-party sources with an in-state address is not an indication of a change affecting continuous eligibility. Contact information with an out-of-state or no forwarding address indicates a potential change in circumstance with respect to state residency, but without additional follow up by the state per 42 CFR 435.952(d), the receipt of this third-party data is not sufficient to make a definitive determination that beneficiaries no longer meet state residency requirements.

4.10. **Annual Reminders of Continued Eligibility:** The state must have procedures and processes in place to provide individuals who qualify for a continuous eligibility period that exceeds 12 months an annual reminder of continued eligibility. The annual reminder of continued eligibility must:

a. Be written in plain language;

b. Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with 42 CFR 435.905(b); and

c. If provided in electronic format, comply with requirements for electronic notices in 42 CFR 435.918.

The annual reminder of continued eligibility must, at a minimum, include:

d. An explanation of the individual's continued eligibility, including the end date of the continuous eligibility period;

e. The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's continuous eligibility;

f. Basic information on the level of benefits and services available as described at 42 CFR 435.917(b)(1)(iv); and

g. If the beneficiary's eligibility is based on having household income at or below the applicable MAGI standard, the content regarding non-MAGI eligibility described at 42 CFR 435.917(c).

4.11. **Cost Sharing within Continuous Eligibility:** Individuals receiving continuous eligibility enrolled in this demonstration may be subject to cost sharing responsibilities, such as monthly premiums and co-payments, to the extent allowable under title XIX requirements or as approved under current section 1115 demonstration authority**.** However, beneficiaries may not be disenrolled from this demonstration for failure to pay a premium during the individual's continuous eligibility period approved in the demonstration.

5. ENROLLMENT

5.1. Medically needy individuals are eligible under the demonstration and will be enrolled into the demonstration if they meet spend-down eligibility:

a. **Members of Pregnant Individuals and Children Medically Needy State Plan Groups** are eligible under the demonstration and will be enrolled in a QUEST Integration health plan upon the determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to STC 5.1(d). Individuals in this group whose gross income exceeds 300 percent FPL are not eligible.

b. **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is not expected to exceed the health plans' monthly capitation payment** are eligible under the demonstration and will be enrolled in a QUEST Integration health plan upon the determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to STC 5.1(d).

c. **Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is expected to exceed the health plans' monthly capitation payment** are eligible under the demonstration and will be enrolled in a QUEST Integration health plan upon the determination of medical expenses in the month of enrollment that meet or exceed their spend-down or cost-share obligation, subject to STC 5.1(d). This group will receive all services through QUEST Integration health plans.

d. **Medically needy individuals who are expected to incur expenses sufficient to satisfy their spend-down obligation for a retroactive period only** will not be enrolled in a QUEST Integration health plan. They will receive services on a fee-for-service basis. (This category might include, for example, persons who become medically needy for a short-term retroactive period due to catastrophic injury or

illness, or persons who incur high medical expenses sporadically and thus will not meet their spend-down obligations every month.)

6. BENEFITS

6.1. **QUEST Integration Benefits.** Benefits provided under the authority of this demonstration are delivered through mandatory managed care (except as specified in STC 6.1(d)), and are as follows, for all populations under the demonstration (except as otherwise provided in this STC):

a. **Full Medicaid State Plan.** Individuals eligible under the demonstration will receive comprehensive benefits including all services as defined in the Medicaid state plan.

b. **Alternative Benefit Plan.** The Affordable Care Act (ACA) Adult Group (described in 42 C.F.R. 435.119) will receive benefits provided through the state's approved alternative benefit plan (ABP) SPA.

c. **Managed Care Plan Change.** Beneficiaries may change managed care plans per 42 C.F.R 438.56(d)(2)(iv) if their residential or employment support provider is no longer available through their current plan.

d. **Benefits Provided to the ID/DD Population.** Medicaid eligibles with developmental disabilities will receive the full Medicaid state plan benefit package through QUEST Integration managed care plans. Case management, section 1915(c) HCBS, and ICF/ID benefits for this group will remain carved out of the capitated benefit package. All QUEST Integration health plans are required to coordinate the state plan benefits received by the ID/DD population with the HCBS that are provided on a fee-for-service basis from the Hawaii Department of Health's (DOH) Developmental Disabilities Division.

e. **Behavioral Health Benefits.** All QUEST Integration plans must provide a full array of standard behavioral health benefits (including substance abuse treatment) to beneficiaries who may need such services as set forth in the Behavioral Health Services Protocol in Attachment E. The state must also provide specialized behavioral health services to beneficiaries with SMI, SPMI, or SEBD. The Behavioral Health Services Protocol includes the following:

i. Services provided by the DOH Child and Adolescent Mental Health Division (CAMHD) to children needing support for emotional and behavioral development (SEBD).

ii. Services provided to adults with SMI or SPMI by the Med-QUEST division's Community Care Services (CCS) behavioral health program, or the contracted plans.

iii. Reimbursement methodology.

iv. A memorandum of agreement (MOA) between each MCO and the state that reflects the current interagency agreement for behavioral health services provided by the DOH to beneficiaries.

v. The process(es) and protocol(s) used for referrals between MCOs and the DOH or CCS, as well as the DOH or CCS and MCOs.

f. **Additional Benefits.** Under the demonstration, the state will provide benefits in addition to Medicaid state plan and alternative benefit plan benefits based on medical necessity and clinical criteria. These additional benefits include home and community-based services (HCBS), specialized behavioral health benefits, cognitive rehabilitation benefits, and habilitation benefits, as described below.

g. **HCBS Eligibility.** QUEST Integration health plans must provide access to a comprehensive HCBS benefit package for individuals who meet institutional level of care and are able to choose to receive care at home or in the community and an expanded sub-set of HCBS services for individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care (the "At Risk" population, re-named from "Personal Care-Level I/Chore" population) in order to prevent a decline in health status and maintain individuals safely in their homes and communities. The population criteria (including institutional level of care definitions), service definitions, and provider types are found in Attachment D of these STCs, while the HCBS standards Hawaii must follow and delivery of care flexibilities are described in section 10. The amount, duration, and scope of all covered long-term care services may vary to reflect the needs of the individual in accordance with the prescribed Care Coordination Plan. The HCBS benefits that will be provided through managed care health plans include the following:

Service	**Available for individuals who are assessed to be at risk of deteriorating to institutional level of care**	**Available for individuals who meet institutional level of care ("1147 certified")**
Adult day care	X	X
Adult day health	X	X
Assisted living facility	X*	X
Community care foster family homes		X
Counseling and training		X
Environmental accessibility adaptations		X
Home delivered meals	X	X
Home maintenance		X
Moving assistance		X
Non-medical		X

Service	Available for individuals who are assessed to be at risk of deteriorating to institutional level of care	Available for individuals who meet institutional level of care ("1147 certified")
transportation		
Personal assistance	X	X
Personal emergency response system	X	X
Residential care		X
Respite care		X
Private duty nursing	X	X
Specialized case management		X
Specialized medical equipment and supplies		X

* Denotes new services in the 2025-2029 extension period for the "At Risk" population under QUEST Integration.

h. **Specialized Behavioral Health Services**: The services listed below (and further described in Attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).

i. Supportive employment.

ii. Financial management services.

i. **Cognitive Rehabilitation Services.** Services provided to cognitively impaired individuals to assess and treat communication skills, cognitive and behavioral ability and skills related to performing activities of daily living. These services may be provided by a licensed physician, psychologist, or a physical, occupational or speech therapist. Services must be medically necessary and prior approved.

j. **Habilitation Services.** Services to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition. These services may be provided by a licensed physician or physical, occupational, or speech therapist. Services must be medically necessary and prior approved.

7. COST SHARING

7.1. **Cost sharing.** Cost sharing must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies. Standard Medicaid exemptions from cost-sharing set forth in 42 C.F.R §447.56 apply to the demonstration.

7.2. **Cost sharing for out-of-state former foster care youth.** Out-of-state former foster care youth will receive the same Medicaid state plan benefits as set forth in the state plan for all other beneficiaries under 21 years of age, i.e., children. Out-of-state former foster care

youth ages 21 to 26 will receive the same Medicaid state plan benefits as set forth in the state plan for beneficiaries 21 years of age and older, i.e., adults. Out-of-state former foster care youth aged 18 to 26 will be subject to the same cost sharing requirements effectuated by the state for the mandatory title IV-E foster care youth eligibility category enacted by the Adoption Assistance and Child Welfare Act of 1980 (Pub. L. 96-272).

8. HEALTH-RELATED SOCIAL NEEDS (HRSN)

8.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in STC 8.2 and Attachment F, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and clinically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social risk criteria across services and with other relevant, non-Medicaid social support agencies, to the extent possible and appropriate. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through other local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans, as applicable, of their responsibilities to make payment for other covered services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on a beneficiary's receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 8.10 and Attachment F.

8.2. **Allowable HRSN Services.** The state may cover the following HRSN services:

a. Housing Interventions, including:

i. Housing supports without room and board, including:

1. Pre-tenancy navigation services (e.g., finding and securing housing).
2. One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household (e.g., security deposit, application and inspection fees, utilities activation fees and payment in arrears as necessary to re-establish utility service (capped at a total of six months of total arrear and prospective payments), movers, relocation expenses, pest eradication, pantry stocking (up to 30 days of food), cooking supplies, and the purchase of household goods and furniture). Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services. This does not include clothing.
3. Tenancy and sustaining services (e.g., eviction prevention, tenant

rights education).

ii. Utility assistance, capped at six months per demonstration period for total prospective/retrospective payments (utility assistance provided as a one-time transition service under STC 8.2(a)(ii)(2) is included in this limit), including activation expenses and back payments to secure utilities, limited to individuals receiving housing supports with or without room and board as described in this STC. Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services.

iii. Home remediations that are medically necessary, including, for example, air filtration devices, air conditioning, ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and/or pest removal, and/or housing safety inspections.

iv. Home/environmental accessibility modifications, including, for example, wheelchair accessibility ramps, handrails, and grab bars.

v. Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including:

1. Short-term pre-procedure housing, where a provider has determined that preparatory steps are required for an upcoming procedure or treatment and integrated, clinically oriented recuperative or rehabilitative services and supports are provided.

2. Short-term recuperative care, where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require ongoing monitoring and continuous access to medical care.

3. Short-term post-transition housing (e.g., post-hospitalization), where integrated, clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required.

vi. Room and board-only supports (also referred to as “rent-only” supports or interventions), limited to a clinically appropriate amount of time, including:

1. First month’s rent as a transitional service.

2. Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment.

b. Nutrition Interventions (standalone, outside of joint room and board interventions):

i. Nutrition interventions without provision of food, including nutrition instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement (for example, guidance on selecting healthy food and healthy meal preparation).

ii. Nutrition interventions with provision of food, including:

1. Home delivered meals or pantry stocking (also referred to as grocery provisions), appropriate for the beneficiary's health condition or status as a child or pregnant person.
2. Medically tailored meals to individuals with nutrition-sensitive conditions (e.g., pregnant individuals, individuals with diabetes), as specified in STC 8.6.
3. Nutrition prescriptions, appropriate for the beneficiary's health condition or status as a child or pregnant person, including, for example, fruit and vegetable prescriptions, protein boxes, food pharmacies, and/or healthy food vouchers.

iii. Cooking supplies outside of HRSN services and covered under separate expenditure authority that are necessary for meal preparation and nutritional welfare of a beneficiary when not covered as an HRSN one-time transition and moving cost or available through other programs (e.g., pots and pans, utensils, refrigerator).

8.3. **HRSN Intervention Duration and Frequency.**

a. Housing interventions with room and board.

i. Housing interventions that are classified as episodic interventions, as described in STC 8.2(b)(v) may be covered for a qualifying beneficiary, as clinically appropriate, up to a combined 6 months per rolling year. For purposes of this demonstration, rolling year is defined as a continuous 12-month period with the start date beginning when the beneficiary begins receiving the service.

ii. Housing interventions that are classified as room and board-only support, as described in STC 8.2(b)(vi), may be covered for a qualifying beneficiary up to a combined 6 months per household per demonstration period.

iii. For each of these 6-month caps, coverage will be permitted in one or more spans or episodes, as long as the total duration remains under the cap for the rolling year or demonstration period. CMS will also apply a total combined cap of 6 months for all types of HRSN housing interventions with room and board (including episodic interventions and room and board-only supports), per beneficiary, in any 12-month period. However, if a beneficiary is considered to have received room and board-only support because that intervention was covered for another member of the beneficiary's household as specified in STC 8.3(b), the beneficiary still may receive up to 6 months of coverage for episodic interventions in the same 12-month period without violating this STC.

b. Nutrition interventions with provision of food.

i. HRSN nutrition interventions with provision of food (full board, i.e., 3 meals/day or any other complete nutritional regimen) are limited to a duration of 6 months, renewable while the beneficiary continues to meet qualifying criteria.

ii. HRSN nutrition interventions with provision of food are not available to the extent that that benefit, together with any other service payments that include payment for food made on behalf of the beneficiary, would exceed full board for the beneficiary, as the HRSN nutrition benefit or payment would be duplicative. For example, medically tailored meal delivery is not available for an individual who is receiving short-term rental assistance for a stay in a facility that provides 3 meals per day included in the payment to the facility, and pantry stocking or nutrition prescriptions are not available for an individual who is receiving a full board regimen of medically tailored meals.

c. The state will define other HRSN service duration limitations in Attachment F, subject to CMS approval as indicated in STC 8.7.

8.4. **Excluded Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction (bricks and mortar) except as needed for approved medically necessary home modifications specified in STC 8.2;

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 8.2 and STC 8.3;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of section 1905(a) of the Act except case management of HRSN services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States;

g. Expenditures that supplant services and/or activities funded by other local, state and/or federal governmental entities;

h. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

i. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

1. For all HRSN housing interventions with room and board, the following setting exclusions apply: Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space.

8.5. **HRSN Infrastructure.**

a. The state may claim FFP for expenditures for infrastructure investments to support the development and implementation of HRSN services, subject to STC 8.3. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, electronic heath record (EHR) modifications or integrations, screening tool and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, and accounting and billing systems.

ii. Development of business or operational practices – e.g., developing policies, procedures and workflows, training and technical assistance, and administrative activities to support or expand HRSN operations.

iii. Workforce development – e.g., recruiting and hiring, salary and fringe benefits for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies and procedures, and training materials.

iv. Outreach, education, and interested parties convening – e.g., design and production of outreach and education materials, translation, obtaining community input, and interested parties convening and community engagement activities.

b. The state may claim FFP for HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 6. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years, not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 6. Annual Limits of Allowable Total Computable Expenditures for HRSN Infrastructure

	DY 32	DY 33	DY 34	DY 35	DY 36	Total
Total Computable Expenditures	$15,378,000	$15,378,000	$15,378,000	$15,378,000	$15,378,000	$76,890,000

c. Infrastructure expenditures will receive the FFP match for applicable administrative costs for the expenditure.

d. This infrastructure funding is separate and distinct from payments for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 8.5 are not included in HRSN service payments (including capitation payments, as applicable) and that there is no duplication of payments to entities providing or administering HRSN service benefits.

e. The state may not claim any FFP in HRSN infrastructure expenditures until Attachment H: HRSN Infrastructure Protocol is approved, as described in STC 8.9. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of when the demonstration expenditure authority for HRSN infrastructure was approved.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

8.6. **Covered Populations.** Expenditures for HRSN services may be made for the populations of focus specified in Attachment F, consistent with this STC. To qualify to receive coverage for HRSN services, individuals must be Medicaid (or Medicaid demonstration)-eligible and have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate, as described STC 8.1, to address the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment F. Attachment Q, the HRSN Service Matrix, describes the full list of clinical and social risk factors the state anticipates incorporating into Attachment F over the course of the demonstration at the time of the demonstration approval of the expenditure authority for HRSN services. While Attachment Q reflects the full list of clinical and social risk factors the state is authorized to implement, the state is not required to implement all of the clinical and social risk factors outlined in Attachment Q. Additionally, the state can later include additional clinical and social risk factors in compliance with STC 8.7 and 8.8.

8.7. **Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services.** The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications to CMS no later than 90 days after approval of the HRSN expenditure authority. The protocol must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a clinically appropriate population of focus for each service, the process by which those criteria will be applied including care plan requirements and/or other documented processes, and provider qualification criteria for each service. Any changes to the initial scope of clinical and social risk factors reflected

in Attachment Q must be effectuated through the process indicated in STC 8.8. The state must resubmit a revised protocol if required by CMS feedback on the initial submission. The state may not claim FFP for HRSN services until CMS approves the initial protocol. Once the initial protocol is approved, the state can claim FFP in expenditures for HRSN services retrospectively to the date of approval of the expenditure authority for HRSN services. The approved protocol will be appended to the STCs as Attachment F.

If the state adds new HRSN services beyond those specified in STC 8.2 through a demonstration amendment, the state must also submit revisions to the Protocol to CMS no later than 90 days after the approval of the amendment to the demonstration. The Protocol revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a clinically appropriate population of focus for each new service, the process by which those criteria will be applied including service plan requirements and/or other documented processes, and provider qualification criteria for each new service. This revised protocol must comply with applicable STCs.

Specifically, the protocol(s) must include the following information:

a. A list of the covered HRSN services (not to exceed those allowed under STC 8.2), with associated service descriptions and service-specific provider qualification requirements.

b. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary qualifications, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may determine the service to be clinically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical and social risk criteria to ensure transparency for beneficiaries and other interested parties.

d. A description of the process for developing care plans based on assessment of need.

    i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

    ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed, as appropriate.

e. A plan to avoid duplication/displacement of existing food assistance/nutrition services, including how the state will prioritize and wrap around Supplemental Nutrition Assistance Program (SNAP) and/or Women Infants and Children (WIC) enrollment, appropriately adjust HRSN demonstration initiative benefits for individuals also receiving SNAP and/or WIC services, and ensure eligible beneficiaries are enrolled to receive SNAP and/or WIC services.

f. An affirmation that the state agrees to meet the enhanced monitoring and evaluation requirements stipulated in STCs 16.5(b) and 17.6, which require the state to monitor and evaluate how the renewals of recurring nutrition services under STC 8.3(b) affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services. As required in STC 16.5 and 17.4, the Monitoring Protocol and Evaluation Design are subject to CMS approval.

8.8. **Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services:**

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachment F and Q. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in Attachment Q, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change in Attachment F by the following process:

i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.

ii. The state must provide public notice.

iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and/or social risk factors than what are included in approved Attachment Q, the state must follow the process below to update the protocol:

i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and/or social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 17.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 8.8(b).

iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this STC 8.8(b). This restriction is not applicable to the process and scope of changes outlined in STC 8.8(a).

8.9. **HRSN Infrastructure Protocol.** The state must submit, for CMS approval, an HRSN Infrastructure Protocol to CMS no later than 90 days after approval of the expenditure authority for HRSN infrastructure expenditures. The protocol must include the state's proposed uses of HRSN infrastructure funds. The state must resubmit the revised protocol as may be required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP for HRSN infrastructure expenditures until CMS approves the protocol. Once the protocol is approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the date of approval of the expenditure authority for HRSN infrastructure. The approved protocol will be appended to the STCs as Attachment H: HRSN Infrastructure Protocol. If the state adds new HRSN services through a demonstration amendment, the state must submit revisions to the Protocol to CMS no later than 90 days after approval, if required based on changes to expenditures for HRSN infrastructure to support the newly added HRSN services. The revisions must include a list of proposed uses of HRSN infrastructure funds, if different than previously submitted.

Specifically, the protocol(s) must include the following information: Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

8.10. **Service Delivery.** HRSN services will be provided in the managed care delivery system and delivered by HRSN service providers. Terms applicable to all HRSN services:

a. When HRSN services are provided to beneficiaries enrolled in Medicaid managed care, the following terms will apply:

i. HRSN services can be provided by managed care plans and paid on a non-risk basis and must be appropriately included in contracts. This can be accomplished by either a separate non-risk contract with a prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP) (see the definition of "non-risk contract" at 42 CFR § 438.2) or as an amendment to a state's existing risk-based managed care plan contract to include a non-risk payment. The state must take measures to ensure there is no duplication of payments for either the delivery of such service or the administrative costs of delivering such services.

ii. For a non-risk contract or a non-risk payment, the managed care plan is not at financial risk for changes in utilization or for costs incurred under the

contract or payment that do not exceed the upper payment limits specified in 42 CFR 447.362 and may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits. For the purposes of this demonstration, fee-for-service as defined in 42 CFR 447.362 is the fee-for-service authorized in this demonstration for HRSN services paid on a fee-for-service basis by the state. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

iii. When the state includes non-risk payments in a risk-based contract, the state must ensure all non-risk payments are separate and apart from risk-based payments and clearly define what services/populations are covered under non-risk payments versus included in risk-based capitation rates. All of the costs of delivering services under a non-risk payment must be excluded from the development of the risk-based capitation rates for the risk-based contracts. Specifically, the costs of delivery the services as well as any costs of administering the non-risk payment must be excluded from the development of the risk-based capitation rates.

iv. Prior written CMS approval pursuant to STC 8.12 is required before the state moves to incorporate the HRSN services into the risk-based capitation rates in Medicaid managed care. When the state incorporates the HRSN services into the risk-based capitation rates in Medicaid managed care, the state must comply with all applicable federal requirements, including but not limited to 42 CFR 438.4, 438.5, 438.6, and 438.7, and may no longer utilize non-risk payments for the services included in risk-based capitation rates.

v. Any applicable HRSN services that are delivered by managed care plans in a risk arrangement, must be included in the risk-based managed care contracts and rate certifications submitted to CMS for review and approval in accordance with 42 CFR 438.3(a) and 438.7(a).

vi. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs.

vii. All expenditures for HRSN services delivered under non-risk contracts must be excluded from MLR reporting. When HRSN services (i.e., HRSN services defined in STC 8.2 for the covered populations outlined in STC 8.6) are included in capitation rates paid to managed care plans under risk-based contracts, and only then, should HRSN services be reported in the medical loss ratio (MLR) reporting as incurred claims.

viii. The state must develop an MLR monitoring and oversight process specific to HRSN services. This process must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. The state should submit this process to CMS at DMCPMLR@cms.hhs.gov. This

process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure, as applicable, will be identified and reported in the MLR as non-claims costs.

b. CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in managed care. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and definition of each HRSN service as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology costs that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 8.20.

8.11. **Requirements for HRSN Services prior to being delivered in risk-based managed care.** The state's plan to incorporate HRSN into risk-based managed care contracts must be submitted to CMS, for review and approval, no later than 6 months prior to the implementation of HRSN services in risk-based managed care contracts and capitation rates. At least 6 months prior to moving HRSN services approved under these STCs into risk-based Medicaid managed care contracts, the state must submit to CMS, for review and written prior approval, documentation that details the following information:

a. Each HRSN service defined in STC 8.2 and each covered population that will receive each HRSN service defined in STC 8.6 where the state is seeking CMS written approval to deliver services to populations through one or more risk-based managed care program(s). The applicable managed care program(s) for each service and population should also be specified.

b. If the HRSN service will be offered in all regions under each risk-based managed care program or if the offerings will be limited geographically.

c. The first rating period the state is seeking to start offering the HRSN service(s) through risk-based managed care. If the HRSN services will be delivered through risk-based managed care on a rolling basis, provide the timeline for each service and/or population.

d. The state's timeline to complete a readiness review pursuant to 438.66(d). Implementation may only begin when each managed care plan has been determined by the state to meet certain readiness and network requirements, including providing any documentation specified by CMS.

e. A transition of care plan that provide continuity of care for beneficiaries transitioning from another delivery system (e.g. FFS) or non-risk contracts into risk-based contracts.

f. A description of base data that the state and its actuary plan to use for capitation rate setting process to develop both the benefit and non-benefit costs, including the types of data used (FFS claims data, managed care encounter data, managed care plan financial data, etc.), and the data source(s) that will be used for capitation rate development. Consistent with Medicaid managed care rate development requirements under 42 CFR 438.5(c), CMS requires at least 3 years of encounter data or similar data (e.g. cost reports, claims data) for the HRSN services defined in STC 8.2 for the covered populations defined in STC 8.6 that will be incorporated into risk-based managed care. CMS will consider exceptions to the requirement for 3 years of base data for periods impacted by COVID-19.

g. The methodology the state's actuary will use in the capitation rate setting process. This includes, but is not limited to, any trend factors and adjustments to the data the state and its actuary will apply to the base data in the capitation rate setting process. The methodology should also include information on the approach the actuary will take to incorporating the HRSN service(s) into capitation rate development (for example, if the actuary will create an add-on that will be applied to some or all existing rates cells, creating a separate rate cell, or some other method) and any changes to or new risk adjustments or acuity adjustments applied due to the inclusion of the HRSN services defined in STC 8.2 for the covered populations defined in STC 8.6.

h. If the state is planning to delegate risk for the delivery of HRSN services to clinical providers, community organizations, and/or subcontractors for specific HRSN services, the capitation rate setting plan should include a description of these proposed delegated arrangements and/or sub-capitated payment arrangements that the state intends to use in the delivery of any HRSN services defined in STC 8.2 for covered populations defined in STC 8.6.

i. Identification of any in lieu of services or settings (ILOSs) the state currently offers through its managed care programs and if there will be changes to those ILOSs as a result of the state moving these HRSN service(s) into risk-based managed care contracts.

j. Because of the uncertainty associated with HRSN services and in alignment with past guidance about situations with high levels of uncertainty, CMS is requiring the state to implement a 2-sided risk mitigation strategy (such as a 2-sided risk corridor) to provide protection for state and federal governments, as well as managed care plans. The HRSN capitation rate setting plan should provide a description of the risk mitigation mechanism(s) that will be used in the transition of HRSN services to risk-based managed care. As part of a plan to

incorporate HRSN into risk-based managed care, the State will also need to develop an MLR monitoring and oversight process specific to HRSN services. This process must specify how HRSN services will be identified for inclusion in the MLR numerator. The state's plan must indicate how expenditures for HRSN administrative costs and HRSN infrastructure, as applicable, will be identified and reported by managed care plans as non-claims costs.

k. All state directed payments the state plans to implement for any HRSN services defined in STC 8.2 for the covered populations defined in STC 8.6 that will be provided under risk-based contracts must comply with all applicable federal requirements, including but not limited to 438.6(c). The state should submit information to establish compliance for any state-directed payments for HRSN services to CMS at statedirectedpayment@cms.hhs.gov.

8.12. **Phased In Implementation of HRSN Services.** As further discussed in the state's Implementation Plan as required in STC 8.23, the state intends to implement HRSN services on a statewide basis, using a phased approach based on readiness, including provider capacity and community infrastructure for each HRSN service. Certain HRSN services, such as pre-tenancy supports and tenancy sustaining supports that were already implemented under the prior demonstration, will be implemented at the beginning of the demonstration period for continuity of services. Other HRSN services, such as nutrition supports, will be phased in later based on readiness. The state will define phased in implementation timelines for HRSN services in the HRSN Implementation Plan. The state must maintain public record on its website of what services are available, as well as notify the public of any changes to the availability of HRSN services, in addition to following the requirements in STC 8.8.

8.13. **Contracted Providers.** Managed care plan contracts must provide, applicable to all HRSN services:

a. Managed care plans will contract with providers to deliver the HRSN services authorized under the demonstration and included in the managed care contract.

b. Managed care plans must establish a network of providers and ensure the HRSN service providers have sufficient experience and training in the provision of the HRSN services being offered. HRSN service providers do not need to be licensed, however, staff offering services through HRSN service providers must be licensed when applicable (i.e., when the staff member is performing activities for which a licensure requirement applies in the state).

c. The managed care plan and contracted providers will use rates set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements. Any state direction of managed care plan expenditures under risk-based contract(s) and risk-based payments would be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

8.14. **Provider Network Capacity.** Managed care plan contracts must ensure the HRSN services authorized under the demonstration are provided to qualifying beneficiaries in a timely manner and shall develop policies and procedures outlining the managed care plan's approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

8.15. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statutes and regulation.

8.16. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each beneficiary receiving HRSN services that is person-centered, identifies the beneficiary's needs and individualized strategies and interventions for meeting those needs, and developed in consultation with the beneficiary and the beneficiary's chosen support network, as appropriate. The service plan must be reviewed and revised as appropriate at least every 12 months, when the beneficiary's circumstances or needs change significantly, or at the beneficiary's request.

8.17. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

8.18. **CMS Approval of Managed Care Contracts.** As part of the state's submission of associated managed care plan contracts to implement HRSN services through managed care, the state must include contract requirements including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize beneficiaries' access to covered services.

ii. Beneficiaries always retain their right to receive covered service on the same terms as would apply if HRSN services were not an option.

iii. Beneficiaries who are offered or who utilize an HRSN service retain all rights and protections afforded under 42 CFR Part 438.

iv. Managed care plans are not permitted to deny a beneficiary a covered service on the basis that the beneficiary is currently receiving HRSN services, has requested those services, has previously qualified for or received those services, or currently qualifies or may qualify in the future for those services.

v. Managed care plans are prohibited from requiring a beneficiary to receive HRSN services.

b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services.

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.

iii. Any data necessary to monitor appeals and grievances for beneficiaries.

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN services initiative.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiative, including cost assessment, including but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries who qualify for HRSN services. When possible, these encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state, or another legally authorized oversight body to aid in ongoing evaluation of the HRSN services initiative or any independent assessment or analysis conducted by the state, CMS, or another legally authorized entity.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing and nutrition resources and to avoid duplication of efforts.

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

8.19. **HRSN Rate Methodologies.** For FFS payment methodologies and/or rates, the state must comply with the payment rate-setting requirements in 42 CFR Part 447, as though a state plan amendment were required, to establish any payment rate and/or methodology for HRSN services as approved under demonstration expenditure authority 5. The state must conduct state-level public notice under 42 CFR 447.205 prior to the implementation of the applicable FFS payment rates or methodologies for HRSN and maintain

documentation of these FFS payment rates or methodologies on its website described in 42 CFR 447.203. The state may receive FFP for HRSN service expenditures authorized under this demonstration upon implementation of the FFS payment rates and/or methodologies for which it has conducted prior public notice and may begin claiming for this FFP (for dates of service no earlier than the effective date of approval for the relevant expenditure authority) no earlier than the date of submission of the payment rates and/or methodology to CMS for approval. However, any FFS payments to providers or claims for FFP prior to CMS approval of the payment rate or methodology must be reconciled to the ultimately approved FFS payment rate and/or methodology within one year of CMS's approval. All requirements for timely filing of claims for FFP continue to apply.

For managed care payments and rates (including capitation rates, non-risk payments, and state directed payments), the state must comply with all federal requirements, including those in 42 CFR Part 438 and these STCs. As applicable, the state must also notify CMS at least 60 days prior to intended implementation if it intends to direct its managed care plans on how to pay for HRSN services (i.e., state directed payments).

All rates/payment methodologies for HRSN services, for both FFS and managed care delivery systems, must be submitted to CMS for review and approval, including but not limited to fee-for-service payments as well as managed care capitation rates, any state directed payments that require prior written approval, and non-risk payments, as outlined in the STCs. For all payment methodologies and/or rates, for both FFS and managed care delivery systems, in addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public comments on the rates and/or methodology (when applicable), and information about Medicaid non-federal share financing.

8.20. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing and housing transition supports and nutrition supports for the duration of the demonstration, not including one-time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan required by STC 8.23 that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 16.5, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

8.21. **Partnerships with State and Local Entities.** To ensure that expenditures for HRSN services under this demonstration do not supplant any other available funding sources available to the beneficiary through other local, state, or federal programs, the state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authorities) to assist beneficiaries in obtaining non-Medicaid funded housing supports, if available, upon the conclusion of temporary demonstration payment for such supports, in alignment with beneficiary needs identified in the

beneficiary's care plan, as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and/or nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 17.5, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

8.22. **Provider Payment Rate Increase.** As a condition of approval of the HRSN services expenditure authority, the state must comply with the provider rate increase requirements in Section 13 of these STCs.

8.23. **HRSN Implementation Plan.**

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The state must submit the MOE information required by STC 8.20 no later than 90 calendar days after approval of demonstration expenditure authority for HRSN services. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration expenditure authority for HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan as initiatives are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment G.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent.

c. The Implementation Plan must include information on, but not limited to, the following:

i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services interested parties to the extent

those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, qualification and consent to receive HRSN services, screening, referrals, and service provision;

iv. A plan for tracking and improving the share of demonstration beneficiaries in the state who are eligible and enrolled in SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and/or federal, state, and local housing and/or other nutrition assistance programs, relative to the number of total eligible demonstration beneficiaries in the state (including those who are eligible but unenrolled);

v. An implementation timeline and considerations for demonstration evaluation that may be impacted by the timeline (e.g., in the case of a phased rollout of HRSN services), to facilitate robust evaluation designs;

vi. Information as required per STC 8.20 (MOE); and

vii. Information as required per STC 8.21 (Partnerships with State and Local Entities).

9. NON-MEDICAL TRANSPORTATION (NMT)

9.1. NMT[1] for HRSN Services:

a. Non-medical transportation (NMT) services may be provided to Medicaid beneficiaries eligible for HRSN services to and from HRSN services authorized under this demonstration. The HRSN services must be described in the beneficiary's care plan.

[1] Non-Medical Transportation is defined as transportation services offered in order to enable participants to gain access to 1915(c) waiver-coverable activities, community services, and resources, as specified by the beneficiary's care plan. NMT may be provided to receive HRSN services.

b. All NMT must be provided in alignment with the technical specifications, and safeguards required for NMT authorized under 1915(c) waiver or under 1915(i) state plan authorities.

9.2. **NMT to HCBS Services**

a. NMT services may be provided to Medicaid beneficiaries eligible for HCBS to and from HCBS services authorized under this demonstration. The HCBS services must also be described in the beneficiary's care plan.

b. All NMT must be provided in alignment with the technical specifications, and safeguards required for NMT authorized under 1915(c) waiver or under 1915(i) state plan authorities.

10. HOME AD COMMUNITY BASED SERVICES (HCBS)

10.1. Hawaii provides HCBS and personal care services to: (1) individuals who meet an institutional level of care requirement and are able to choose to receive care at home or in the community (a 1915(c)-like population); and to (2) individuals who do not meet an institutional level of care requirement but are assessed to be at risk of deteriorating to institutional level of care (i.e., the "at risk" population, a 1915(i)-like population). STC 6.1(g) and Attachment D describe the benefits, population criteria, service definitions, and provider types.

10.2. **HCBS Standards.** The state must assure compliance with CMS standards for HCBS settings as articulated in current section 1915(c) and 1915(i) policy and as modified by subsequent regulatory changes. All statutory and regulatory requirements not expressly waived or made not applicable related to HCBS or LTSS in this demonstration apply. HCBS requirements include the following:

a. **HCBS Electronic Visit Verification System**. The state must demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) and home health services in accordance with section 12006 of the 21st Century CURES Act.

b. **Quality Strategy for 1915(c)-like or 1915(i)-like HCBS Services**. For services that could have been authorized to individuals under a 1915(c) HCBS waiver or 1915(i) HCBS state plan amendment, the state must have an approved Quality Improvement Strategy (QIS) that encompass LTSS specific measures set forth in the federal managed care rule at 42 C.F.R. 438.330 and must also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal assurances and requirements at 42 C.F.R. 441.301, 441.302 and 441.745(b), and is required to develop performance measures to address the following requirements:

i. **Administrative Authority:** The state must have performance measures to demonstrate that the State Medicaid Agency (SMA) retains ultimate

administrative authority and responsibility for the operation of the HCBS program by exercising oversight of the functions delegated to other state and local/regional non-state agencies (if appropriate) and contracted entities.

ii. **Eligibility based on Section 1115 Requirements**. Performance measures are required for the following: a) that an evaluation for HCBS eligibility is provided to all applicants for whom there is reasonable indication that HCBS services may be needed in the future, b) the processes and instruments described in the approved demonstration for determining HCBS eligibility are applied appropriately, and c) the HCBS eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved demonstration.

iii. **Qualified Providers:** The state must have performance measures to demonstrate each of the following: a) that the state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to their furnishing HCBS services, b) that the state monitors non-licensed/non-certified providers to assure adherence to demonstration requirements, and c) that the state implements policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved demonstration.

iv. **Service Plans:** The state must have performance measures to demonstrate each of the following: a) service plans address all individuals' assessed needs (including health and safety risk factors) and personal goals, either by the provision of HCBS services or through other means, b) service plans are updated/revised at least annually or when warranted by changes in participant's needs, c) services are delivered in accordance with the service plan, including in the type, scope, amount, duration, and frequency specified in the service plan, and d) participants are afforded choice between/among HCBS services and providers.

v. **Health and Welfare:** The state must have performance measures to demonstrate each of the following: a) that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death, b) that it has an incident management system in place that effectively resolves incidents and prevents further similar incidents to the extent possible, c) that state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusions) are followed, and d) that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

vi. **Financial Accountability**: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. The state must have performance measures to demonstrate that: a) claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and

only for services rendered, and b) it provides evidence that rates remain consistent with the approved rate methodology throughout the demonstration period.

vii. **HCBS Settings Requirements**. The state must have performance measures to demonstrate that settings meet the home and community-based setting requirements in accordance with 42 CFR 441.301(c)(4) and 42 CFR 441.710(a)(1) and (2).

c. The state must submit the QIS and performance measures to CMS for review and approval within 90 days following approval of the demonstration.

d. **1915(c)/1915(i)-like Combined HCBS Reporting Requirements:**

i. **Enrollment**. The state must annually report to CMS the projected number of individuals to be enrolled in the HCBS demonstration and the actual number of unduplicated individuals enrolled in the HCBS demonstration in the previous year. This report is due 90 days post the end of each Demonstration Year.

ii. The state must report annually to CMS on the deficiencies found during the monitoring and evaluation of the HCBS performance measures and assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or unexplained death in the HCBS demonstration, the actions taken regarding the incidents and how they were resolved. Submission to CMS is due 6 months following the end of the Demonstration Year.

iii. The state will submit a report to CMS, following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Oversight (DHCBSO), no later than 21 months prior to the end of the approved demonstration period, which includes evidence on the status of the approved HCBS quality performance measures and requirements that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in § 1915(c) Home and Community–Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a draft report to the state and the state will have 90 days to respond. The DHCBSO will review and assess the evidentiary report to determine whether the performance measures and requirements have been met and will issue a final report to the state 60 days following receipt of the state's response to the draft report.

e. **HCBS Beneficiary Protections:**

i. **Person-Centered Service Planning.** The state assures there is a person–centered service plan for each beneficiary determined to be eligible for

HCBS. The person–centered service plan is developed using a person–centered service planning process in accordance with 42 CFR 441.301(c)(1) and the written person–centered service plan meets federal requirements at 42 CFR 441.301(c)(2). The state must ensure that the person–centered service plan is reviewed, and revised as appropriate, based upon reassessment of functional need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual, including demonstrating that minimum performance levels are met through reporting requirements at 42 CFR 441.311(b)(3), as required in 42 CFR 441.301(c)(3).

ii. **HCBS Conflict of Interest**. The state assures compliance with the HCBS conflict of interest protections at 42 CFR 441.301(c)(1)(vi) and 441.730(b). The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCBS services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

iii. **HCBS Settings Requirements**. The state must assure compliance with the characteristics of HCBS settings as described in 42 CFR 441.301(c)(4) and 42 CFR 441.710(a)(1) and (2) in accordance with implementation/effective dates as published in the Federal Register.

10.3. The state, either directly or through its MCO contracts, must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant.

10.4. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

a. Any revisions to the QUEST Integration delivery system for Behavioral Health Services as defined in this STC requires a revision to Attachment E.

b. **Cost of Room and Board Excluded from Capitation Rate Calculations**. For purposes of determining capitation rates, the cost of room and board is not included in noninstitutional care costs.

10.5. **Delivery of care flexibilities.** Hawaii is permitted to utilize the following flexibilities for populations receiving LTSS and HCBS services, subject to the accompanying requirements as made applicable next to each flexibility. The state must attest to compliance with requirements and guardrails as applicable prior to providing these flexibilities in conjunction with new services or populations:

a. Hawaii may allow for remote level of care evaluations, functional assessments, and person-centered service planning that have historically only been available in face-to-face meetings. While in-person meetings will remain the default approach,

beneficiaries now have the option to elect to receive evaluations, assessments, and service planning telephonically or virtually. Telephonic and/or virtual options are available when medically appropriate and in accordance with the individual's service plan.

i. All initial, annual, and significant change assessments/evaluations/re-evaluations of a participant's level of care must be conducted by case managers through a face-to-face, telephonic, or other technology media client interview. Interviews related to the participant's ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs), strengths, and weaknesses could have all or parts of the assessment completed through telephonic or other technology media. When completing evaluations and re-evaluations, 42 CFR 441.301(c) must be followed. Telephonic or assessment through other technology media would be available for all individuals, and all individuals are provided the opportunity for an in-person assessment in lieu of one performed telephonically. A home visit would be required if the results appear to be affected based on the use of telephonic or other technology media. The state will utilize Health Insurance Portability and Accountability Act (HIPAA)-compliant technology platforms, and case managers will conduct assessments in private settings, maintain the participant's privacy at all times, and verify the participant's identity before conducting the assessment.

ii. All initial, annual, and significant change assessments of a participant's service plan are conducted by case managers through a face-to-face or telephonic or other technology media client interview, for any client. Annual updates and significant change assessments could have all or parts of the assessment completed through telephonic or other technology media. When completing evaluations and re-evaluations, 42 CFR 441.301(c) must be followed. Telephonic or assessment through other technology media would be available for all individuals, and all individuals are provided the opportunity for an in-person assessment in lieu of one performed telephonically. In addition to the contact at the time of assessment, case managers are required to make at least one additional contact (in-person or by phone) during the service plan year. Additional contacts are also required if the participant is identified as Targeted Case Management. Assessments conducted face-to-face is the primary method for participant interview, and telephonic or other technology media options may be used when a face-to-face option is not available due to certain circumstances or conditions. (i.e., health and safety of participant and/or provider, inclement weather, etc.).

b. Hawaii may permit an electronic method of signing off on required documents when meetings are held virtually.

i. The state will establish a policy and process for accepting electronic signatures to be used to sign person-centered service plans when meetings are held virtually. When scheduling meetings, the state will ask individuals

who request a virtual meeting whether they are able to use the technology to participate in a virtual meeting and what assistance they may need to do so. If the individual requires assistance before or during the meeting, the staff facilitating the meeting will offer that assistance (e.g., information on how to log into the meeting or the correct steps to access functions like screen sharing, etc.). As part of the Case Management service, all individuals, including those who choose to participate in virtual person-centered service planning, will receive an in-person contact at least once every six (6) months if this meets the individual's needs and preserves the health and welfare of the individual.

c. Hawaii may add remote service delivery for the following demonstration services - to be provided remotely in the home setting: adult day health, adult day care, and counseling and training activities. Telehealth will be a secondary option for select services and must be at the option/preference of the beneficiary. Telehealth will be provided in more limited circumstances (i.e., if the beneficiary is unable to attend in person due to either illness or injury or other structural barriers).

    i. Hawaii may utilize this flexibility in order to allow remote service delivery for select demonstration services. The state must outline the services that may be delivered remotely publicly, in addition to the state's adherence to the following guardrails:

        1. How the remote service will be delivered in a way that respects the privacy of the individual especially in instances of toileting, dressing, etc.
        2. How the telehealth service delivery will facilitate community integration.
        3. How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service may be rendered without someone who is physically present or is separated from the individual.
        4. How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.
        5. How the telehealth will ensure the health and safety of an individual.

    ii. To ensure guardrails are met, Hawaii will adhere to processes, including but not limited to:

        1. Providers must assess the individual needs of each patient ahead of an appointment to determine which, if any, services can be delivered via telehealth and the supports an individual may need to ensure they receive high-quality care.

2. Hawaii will set a minimum requirement for monthly in-person visits for telehealth monitoring to ensure the participant's health and welfare.
3. When remotely communicating with beneficiaries and delivering services via telehealth, Medicaid providers must comply with relevant HIPAA requirements to protect the privacy and security of individuals.
4. In instances where privacy is a particular concern, alternative modalities, such as text-based communication or audio-only technologies, may be considered.
5. Individuals, providers, and case managers will be required to undergo training about privacy considerations related to telehealth and how they should document and address privacy concerns when implementing telehealth services.
6. While some ADLs still need to be addressed while telehealth activities are being delivered, certain activities by the caregiver will be completed with the camera off.
7. Services that support community integration (e.g., adult day care and adult day health) will be delivered via telehealth on a temporary basis. In-person participation is the primary modality for these services. When these services are delivered via telehealth, care managers must facilitate community integration, for example, by planning and scheduling future outings into the community.
8. Hawaii will provide health coordination services to support individuals who need assistance with using the technology required for telehealth delivery of services.

d. Hawaii may allow payment for family caregivers (i.e., relatives/legal guardians) or legally responsible individuals (LRIs) to render personal assistance Level I and personal assistance Level II services.

    i. Hawaii may utilize this flexibility in order to allow payment for services rendered by family caregivers or legally responsible individuals for personal care services as an alternative to agency or independent and unrelated self-direct workers.

        1. The state must publicly describe:

            a. The types of legally responsible individuals and family caregivers to whom payment may be made;

                i. Legally Responsible Individuals are persons who have a duty under State law to care for another person. This category typically includes: the parent (biological or adoptive) of a minor child; the guardian of a minor

child who must provide care to the child; or the spouse of a member. Legally responsible individuals and family caregivers must meet Hawaii's employment qualifications and training standards. The caregiving services they provide must meet the definition of a covered services and be specified in the member's approved care plan.

b. The method for determining that the amount of personal care or similar services provided by the legally responsible individual or family caregiver is "extraordinary care," exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization;

    i. Hawaii will determine the need for extraordinary care during assessment and person-centered planning. Assessments will be completed initially upon enrollment to the HCBS program, annually, and upon significant changes in status/condition. Person-centered service planning follows the administration of assessment.

c. The state policies to determine that the provision of personal care or similar services by a legally responsible individual or family caregiver is in the best interests of the participant;

    i. An LRI or family caregiver can be hired as a paid caregiver for these members under extraordinary circumstances, which include the inability to find and retain other qualified, suitable caregivers when the parent/guardian/spouse (LRI) would be absent from the home and, thus, the LRI or family caregiver must stay at home to ensure the member's health and safety and to avoid institutionalization.

d. When the legally responsible individual or family caregiver has decision-making authority over the selection of providers of demonstration services, the state's process for ensuring that the legally responsible individual uses substituted judgement on behalf of the individual;

e. Any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made;

    i. Hawaii will limit legally responsible individuals and family caregivers to provide no more than forty (40)

hours of services in a seven-day period based upon the authorized amount of personal care services. They cannot be paid for any services that they would ordinarily perform in the household for individuals of the same age who do not have a disability or chronic illness.

f. The procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered.

i. Hawaii will require legally responsible individuals and family caregivers to use an EVV system as the source document to capture visits to receive payment for services rendered and to follow all EVV protocols. MCOs will be required to complete at a minimum: (1) quarterly face-to-face visits with the member; (2) quarterly reviews of expenditures and the health, safety, and welfare status of the member; and (3) monthly reviews of hours billed for family-provided services and the total amounts billed for all goods and services during the month.

11. DELIVERY SYSTEM

11.1. **Forms of Managed Care.** The state is authorized to contract with Managed Care Organizations (MCOs) and Prepaid inpatient health plans (PIHPs) all of which are defined under 42 CFR 438.2.

11.2. **Compliance with Managed Care Regulations.** The state, its MCOs and any subcontractor delegated to perform activities under the managed care contract, must comply with the managed care regulations published in 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority.

11.3. **Contracts.** All contracts and contract modifications of existing contracts between the state and Managed care entities must be prior approved by CMS in accordance with 42 C.F.R. 438.3. The state must provide CMS with a minimum of 90 days to review changes for consideration of approval.

11.4. **QUEST Integration Plans**. QUEST Integration (QI) plans are MCOs as defined under 42 CFR 438.2. Eligible individuals will be enrolled in a QI plan upon initial eligibility consistent with 42 CFR 438.54 and as outlined here. Eligible individuals will choose among participating QI plans offered to provide the full range of primary, acute, home and community-based services and standard behavioral health benefits (including substance abuse treatment). Eligible individuals must be provided with information on the available health plans by the state. The state must ask each applicant to select a

health plan upon determination of eligibility. If an eligible individual does not make a selection at the time of the approval of eligibility, the individual is automatically assigned to a plan that operates on the island of residence, consistent with 42 CFR 438.54, and will have 15 days from the date of auto assignment to select a different health plan from the list provided. The state must send a notice of enrollment upon auto assigning the individual. The state may place an enrollment limit on health plans in order to assure adequate capacity and sufficient enrollment in all participating health plans, as long as at least two QI health plans operating on an island do not have an enrollment limit.

11.5. **Specialized Behavioral Health plan**. Acting as a PIHP as defined under 42 CFR 438.2, the Community Care Services (CCS) provides standard behavioral health services and specialized behavioral health services to beneficiaries 18 and older with serious mental illness (SMI) or serious and persistent mental illness (SPMI).

11.6. **Physical and Behavior Health Integration.** If the state chooses to integrate the specialized behavioral health services provided to any beneficiaries or subset of beneficiaries with SMI or SPMI into the QI Plans, the state must assess readiness pursuant to § 438.66(d). Assignment of any beneficiaries or subset of beneficiaries with SMI or SPMI into the QI Plans must comply with § 438.54 and may only begin when each QI Plan has been determined by the state and CMS to meet certain readiness and network requirements. The state must notify CMS of the intended integration at least 9 months prior to the assignment of beneficiaries. Any beneficiaries or subset of beneficiaries with SMI or SPMI may be mandatorily enrolled into a QI Plan providing fully integrated services pursuant to the state's expenditure and waiver authorities that provide for plan choice.

11.7. **Enrollment and Disenrollment Processes.**

a. **Enrollment process.** The state must maintain a managed care enrollment and disenrollment process that complies with 42 CFR Part 438, except that disenrollment without cause from a MCO will be more limited in cases where the enrollee was not passively enrolled to the MCO. If the enrollee was not passively enrolled to the MCO, the state must maintain a process by which the enrollee may change MCOs (consistent with STC 11.4) only if both MCOs agree to the change. The state must track and report to CMS these requests on an annual basis.

b. **Disenrollment With and Without Cause**. The provisions of 42 CFR section 438.56(c), relating to disenrollment with and without cause, must apply to individuals enrolled in QUEST Integration health plans. The state must track the number of plan change requests from aged, blind and disabled beneficiaries that occur during that timeframe and include this data in quarterly reports described in STC 51. Individuals who have been enrolled in a plan within the last 6 months will be reassigned to the prior plan unless the beneficiary exercises his/her option to disenroll for cause.

11.8. **State Oversight of Medical Loss Ratio (MLR):** For risk-based plans under the demonstration (i.e., MCOs, and the PIHP), the State must submit the plan generated MLR reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR 438.8(k) to CMS at DMCPMLR@cms.hhs.gov. In accordance with 42 CFR 438.66(e)(2)(i) and 438.66(e)(3)(i), the state must post MLR results on the state's public website.

a. For managed care plans that delegate risk to subcontractors, the State's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to third-party vendors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf. The State must submit its plan to operationalize STC 11.8 to CMS for review and approval, at DMCPMLR@cms.hhs.gov, no later than six months after the demonstration approval. The workplan must outline key deliverables and timelines to meet the requirements of STC 11.8.

b. Effective January 1, 2026, the State must require risk-based plans contracted with the State to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.

c. No later than January 1, 2027, the State must require risk-based plans contracted with the State to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.

d. STC 11.8(b) and (c) must apply for all of the following entities:

    i. Risk-based plans for which the State receives federal financial participation for associated expenditures;

    ii. Full and partially delegated plans;

    iii. Other subcontractors, as applicable, that assume delegated risk from either the prime managed care plan contracted with the State, or plans referenced in STC 11.4 and 11.5; and

    iv. Other subcontractors, as applicable, that assume delegated risk from entities, referenced in STC 11.4 and 11.5.

e. The State must work with CMS to effectuate an audit of the MLR data covering all complete rating periods of this 1115 demonstration renewal package. Final audit results and reporting must be provided to CMS no later than two years after the expiration of the current demonstration period. In accordance with 42 CFR 438.602(e) and 438.602(g)(4), the state must post these audit results to the state's public website.

12. DESIGNATED STATE HEALTH PROGRAMS (DSHP)

12.1. The state may claim FFP for designated state health programs (DSHP), subject to the limits described in this Section 12 of the STCs. DSHP are specific state programs that: (1) are population- or public health-focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the DSHP will impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals. This DSHP authority will enable the state to use state dollars that it otherwise would have spent on the DSHP specified in the Approved DSHP List (Attachment I), for which it may use as non-federal share as specified in Section 12 DSHP Funded Initiatives, on demonstration expenditures to support DSHP-funded initiatives, as described in STC 12.3(c). This DSHP authority will be available from DY 32 - DY 36.

a. The DSHP will have an established limit in the amount of $128,100,000 total computable expenditures, in aggregate, for DY 32-DY 36.

b. The state may claim FFP for up to the annual amounts outlined in the table below, plus any unspent amounts from prior years. In the event the state does not claim the full amount of FFP for a given demonstration year, the unspent amount, available for claiming, will roll over to one or more demonstration years not to exceed the total for this demonstration period. The total amount of DSHP FFP that the state may claim in DY 32 - DY 36 combined may not exceed the non-federal share of amounts actually expended by the state for the DSHP-funded initiatives.

Table 7. Annual Limits of Total Computable Expenditures for DSHP

	DY 32	DY 33	DY 34	DY 35	DY 36
Total Computable Expenditures	$25,620,000	$25,620,000	$25,620,000	$25,620,000	$25,620,000

c. The state must contribute $11,302,941 in original, non-freed up DSHP funds, for the remaining demonstration period towards its initiatives described in STC 12.3. These funds may only derive from other allowable sources of non-federal share and must otherwise meet all applicable requirements of these STCs and the Medicaid statute and regulations.

d. The state attests, as a condition of receipt of FFP under the DSHP expenditure authority, that all non-federal share for the DSHP is allowable under all applicable statutory and regulatory requirements, including section 1903(w) of the Act and its implementing regulations. The state acknowledges that approval of the DSHP expenditure authority does not constitute approval of the underlying sources of non-federal share, which may be subject to CMS financial review.

e. The Approved DSHP List is limited to programs that are: (1) population- or public heath- focused; (2) aligned with the objectives of the Medicaid program with no likelihood that the program will impede the primary objective of Medicaid to provide coverage for services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals. The state may only claim FFP for DSHP effective January 8, 2025 that added this STC. The Approved DSHP List is Attachment I. Any changes the state wants to make to its DSHP program will require an amendment as specified in STC 3.7.

12.2. **Prohibited DSHP Expenditures**

a. Allowable DSHP expenditures do not include any expenditures that are funded by federal grants or other federal sources (for example, American Rescue Plan Act funding, grants from the Health Resources and Services Administration, or the Centers for Disease Control and Prevention) or that are included as part of any maintenance of effort or non-federal share expenditure requirements of any federal grant.

b. Additionally, allowable DSHP expenditures do not include expenditures associated with the provision of non-emergency care to individuals who do not meet citizenship or immigration status requirements to be eligible for Medicaid. To implement this limitation, 3.1 percent of total provider expenditures or claims through DSHP described in STC 12.1 will be treated as expended for non-emergency care to individuals who do not meet citizenship or immigration status requirements, and thus not matchable. This adjustment is reflected in the Approved DSHP List (Attachment I). Therefore, the state can claim up to the program limits in the Approved DSHP List.

c. In addition to STC 12.2(a), the following types of expenditures are not permissible DSHP expenditures: expenditures that are already eligible for federal Medicaid matching funds, that are not likely to promote the objectives of Medicaid, or are otherwise prohibited by federal law. Exclusions that have historically fallen into these categories include, but are not limited to:

i. Bricks and mortar;

ii. Shelters, vaccines, and medications for animals;

iii. Coverage/services specifically for individuals who are not lawfully present or are undocumented;

iv. Revolving capital funds; and

v. Non-specific projects for which CMS lacks sufficient information to ascertain the nature and character of the project and whether it is consistent with these STCs.

12.3. **DSHP-Funded Initiatives**

a. **Definition.** DSHP-funded initiatives are Medicaid section 1115 demonstration activities supported by DSHPs, for which the state may claim FFP in accordance with STC 12.1 and 12.2 to fund the DSHP-funded initiatives as specified in STC 12.3(c).

b. **Requirements.** CMS will only approve those DSHP-funded initiatives that it determines to be consistent with the objectives of the Medicaid statute; specifically, to expand coverage (e.g., new eligibility groups or benefits), improve access to covered services including HCBS and behavioral health services, improve quality by reducing health disparities, or increase the efficiency and quality of care.

c. **Approved DSHP-Funded Initiatives.** The initiatives listed below are approved DSHP-funded initiatives for this demonstration. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements.

    i. HRSN services

12.4. **DSHP Claiming Protocol.** The state will develop a DSHP Claiming Protocol, which the state will make available to CMS upon request. State expenditures for the DSHP must be documented in accordance with the protocol. The state may only claim FFP for DSHP effective January 8, 2025 that added this STC.

a. For all eligible DSHP expenditures, the state will maintain and make available to CMS upon request:

    i. Certification or attestation of expenditures.

    ii. Actual expenditure data from state financial information system or state client sub-system. The Claiming Protocol will describe the procedures used that ensure that FFP is not claimed for the non-permissible expenditures listed in STC 12.2.

b. The state will claim FFP for DSHP quarterly based on actual expenditures.

12.5. **DSHP Claiming Process.** Documentation of all DSHP expenditures must be clearly outlined in the state's supporting work papers and be made available to CMS, upon request. Federal funds must be claimed within two years after the calendar quarter in which the state disburses expenditures for the DSHPs.

a. Sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. To the extent that DSHPs receive federal funds from any other federal programs, such funds shall not be used as a source of non-federal share to support expenditures for DSHPs or DSHP-funded initiatives under this demonstration.

b. The administrative costs associated with DSHPs (that are not generally part of normal operating costs for service delivery) shall not be included in any way as demonstration and/or other Medicaid expenditures.

c. DSHP will be claimed at the administrative matching rate of 50 percent.

d. Expenditures will be claimed in accordance with the state's DSHP Claiming Protocol.

e. DSHP program expenditures are eligible for federal match, for dates of payment made on or after the approval date of the DSHP expenditure authority within an amendment, extension, or new demonstration, as long as the services or costs were incurred in the State Fiscal Year (SFY) that corresponds to the date of the DSHP expenditure authority.

12.6. **Sustainability Plan.** The DSHP Sustainability Report will describe the scope of DSHP-funded initiatives the state wants to maintain and the strategy to secure resources to maintain these initiatives beyond the current approval period. As part of the monitoring reports the state shall submit the DSHP Sustainability Report section in its annual report.

13. PROVIDER RATE INCREASE REQUIREMENTS

13.1. The provider payment rate increase requirements described hereafter are a condition for the HRSN and DSHP expenditure authorities, as referenced in expenditure authorities #5, #6 and #7.

13.2. As a condition of approval and ongoing provision of FFP for the HRSN and DSHP expenditures over this demonstration period of performance, DY 32 through DY 36, the state will, in accordance with these STCs, increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state is required to increase provider payments for the delivery system for which the ratio is below 80 percent. If the state's average Medicaid rates already equal or exceed 80 percent of Medicare in any of these three categories for either FFS or managed care, then the state is not subject to a provider rate increase requirement in that service category and delivery system, but the state must at least sustain rates for such categories at existing levels for the remainder of the demonstration period.

13.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

13.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this STC section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

13.5. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

i. For primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

ii. For behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 13.4;

ii. Medicaid and Medicare data must be from the same year and not older than 2019.

iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data

and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

13.6. To establish the state's ratio for each service category identified in STC 13.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 13.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); OR

b. The data and methodology for any or all of the service categories as provided in STC 13.5(b) using Medicaid managed care provider payment rate and utilization data.

13.7. In determining the ratios required under STC 13.5 and 13.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans through December 31, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d).

13.8. If the state is required to increase provider payment rates for managed care plans per STC 13.2 and 13.6, the state must:

a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

13.9. For the entirety of DY 34 through DY 36, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 32, and such rate will be in effect on the first day of DY 34. A required payment rate increase shall apply to all services in a service category as defined under STC 13.4.

13.10. If the state uses a managed care delivery system for any of the service categories defined in STC 13.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY 34 through DY 36, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 32 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 13.4.

13.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY 34 (or, as applicable, the first day of the first rating period that starts in DY 34), the state will provide an alternative effective date and rationale for CMS review and approval.

13.12. Hawaii will provide the information to document the payment rate ratio required under STC 13.5 and 13.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

13.13. For demonstration years following the first year of provider payment rate increases, if any, Hawaii will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

13.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 13.5 and 13.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment P.

Table 8. Hawaii HRSN and DSHP Related Provider Payment Increase Assessment – Attestation Table

Hawaii HRSN and DSHP Related Provider Payment Increase Assessment – Attestation Table		
The reported data and attestations pertain to HRSN and DSHP related provider payment increase requirements for the demonstration period of performance DY 32 through DY 36.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service Ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	*[insert percent, or N/A if state does not make Medicaid fee-for-service payments]*	*[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[insert approach, either ratio derived under STC 13.5(a) or STC 13.5(b)]	*[insert approach, either ratio derived under STC 13.6(a) or STC 13.6(b), and insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]*

Obstetric Care Services	*[insert percent, or N/A if state does not make Medicaid fee-for-service payments]*	*[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[insert approach, either ratio derived under STC 13.5(a) or STC 13.5(b)]	*[insert approach, either ratio derived under STC 13.6(a) or STC 13.6(b), and insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]*
Behavioral Health Care Services	*[insert percent, or N/A if state does not make Medicaid fee-for-service payments]*	*[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[insert approach, either ratio derived under STC 13.5(a) or STC 13.5(b)]	*[insert approach, either ratio derived under STC 13.6(a) or STC 13.6(b), and insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]*
In accordance with STCs 13.1 through 13.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on January 1, 2027 and will not be lower than the highest rate for that service code in DY 32 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least December 31, 2029. For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be		

excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 13.4 will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b. below]

☐a. The effective date of the rate increases is the first day of DY 34 (January 1, 2027) and will be at least sustained, if not higher, through DY 36 (December 31, 2029).

☐b. Hawaii has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of DY 34 (January 1, 2027). Hawaii will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 36 (December 31, 2029).

Hawaii *[insert does or does not]* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the HRSN and DSHP STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*].

Hawaii *[insert does or does not]* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the HRSN and DSHP STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 13.10 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than [*insert date*].

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 13.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will

be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Hawaii further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 13.
I, *[insert name of SMD or CFO (or equivalent position)] [insert title],* attest that the above information is complete and accurate. [*Provide signature*_____*] [Provide date*_____*]* *[Provide printed name of signatory]*

14. CONTINGENCY MANAGEMENT

14.1. Contingency Management Overview.

a. Beginning no earlier than January 1, 2026, DHS will implement a new contingency management benefit for qualifying beneficiaries with a stimulant use disorder and/or opioid use disorder (OUD) in eligible provider settings.

b. Under the demonstration, the contingency management benefit will be available to qualified beneficiaries who meet the eligibility requirements described below, who may receive services from a participating provider approved by DHS to provide this benefit.

14.2. **Eligibility.** To qualify for the contingency management benefit, a beneficiary must meet the following conditions:

a. Must be enrolled in the Hawaii-Medicaid (Med-QUEST) program;

b. Age 18 or older diagnosed with a stimulant use disorder and/or OUD to qualify for the twenty-four-week program;

c. Be assessed and determined to have a stimulant use disorder and/or OUD as a diagnosis for which the contingency management benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based intervention. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving contingency management services;

d. Not be enrolled in another contingency management program for stimulant use disorder or OUD;

e. Receive services from an eligible provider that offers the contingency management benefit in accordance with DHS policies and procedures; and

f. Not receive contingency management as an alternative for medication treatment for other substance use disorders for which medication treatment is a medically appropriate option (e.g. alcohol use disorder (AUD)).

14.3. **Service Description.**

a. The contingency management benefit provides a series of motivational incentives for meeting treatment goals. The motivational incentives may consist of cash equivalents, e.g., gift cards of low retail value, with restrictions placed on the incentives so they are not used to purchase cannabis, tobacco, alcohol, over-the-counter preparations containing possible intoxicants such as dextromethorphan, weapons (including firearms/ and ammunition), gambling-related items such as lottery tickets, pornographic materials or additional items as identified by the state. The motivational incentives are consistent with evidence-based clinical research for treating a stimulant use disorder and/or opioid use disorder as described below. These motivational incentives are central to contingency management, based on the best available scientific evidence for treating a stimulant use disorder and not as an inducement to use other medical services.

b. The contingency management benefit uses an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or treatment adherence. The contingency management benefit provides motivational incentives for treatment adherence or non-use of stimulants as evidenced by negative point of care, rapid, Clinical Laboratory Improvement Amendments (CLIA)-waived drug tests.

c. Contingency management is offered along with other therapeutic interventions, as appropriate, such as cognitive behavioral therapy, that meet the definition of rehabilitative services as defined by 1905(a) of the Act and 42 CFR 440.130(d). The provision of the contingency management benefit is not conditioned on a beneficiary's engagement in other psychosocial services.

d. For purposes of this demonstration, these motivational incentives are considered a Medicaid-covered item or service and are used to reinforce objectively verified recovery behaviors using a clinically appropriate contingency management protocol consistent with evidence-based research. Consequently, neither the Federal anti-kickback statute (42 U.S.C. § 1320a-7b(b), "AKS") nor the civil monetary penalty (CMP) provision prohibiting inducements to beneficiaries (42 U.S.C. § 1320a-7a(a)(5), "Beneficiary Inducements CMP") would be implicated.

e. The contingency management benefit consists of a set of modest motivational incentives available for beneficiaries who meet treatment goals. Under the benefit, a beneficiary will be limited in motivational incentives during the course of a contingency management treatment episode as detailed in the Contingency Management Protocol (Attachment K) which the state must submit no later than

three months prior to the state's intended implementation date for contingency management.

i. To qualify for a motivational incentive under the contingency management benefit, a beneficiary must be a participant in the twenty-four-week program for stimulant use disorder and demonstrate non-use of stimulants or be a participant in the twenty-four-week program for opioid use disorder and demonstrate treatment adherence. By participating in the programs, a beneficiary can receive incentive payments for each visit or other established schedule, where they test negative for the substance being treated for the stimulant use disorder program or demonstrate treatment adherence for the opioid use disorder program.

ii. The size, nature, and distribution of all contingency management motivational incentives shall be determined in strict accordance with DHS procedures and protocols, listed in Attachment K. These procedures and protocols will be based on established clinical research for contingency management. The following guardrails shall ensure the integrity of the contingency management benefit and mitigate the risk of fraud, waste, or abuse associated with the motivational incentive:

    1. Providers have no discretion to determine the size or distribution of motivational incentives, which will be determined by DHS.
    2. Motivational incentives will be managed through an incentive management tool that includes safeguards against fraud and abuse. These safeguards will be detailed in DHS's guidance and listed in the Contingency Management Protocol Attachment K.
    3. To calculate and generate the motivational incentives in accordance with the schedule in Attachment K, providers shall enter the outcome of the test of the beneficiary receiving the contingency management benefit into an incentive management tool.

iii. The aggregate annual amount of incentive payments that an individual can receive by participating in the contingency management program shall be determined by DHS and memorialized in statewide operational guidance.

iv. There is not a limit on the number of times a beneficiary can participate in the program.

14.4. **Eligible Contingency Management Providers.**

a. The contingency management benefit will be delivered by eligible providers that meet specified programmatic standards and agree to deliver the contingency management benefit in strict accordance with standardized procedures and protocols that will be detailed in DHS guidance and listed in the Contingency Management Protocol Attachment K, and other applicable laws, regulations, and requirements.

b. To be eligible to offer the contingency management benefit, a provider shall offer the benefit in strict accordance with DHS standards that will be outlined in DHS guidance included in Attachment K and shall meet the following requirements:

    i. Must serve beneficiaries residing in Hawaii;

    ii. Must be enrolled in Hawaii Medicaid, and certified to provide Hawaii Medicaid services, including without limitation primary care, behavioral health and substance use service providers;

    iii. Require the staff providing or overseeing the contingency management benefit to participate in contingency management-specific training and participate in ongoing training, and technical assistance offered by DHS and/or the state's designated contractor(s);

    iv. Undergo a readiness review by DHS and/or the state's designated contractor(s) to ensure that they are capable of offering the contingency management benefit in accordance with DHS standards that will be detailed in DHS guidance;

    v. Shall comply with any billing and data reporting requirements established by DHS to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation; and must employ or contract with a sufficient number of licensed mental health professionals that have SUD specific scope and training as further specified in STC 14.5(b), for provision of services and ensure:

        1. They maintain their licensure in accordance with applicable laws and regulations governing their licensure; and

        2. They provide services to beneficiaries receiving the contingency management benefit within the scope of their licensure.

c. The following practitioners delivering care at eligible providers can deliver the contingency management benefit through activities, such as administering point of-care drug tests, informing beneficiaries of the results of the evidence/point of care drug test, entering the results into a software program, providing educational information, and distributing motivational incentives, as part of the contingency management benefit:

    i. Primary care physician (PCP), physician (MD), physician's assistant (PA), and advanced practice registered nurse (APRN); or

    ii. Licensed mental health (MH) professional with SUD specific scope and training (e.g., licensed clinical social worker (LCSW), board-certified behavior analyst, psychologist, behavioral health (BH) or MH counselor, MH social worker, marriage/ family therapist); or

    iii. Trained staff with appropriate supervision by licensed health professionals.

14.5. **Program Oversight.**

a. DHS and/or the state's designated contractor(s) shall monitor the ongoing performance, including fidelity of treatment to the evidence-based practice, of contingency management providers and identify and support providers requiring further training or technical assistance in accordance with DHS set standards, to be outlined in DHS guidance.

b. DHS and/or the state's designated contractor(s) will provide training, technical assistance and monitoring to providers throughout the implementation process. The training and technical assistance will be provided through a qualified contractor designated by DHS, and will include staff training, provider readiness reviews, and ongoing technical assistance during the first phase of the pilot.

14.6. **Changes in Medicaid Policy on Contingency Management.** In accordance with STC 3.3, nothing in this demonstration absolves the state of Hawaii from being subject to future requirements on contingency management set forth in Medicaid law, regulation, or policy and the state would otherwise need to come into compliance with such requirements.

14.7. **Contingency Management Evaluation.** In alignment with the QUEST Integration demonstration evaluation requirements outlined in Section 17 of these STCs, DHS will conduct an evaluation of the effectiveness of the Contingency Management program to assess its overall effectiveness, including cost effectiveness of these services, and its effects on beneficiary health and recovery outcomes. To the extent feasible, the state will conduct the evaluation to support assessment stratified by stimulant use disorder and other types of SUD, as applicable.

15. REENTRY DEMONSTRATION INITIATIVE

15.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in jails, prisons, and youth correctional facilities (hereinafter "correctional facilities"). To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid as determined pursuant to an application filed before or during incarceration and must have an expected release date no later than 90 days as further specified in the STCs below.

15.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The reentry demonstration initiative provides short-term

Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release;

i. Advance the state's health equity priorities for racial and ethnic groups overrepresented in the justice-involved population (e.g., Native Hawaiians and Pacific Islanders);

j. Identify unaddressed medical and health-related social needs prior to release, and improve insights into healthcare delivery for justice-involved individuals; and

k. Reduce rates of recidivism among the justice-involved population.

15.3. **Qualifying Criteria for Pre-Release Services.** To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 15.1;

b. Have been determined eligible for Medicaid; and

c. Have an expected release date within 90 days.

15.4. **Scope of Pre-Release Services.** The pre-release services authorized under the reentry demonstration initiative include the following services, which are described in Attachment L, Reentry Demonstration Initiative Services.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

iii. Practitioner office visit (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);

iv. Diagnostic services, including laboratory and radiology services;

v. Medical equipment and supplies; and

vi. Peer support services.

b. The state must also provide a 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid or CHIP state plan coverage authority and policy.

c. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Hawaii Medicaid State Plan, as relevant, that are not included in the above-described pre-release services (e.g., EPSDT treatment services for qualifying Medicaid

beneficiaries under age 21) are not available to qualifying individuals through the reentry demonstration initiative.

15.5. **Participating Correctional Facilities.** The pre-release services will be provided at jails, prisons, and youth correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to Hawaii's Department of Human Services approval of a facility's readiness, according to the implementation timeline described in STC 15.9. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

15.6. **Participating Providers.**

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Hawaii's scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

15.7. **Suspension of Coverage.** Upon entry of a Medicaid-enrolled individual into a correctional facility, Hawaii Department of Human Services must not terminate and generally shall suspend their Medicaid coverage.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

15.8. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles**. To the extent Hawaii's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality expenditure limit, the state will

claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

15.9. **Reentry Demonstration Initiative Implementation Timeline.** Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The Department of Human Services will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 15.3;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. Hawaii will require participating facilities to select a Service Level for implementation. Service Level One consists of the expected minimum set of pre-release services as indicated in the State Medicaid Director Letter (SMDL) (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated) and identified in STC 15.4(a) and (b), and must be the first Service Level category that is implemented. The state may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the state that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable;

e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans;

f. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

g. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

h. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

i. Reporting of data requested by the Department of Human Services to support program monitoring, evaluation, and oversight; and

j. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

15.10. **Reentry Demonstration Initiative Implementation Plan.** The state is required to submit a Reentry Demonstration Initiative Implementation Plan. As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan will be incorporated into the STCs as Attachment M titled "Reentry Demonstration Initiative Implementation Plan."

CMS will provide the state with a template to support the development of the Implementation Plan.

15.11. **Reentry Demonstration Initiative Reinvestment Plan.** To the extent that the reentry demonstration initiative covers services that are the responsibility of and were previously

provided or paid by the correctional facility with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment N) and subject to CMS approval. The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the reentry demonstration initiative, defined as services not previously provided or paid by the correctional facility with custody of qualifying individuals prior to the facility's implementation of the reentry demonstration initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative, with respect to the relevant increase in expenditures, as described in Attachment N the Reentry Demonstration Initiative Reinvestment Plan) is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

    i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

    iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

    v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

    vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

    vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or

better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment N) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment N titled "Reentry Demonstration Initiative Reinvestment Plan."

15.12. **Reentry Demonstration Initiative Planning and Implementation.**

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications. In addition, reentry demonstration initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the reentry demonstration initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the Department of Human Services and Qualified Applicants listed in STC 15.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the reentry demonstration initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 15.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange

and linkages with Qualified Applicants listed in STC 15.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 15.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for reentry demonstration initiative services.

vi. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration among Hawaii's Qualified Applicants in STC 15.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid application; (3) submitting the Medicaid application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date

of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 9. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 9. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 32	DY 33	DY 34	DY 35	DY 36
Total Computable Expenditures	$4,965,625	$2,482,813	$2,482,813	$0	$0

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid agency.

16. MONITORING AND REPORTING REQUIREMENTS

16.1. **Submission of Post-Approval Deliverables.** The state must submit deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

16.2. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its

rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable(s) were due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable(s) were not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay, the steps the state has taken to address such issue(s), and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b) above, and the state fails to comply with the corrective action plan or despite the corrective action plan, still fails to submit the overdue deliverable(s) that meet the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in MBES/CBES following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

    i. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

16.3. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115 demonstration, Transformed Medical Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

16.4. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment O. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

a. At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 16.5), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

b. The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant

transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

c. In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

d. For the qualitative elements (e.g., operational updates as described in STC 16.5(a), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

16.5. **Monitoring Reports.** The state must submit three Quarterly Reports and one Annual Monitoring Report each demonstration year (DY). The fourth quarter information that would ordinarily be provided in a Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including fourth quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by individuals; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable.

c. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on individuals' outcomes as well as outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and must follow the framework provided by CMS to support federal tracking and analysis.

d. Specifically, the state must undertake standardized reporting on categories of metrics including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

e. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 15.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the

transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

f. For the HRSN component, in addition to reporting on the metrics described above, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations. The state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs, such as, SNAP and WIC for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

g. In consultation with CMS, HCBS performance metrics should continue to be tracked as before but account for the expanded HCBS ("at risk") enrollment.

h. For the continuous eligibility policy, monitoring metrics must support tracking enrollment and ex parte renewals. The state must describe successes and challenges related to annual attempts to update beneficiary contact information, provide beneficiaries reminders of continued eligibility, verify beneficiary residency, and confirm that the beneficiary is not deceased, for all beneficiaries who qualify for a continuous eligibility period that exceeds 12 months.

i. For the Contingency Management program, the state's reporting must cover metrics for domains including but not limited to enrollment, overall incentives provided, and average incentives provided per beneficiary during the treatment phase as well as types and counts of aftercare and treatment services rendered during the aftercare phase.

j. Budget Neutrality and Financial Reporting Requirements- Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the Form CMS-64.

k. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of

evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

16.6. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

e. CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

16.7. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

16.8. **Close-Out Report**. Within 120 calendar days after the expiration of the demonstration, the state must submit a Draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 17.7 and 17.8, respectively.

c. The state will present to and participate in a discussion with CMS on the close-out report.

d. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.

e. A revised close-out report is due to CMS no later than 30 calendar days after receipt of CMS' comments.

f. A delay in submitting the draft or final version of the Close-Out report may subject the state to penalties described in STC 16.2.

16.9. **Monitoring Calls**. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations, to include but not limited to, any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, enrollment and access, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

16.10. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its Medicaid website. The state must also post the most recent Annual Monitoring Report on its Medicaid website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

17. EVALUATION OF THE DEMONSTRATION

17.1. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

17.2. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities that collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation—including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable—in a federal learning collaborative aimed at cross state

technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring, and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 16.2.

17.3. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

17.4. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than one 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance specific to the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic)—as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of an independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 17.7 and 17.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amended Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

17.5. **Evaluation Design Approval and Updates.** The state must submit to CMS a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as an

attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's Medicaid website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

17.6. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by NQF.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Evaluation hypotheses for the HRSN demonstration components must focus on areas such as assessing the effectiveness of the HRSN services in mitigating identified needs of

beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on prevalence and severity of beneficiaries' HRSNs and the provision of beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care; utilization of and costs associated with potentially avoidable, high-acuity health care; utilization of hospital and institutional care; and beneficiary physical and mental health outcomes. The state must also evaluate the impact of non-HRSN services, as appropriate.

In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

Hypotheses must be designed to help understand, in particular, the impact of housing supports, case management, nutritional services, and transportation support toward accessing covered HRSN services and case management activities on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level. The state must also include research questions and hypotheses focused on how renewals of recurring nutrition services affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports and nutrition services change over time in concert with new Medicaid funding toward those services. In addition, considering how the demonstration's HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

The state's evaluation efforts must develop robust hypotheses and research questions to assess the effectiveness of the state's DSHP-funded initiatives in meeting the desired goals of such programs in advancing and complementing its broader HRSN and other applicable initiatives for its Medicaid beneficiaries and other low-income populations. The analysis must be designed to help demonstrate how these programs support, for example, expanding coverage, improving access, reducing health disparities, and/or enhancing home-and-community-based services or services to address HRSN or behavioral health.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

For the continuous eligibility policy, the state must evaluate the impact of the policy on all relevant populations, appropriately tailored for the specific time span of eligibility. Evaluation hypotheses must focus on, but may not be limited to, enrollment continuity, utilization of age-appropriate preventive care, inpatient admissions and avoidable emergency care, and health disparities.

The state must also test hypotheses around the Contingency Management component of the demonstration, which align with the state's broader goals around substance abuse prevention.

As part of its evaluation efforts, the state must also conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

Finally, the state must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

17.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's Medicaid website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for the extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and a description of how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination of suspension. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.

d. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

17.8. **Summative Evaluation Report.** The state must submit to CMS a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

17.9. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and/or the Summative Evaluation Report.

17.10. **Public Access**. The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.

17.11. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

17.12. **Corrective Action Plan Related to Evaluation**. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where

evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

18. GENERAL FINANCIAL REQUIREMENTS

18.1. **Allowable Expenditures.** This demonstration project is approved for authorized expenditures applicable to services rendered and for services incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

18.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter that just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

18.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

18.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third

parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

18.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

18.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

18.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 16.2. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

18.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 19:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

18.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

18.10. **Medicaid Expenditure Groups (MEG).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 10. Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
EG 1 – Children	Main	X		X	All expenditures for medical assistance for the groups identified in Tables 2-4 as Children.
EG 2 - Adults	Main	X		X	All expenditures for medical assistance for the groups identified in Tables 2 – 4 as Adults.
EG 3 - Aged	Main	X		X	All expenditures for medical assistance for the groups identified in Tables 2 – 4 as Aged.
EG 4 – Blind/Disabled	Main	X		X	All expenditures for medical assistance for the groups identified in Tables 2 – 4 as Blind/Disabled.
EG 5 – Group VIII	Main	X		X	All expenditures for medical assistance for the groups identified in Tables 2 – 4 as Group VIII.
Cooking Supplies	Main			X	All expenditures for cooking supplies for qualifying beneficiaries.
DSHP	Main			X	All expenditures for DSHP described in Section 12.
Contingency Management	Main			X	All expenditures for contingency management for qualifying beneficiaries.
Children – CE	Hypo 1	X		X	All expenditures for continued benefits for children who have been determined eligible for the continuous eligibility period who would otherwise lose

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
					coverage during an eligibility determination.
Non-Medical Transportation	Hypo 2	X		X	All expenditures for non-medical transportation.
Reentry Services	Hypo 3	X		X	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.
Reentry Non-Services	Hypo 3		X	X	Expenditures for allowable planning and non-services for the reentry demonstration initiative.
HRSN Services	SHAC		X	X	All expenditures for approved HRSN initiatives.
HRSN Infrastructure	SHAC		X	X	All allowable infrastructure expenditures for certain HRSN initiatives.
ADM	N/A				All additional administrative costs that are directly attributable to the demonstration and not described elsewhere and are not subject to budget neutrality.

18.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00001/9). For the CE MEG, 2.6 percent for adults or 0.11 percent for children of expenditures are allocated to the CE MEG. Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year must be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in Section 20, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in Section 17, the state must report the actual number of "eligible member months" and expenditures for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below, with the

exception of the Continuous Eligibility (CE) MEGs. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

For CE MEGs, states will report a calculated number, or percentage, of the actual member months and expenditures of the corresponding non-CE MEG. As applicable, the corresponding non-CE MEG member months and expenditures will then be reduced by the same percentage. For the CE Children MEG, this percentage will be 0.11 percent. For example, the actual member months and expenditures for individuals aged 0 to 19 for the Children MEG will be reduced by 0.11 percent and the equivalent member months and expenditures will be reported on the CE Children MEG so that the total calculated member months and expenditures between the two MEGs are equal to the actual member months and expenditures for the Children group.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual (or calculated for the Children – CE MEG) expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 11. MEG Detail for Expenditure and Member Months Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
EG 1 – Children	Report all medical assistance expenditures for the groups identified in Tables 2-4 as Children.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	8/1/94	12/31/29
EG 2 - Adults	Report all medical assistance expenditures for the groups identified in Tables 2-4 as Adults.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	8/1/94	12/31/29
EG 3 - Aged	Report all medical assistance expenditures for the groups identified in Tables 2-4 as Aged.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	8/1/94	12/31/29
EG 4 – Blind/Disabled	Report all medical assistance expenditures for the groups identified in Tables 2-4 as Blind/Disabled.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	8/1/94	12/31/29
EG 5 – Group VIII	Report all medical assistance expenditures for the groups identified in Tables 2-4 as Group VIII.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	10/1/13	12/31/29

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Cooking Supplies	Report all expenditures for the cooking supplies benefit.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	N	1/8/25	12/31/29
DSHP	Report all DSHP expenditures.	N/A	Follow standard CMS-64.10 Category of Service Definitions	Date of Payment	ADM	N	1/8/25	12/31/29
Contingency Management	Report all expenditures associated with the contingency management program.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	N	1/8/25	12/31/29
Children – CE	Expenditures for individuals aged 0 to 19 who are eligible via CE, equaling 0.11% of total Medicaid expenditures for the applicable portion of the Children MEG	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y, 0.11% of total member months for the applicable portion of the Children MEG	11/14/24	12/31/29
Non-Medical Transportation	Report all expenditures for NMT.	N/A	Follow standard CMS-64.9	Date of Service	MAP	Y	1/8/25	12/31/29

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
			Category of Service Definitions					
Reentry Services	Report expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to release from participating facilities.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	1/8/25	12/31/29
Reentry Non-Services	Report expenditures for allowable planning and non-services for the reentry demonstration initiative.	N/A	Follow standard CMS-64.10 Category of Service Definitions	Date of Payment	ADM	N	1/8/25	12/31/29
HRSN Services	Report all expenditures for approved HRSN initiatives.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of Service	MAP	Y	1/8/25	12/31/29
HRSN Infrastructure	Report all infrastructure expenditures for approved HRSN initiatives.	N/A	Follow standard CMS-64.10 Category of Service Definitions	Date of Payment	ADM	N	1/8/25	12/31/29
ADM	Report all additional administrative costs that are	N/A	Follow standard CMS-64.10	Date of Payment	ADM	N	8/1/94	12/31/29

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
	directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.		Category of Service Definitions					

18.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 12. Demonstration Years

Demonstration Year 32	January 8, 2025 to December 31, 2025	~12 months
Demonstration Year 33	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 34	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 35	January 1, 2028 to December 31, 2028	12 months
Demonstration Year 36	January 1, 2029 to December 31, 2029	12 months

18.13. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 19. CMS will provide technical assistance, upon request.[2]

18.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

18.15. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined

[2] Per 42 CFR §431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets must reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, must result in a modified budget neutrality expenditure limit.

18.16. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 18.16(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

19. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

19.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality test, as described below. CMS's

assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

19.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 10, Master MEG Chart and Table 11, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

19.3. **Calculation of Budget Neutrality Limits and How They Are Applied**. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual (or calculated for the Children – CE MEG) number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

19.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table 13. Main Budget Neutrality Test

MEG	PC or Agg*	WOW Only, WW Only, or BOTH	Trend Rate	DY 32	DY 33	DY 34	DY 35	DY 36
EG 1 – Children	PC	Both	4.8%	$348.70	$365.29	$382.82	$401.20	$420.46
EG 2 - Adults	PC	Both	4.8%	$590.15	$618.24	$647.92	$679.02	$711.61
EG 3 - Aged	PC	Both	4.3%	$1,429.41	$1,490.35	$1,554.44	$1,621.28	$1,691.00
EG 4 – Blind/Disabled	PC	Both	5.5%	$2,041.68	$2,153.01	$2,271.43	$2,396.36	$2,528.16
EG 5 – Group VIII	PC	Both	5.2%	$671.87	$706.51	$743.25	$781.90	$822.56
Cooking Supplies	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
DSHP	Agg	WW only	N/A	The state must have savings to offset these expenditures.				
Contingency Management	Agg	WW only	N/A	The state must have savings to offset these expenditures.				

19.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings,

CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

19.6. **Hypothetical Budget Neutrality Test 1: Children - CE.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 14. Hypothetical Budget Neutrality Test 1

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 32	DY 33	DY 34	DY 35	DY 36
Children - CE	PC	Both	4.8%	$348.70	$365.29	$382.82	$401.20	$420.46

19.7. **Hypothetical Budget Neutrality Test 2: Non-Medical Transportation.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 15. Hypothetical Budget Neutrality Test 2

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 32	DY 33	DY 34	DY 35	DY 36

Non-Medical Transportation	PC	Both	5.2%	$314.62	$330.98	$348.19	$366.30	$385.35

19.8. **Hypothetical Budget Neutrality Test 3: Reentry Demonstration Initiative Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 16. Hypothetical Budget Neutrality Test 3

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 32	DY 33	DY 34	DY 35	DY 36
Reentry Services	PC	Both	5.6%	$914.03	$965.22	$1,019.27	$1,076.35	$1,136.63
Reentry Non-Services	Agg	Both	N/A	$4,965,625	$2,482,813	$2,482,813	N/A	N/A

19.9. **Supplemental HRSN Aggregate Ceiling (SHAC) Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in Section 8), CMS considers these expenditures to be "supplemental HRSN aggregate ceiling (SHAC)" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS

currently applies a separate, independent SHAC Budget Neutrality Test, which subjects SHAC expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's SHAC spending exceeds the SHAC Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the SHAC.

19.10. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the SHAC Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table 17. SHAC Budget Neutrality Test

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 32	DY 33	DY 34	DY 35	DY 36
HRSN Services	Agg	Both	N/A	$34,858,643	$60,957,611	$95,434,017	$113,346,630	$131,113,099
HRSN Infrastructure	Agg	Both	N/A	$15,378,000	$15,378,000	$15,378,000	$15,378,000	$15,378,000

19.11. **Composite Federal Share**. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to

method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

19.12. **Exceeding Budget Neutrality**. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from January 8, 2025 to December 31, 2029. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (August 1, 2014 – July 31, 2024). If at the end of the demonstration approval period the Main Budget Neutrality Test or the SHAC Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

19.13. **Budget Neutrality Savings Cap.** The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 19.12 or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $2,563,420,583.

19.14. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 18. Budget Neutrality Test Corrective Action Plan Calculation

Demonstration Year	Cumulative Target Definition	Percentage
DY 32	Cumulative budget neutrality limit plus:	2.0 percent
DY 32 through DY 33	Cumulative budget neutrality limit plus:	1.5 percent
DY 32 through DY 34	Cumulative budget neutrality limit plus:	1.0 percent
DY 32 through DY 35	Cumulative budget neutrality limit plus:	0.5 percent
DY 32 through DY 36	Cumulative budget neutrality limit plus:	0.0 percent

19.15. **Former Foster Care Youth Budget Neutrality Impact.** CMS has determined that the out of state FFCY demonstration population is budget neutral based on CMS's assessment that the expenditure authority granted for the demonstration has minimal federal Medicaid expenditures and these populations could have been covered through waiver only authority. The state will not be allowed to obtain budget neutrality "savings" from this

demonstration population. The demonstration will not include a budget neutrality expenditure limit for out of state FFCY; however, the state is required to report total expenditures and member months in their demonstration monitoring reports, per STC 16.5. The state must report quarterly claims and report expenditures on the CMS 64.9 WAIVER form. Failure to report FFCY expenditures and member months will result in reinstatement of the budget neutrality requirement. CMS reserves the right to request budget neutrality worksheets, requirements, limits, and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7.

20. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION PERIOD

Due Date	Deliverable	STC Reference
30 calendar days from approval letter date	State Acceptance of Demonstration Extension, STCs, Waivers, and Expenditure Authorities.	Approval letter
90 calendar days after the approval of the extension	Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services	8.7
150 calendar days after approval	Monitoring Protocol	16.4
60 calendar days after January 8, 2028	Reentry Mid-point Assessment	16.6
60 calendar days after receipt of CMS comments	Revised Reentry Mid-point Assessment	16.6
180 calendar days from approval letter date	Draft Evaluation Design	17.4
60 calendar days after receipt of CMS comments	Updated Evaluation Design	17.5
One year prior to demonstration expiration	Draft Interim Evaluation Report	17.7
60 calendar days after receipt of CMS comments	Revised Interim Evaluation Report	17.7
18 months after the end of the demonstration	Draft Summative Evaluation Report	17.8
60 days after receipt of CMS comments	Revised Summative Evaluation Report	17.8
Monthly	Monitoring Calls	16.9
Quarterly Deliverables Due 60 calendar days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports, including implementation updates	16.5
No later than 30 days after the end of each quarter	Quarterly Expenditure Reports	18.2

Due Date	Deliverable	STC Reference
Annual Deliverables – Due 90 calendar days after end of each 4th quarter	Annual Monitoring Report	16.5
Within 90 days of the extension approval	Provider Rate Increase Attestation Table and Supporting Information	13.14
Annually, as part of the demonstration annual report	Annual Attestation of Provider Rate Increase	13.14
No later than 120 calendar days after approval of reentry demonstration initiative	Draft Reentry Demonstration Initiative Implementation Plan	15.10
No later than 60 days after receipt of CMS feedback	Revised Reentry Demonstration Initiative Implementation Plan	15.10
No later than 6 months after approval of reentry demonstration initiative	Reentry Demonstration Reinvestment Plan	15.11
No later than 3 months prior to state's intended implementation of CM program	Contingency Management Protocol	14.3
No later than 9 months after approval of demonstration extension	HRSN Implementation Plan	8.23
No later than 90 calendar days after approval of demonstration extension	HRSN Maintenance of Effort Information	8.20
No due date	HRSN Payment Methodology	8.19
No due date – to be made available to CMS upon request	DSHP Claiming Protocol	12.4
No later than 90 days	Quality Improvement Strategy and Performance	10.2

Due Date	Deliverable	STC Reference
following approval of the demonstration	Measures	
No later than 90 days following the end of each demonstration year	HCBS Enrollment Report	10.2(d)
No later than 21 months prior to the end of the current demonstration period	HCBS Evidence Report	10.2(d)
No later than 90 days following receipt of CMS feedback	Response to CMS feedback on HCBS Evidence Report	10.2(d)
No later than 120 days following the expiration of the demonstration	Close-out Report	16.8
No later than 30 days after receipt of CMS feedback	Revisions to Close-out Report following CMS feedback	16.8(e)
Two years following expiration of current demonstration period	MLR Audit	11.8

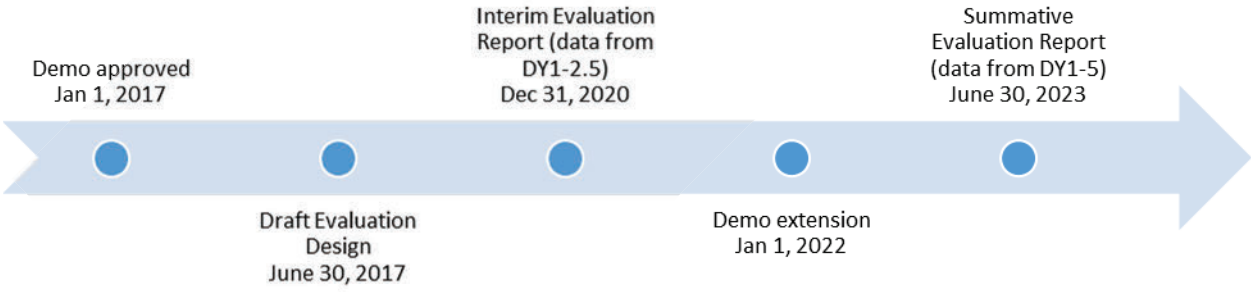
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations.

The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, the potential magnitude of the issues, and why the state selected this course of action to address the issues (e.g., a narrative on why the state submitted a section 1115 demonstration application).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.

5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre–test or

post–test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid–Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t–tests, chi–square, odds ratio, ANOVA, regression).

b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
c. Include a discussion of how propensity score matching and difference–in–differences designs may be used to adjust for differences in comparison populations over time, if applicable.
d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	–Measure 1 –Measure 2 –Measure 3	–Sample e.g. All attributed Medicaid beneficiaries –Beneficiaries with diabetes diagnosis	–Medicaid fee–for–service and encounter claims records	–Interrupted time series
Research question 1b	–Measure 1 –Measure 2 –Measure 3 –Measure 4	–Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	–Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	–Measure 1 –Measure 2	–Sample, e.g., PPS administrators	–Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long–

standing, it may be difficult for the state to include baseline data because any pre–test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non–complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS–64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation–related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

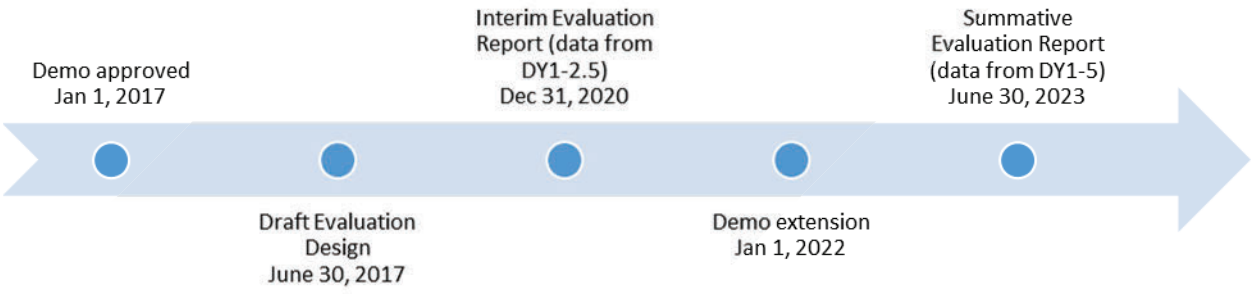
ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5–year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already–approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and

comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section–1115–demonstrations/1115–demonstration–monitoring–evaluation/1115–demonstration–state–monitoring–evaluation–resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
    1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, how the state became aware of the issues, the potential magnitude of the issues, and why the state selected this course of action to address the issues.
    2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
    3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:
   1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
   2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
   3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
   4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

   An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

   This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

   1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post–only data, with or without comparison groups, etc.

2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected.

4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t–tests, chi–square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:
    1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    2. If the state did not fully achieve its intended goals, why not?
    3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long–range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by

the demonstration who understand the cultural context in which the demonstration was implemented.

I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:
    1. What lessons were learned as a result of the demonstration?
    2. What would you recommend to other states which may be interested in implementing a similar approach?

Hawai‘i QUEST Integration Section 1115 Demonstration 2025-2029

Evaluation Design

Draft prepared for CMS review May 5th, 2026

Center for Research and Evaluation in the Social Sciences
Social Science Research Institute
College of Social Sciences | University of Hawai‘i at Mānoa

For questions, please contact:
John P. Barile
Director & Professor
Social Science Research Institute

Social Science Research Institute
2424 Maile Way, Saunders Hall 704
Honolulu, HI 96822
https://ssri.manoa.hawaii.edu/

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I. General Background Information

The State of Hawai‘i, Department of Human Services (DHS), Med-QUEST Division (MQD) is Hawai‘i’s Medicaid agency. MQD first implemented QUEST (Quality care, Universal access, Efficient utilization, Stabilizing costs, and Transforming the way health care is provided) on August 1, 1994. QUEST was a statewide Section 1115 Demonstration project that initially provided medical, dental, and behavioral health services through a competitive managed care delivery system.

Since its initial implementation in 1994, the Centers for Medicare & Medicaid Services (CMS) has renewed the QUEST Demonstration six times. CMS approved Hawai‘i’s most recent request to extend the Section 1115 Demonstration project titled “Hawai‘i QUEST Integration” (“Demonstration”) (Project No. I l-W-00001/9) with an effective date of January 8, 2025 running through December 31, 2029.

The current Demonstration continues to use capitated managed care as the primary delivery system. QUEST Integration (QI) provides Medicaid state plan benefits and additional benefits (including home- and community-based long-term-services and supports [LTSS]) to beneficiaries eligible under the state plan and to the Demonstration populations. In addition to the QI health plans, a separate behavioral health organization (BHO) provides beneficiaries with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) with specialized and non-specialized behavioral health services.

MQD is using this Demonstration as a vehicle to implement the Hawai‘i ‘Ohana Nui Project Expansion (HOPE) Program (Med-QUEST Division, 2017), an effort that furthers MQD’s mission to “*empower Hawai‘i’s residents to improve and sustain wellbeing by developing, promoting and administering innovative and high-quality healthcare programs with aloha*.” MQD consolidated and updated previous Demonstration objectives to align past efforts with future goals as framed by the HOPE Initiative. Through this process, MQD established three objectives for the current Demonstration:

1. Improve health outcomes for Medicaid-enrolled individuals covered under the Demonstration;
2. Maintain a managed care delivery system that leads to more appropriate utilization of the healthcare system and a slower rate of expenditure growth; and
3. Address social drivers of health to improve health outcomes and lower healthcare costs.

The HOPE Initiative serves as both the foundation and a primary organizing principle for the Demonstration and our evaluation of it. For example, our focus on primary care and social drivers of health is inspired by HOPE initiatives and will be effectuated through the managed care authorities in the Demonstration. The principles and strategies outlined in the HOPE Initiative build on the successes of previous efforts and are meant to leverage community initiatives and resources, while maximizing return on investment and ensuring broad community support beyond Medicaid. The evaluation encompasses all populations described in the Special Terms & Conditions (STCs).

Demonstration Benefits and Features

Grounded on the three aforementioned objectives, approval of Hawai‘i’s QUEST Integration Demonstration extension for 2025-2029 includes the following new initiatives covered under the evaluation of the current Demonstration: Health related social needs (HRSN) interventions; Pre-

release services under the reentry Demonstration initiative; Contingency Management (CM) services for certain beneficiaries with a stimulant use disorder (StimUD) and/or opioid use disorder (OUD); Coverage for out-of-state former foster care youth (FFCY); and, extension and amendment of existing authorities.[3] **Table I.1** shows the new and existing initiatives covered under the evaluation of the current Demonstration. In alignment with applicable CMS evaluation guidance in STC 17.6, this evaluation design outlines and addresses hypotheses and research questions for the following key Demonstration policy components described in the table below.
Table I.1. Initiatives Covered Under the Current Demonstration and Evaluation

Demonstration Objectives	**Initiatives and Evaluation Projects**	**New Initiative in the 2025-2029 Demonstration and/or Existing Initiative from Previous Demonstration**
1. Improve health outcomes for Medicaid-enrolled individuals covered under the Demonstration	Pre-Release Services (Project 1A)	New
	CM Services (Project 1B)	New
	Continuous Eligibility for Medicaid Children and Coverage for (FFCY) and Youth Aged Out from Adoption System/Kinship Guardianship System (Project 1C)	New and existing
2. Maintain a managed care delivery system that leads to more appropriate utilization of the healthcare system and a slower rate of expenditure growth	Value-Based Purchasing and Alternative Payment Models (APMs) (Project 2)	Existing
3. Address social drivers of health to improve health outcomes and lower healthcare costs	HRSN Interventions (Project 3) ● Housing interventions (New and existing) ● Nutrition interventions (New) ● Non-medical transportation (NMT) (New) ● Cooking supplies (New)	New and existing

In alignment with applicable CMS evaluation guidance in STC 17.6, this evaluation design outlines and addresses hypotheses and research questions for the following key Demonstration policy components described in **Table I.1.**

[3] In addition to the activities listed here and in Table I.1, the Demonstration includes authority for additional benefits not assessed within the evaluation.

Project 1A: Pre-Release Services under the Reentry Demonstration Initiative

Pre-release Medicaid enrollment is aimed at improving the health and social outcomes of individuals transitioning from incarceration back into the community. Traditionally, the Federal Medicaid Inmate Exclusion Policy has prevented most incarcerated individuals from accessing Medicaid, except for limited inpatient services (Albertson, et al., 2020). This longstanding exclusion leaves many people, who often have high rates of chronic illnesses, mental health issues, and substance use disorders (SUDs) without essential healthcare at the critical time of their release. The immediate post-release period is particularly risky, marked by increased chances of overdose, hospitalization, death, and recidivism. The current Demonstration allows coverage of pre-release services up to 90 days before a person's expected release.

The initiative seeks to bridge the healthcare gap between incarceration and community reentry by providing pre-release healthcare services and case management to eligible individuals incarcerated in jails, prisons, and youth correctional facilities up to 90 days before their expected release. Medicaid eligible individuals with a release date that falls within a 90-day window will qualify for this program.

The key benefits of this pre-release program include increased coverage and continuity of care for justice-involved individuals, leading to appropriate service uptake and improved healthcare outcomes. At the systems level, this program seeks to improve coordination among correctional facilities, Medicaid, managed care plans, and community-based providers. Ultimately, the State seeks to reduce acute care utilization, such as emergency department (ED) visits and inpatient hospitalizations, and all-cause deaths.

Program features include case management, Medication-Assisted Treatment (MAT) for SUDs, practitioner office visits, diagnostic services, medical equipment and supplies, and peer support services. Upon release, individuals will receive a 30-day supply of prescription and over the counter medications. These and other program features are designed to provide a wide range of pre-release services in order to meet the physical and behavioral health needs of eligible individuals.

Project 1B: Contingency Management (CM) Services

In December 2021, CMS approved the first CM Demonstration in California and has since approved CM Demonstrations in four additional states: Hawai‘i, Delaware, Montana, and Washington. CM Services encourage individual positive behavior change consistent with substance non-use or medication/treatment adherence. Hawai‘i has chosen to implement CM in order to increase the number of beneficiaries using SUD delivery services and to increase adherence to and retention in SUD treatment. The addition of CM aims to expand reimbursed services, promote standardized evidence-based practices, and ensure long-term sustainability for providers to meet increasing treatment needs. Existing evidence supporting the efficacy of CM programs suggests that its implementation in Hawai‘i aligns with the MQD principles and strategies described in the HOPE Initiative; namely emphasis and investment in health promotion, prevention, and primary care, and improved outcomes for high-need, high-cost individuals (Ginley et al. 2021; Fingar & Owens, 2021).

The Demonstration will provide CM for Medicaid beneficiaries with a qualifying SUD, which includes StimUDs and OUDs. The State will enroll providers who will receive training and oversight as they implement the 24-week program for beneficiaries. CM will consist of a complementary course of SUD treatment and a series of motivational incentives to advance SUD

treatment goals, which may include negative drug tests. The motivational incentives may consist of cash equivalents, e.g., gift cards of low retail value, with restrictions placed on the incentives so they are not used to purchase cannabis, tobacco, alcohol, over-the-counter preparations containing possible intoxicants such as dextromethorphan, weapons (including firearms/ and ammunition), pornographic materials, or additional items as identified by the State. The State intends to determine the size, nature, and distribution of all motivational incentives in detailed guidance, procedures, and protocols issued well in advance of implementation. The State will provide guidance on the frequency of reassessments for eligibility. Hawai‘i’s CM program will not require participation in other SUD treatment as an eligibility requirement for participating in CM. Beneficiaries are allowed to access other treatment programs provided there is no duplication.

The CM program will be limited by the number of qualifying providers that elect to and are approved by the State to participate. Participation is expected to ramp up over the course of the proposed program thereby increasing CM access to more qualifying individuals with SUD diagnoses. Further, a key focus in implementation will be ensuring that Hawai‘i’s CM program dovetails and integrates within the existing behavioral health system, inclusive of MQD’s sister agencies within DHS.

The evaluation will compare a sample of beneficiaries who meet the eligibility criteria for CM services and received services, vs. those that met eligibility criteria and did not receive services. The eligibility criteria for CM services are:

- Be assessed and determined by qualifying providers to have a qualifying SUD for which CM is medically necessary and appropriate based on the fidelity of treatment to the evidence-based intervention.
- The presence of additional substance disorders and/or diagnoses shall not disqualify an individual from receiving CM;
- Not be enrolled in another CM program for SUD; and
- Receive services from an eligible provider that offers CM in accordance with the State laws, policies, procedures, and guidance.

Project 1C: Continuous Eligibility for Medicaid Children and Coverage for Former Foster Care Youth (FFCY) and Youth Aged Out from Adoption System/Kinship Guardianship System

Continuous Eligibility for Children

The current Demonstration continues the expenditure authority for providing continuous eligibility for children, as approved in the recent amendment to the Demonstration on November 14, 2024. The expenditure authority allows the State to provide continuous eligibility for children up to age 6, from birth through the end of the month in which their sixth birthday falls, and to children ages 6 up to age 19 for 24 months.

Coverage for FFCY

In-State FFCY

The Demonstration will maintain coverage for FFCY who are under 26 years of age, were in foster care under the responsibility of another state or tribe on the date of attaining 18 years of age (or such higher age as the state has elected), and who were enrolled in Medicaid on that date.

Out-of-State FFCY

With this approval, Hawai‘i is expanding coverage to out-of-state FFCY who turned 18 years old on or before December 31, 2022. Section 1002(a) of the SUPPORT Act created a new Former Foster Care Children Medicaid state plan eligibility group, providing coverage for individuals who were receiving Medicaid while in foster care under the responsibility of any state; however, the new requirements apply exclusively to those who turn 18 on or after January 1, 2023. As a result, Hawai‘i still needs Section 1115 Demonstration authority to continue coverage for individuals who turned 18 years old on or before December 31, 2022, until a beneficiary reaches age 26.

Coverage for Youth Aged Out from Adoption System/Kinship Guardianship System

Coverage for individuals under age 26 who aged out of an adoption assistance or a kinship guardianship assistance in Hawai‘i or out of state

This approval continues existing authority for Hawai‘i to provide Medicaid coverage to individuals under age 26 who aged out of an adoption assistance or a kinship guardianship assistance agreement (either Title IV-E or non-Title IV-E) and who were enrolled in Hawai‘i Medicaid while receiving assistance payments under such agreement. With this extension, CMS is providing new Demonstration authority to cover those populations who aged out of agreements with other states, as this is not otherwise covered by the state plan.

Coverage for individuals age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance

This Demonstration will continue to provide Medicaid coverage to individuals ages 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance.

Project 2: Value-Based Purchasing and Alternative Payment Models (APM)

CMS has sought to transform U.S. health care to a system that rewards the value and quality of services rather than incentivizing volume (Werner et al., 2021). CMS developed advanced APMs that hold providers financially accountable for the cost of care delivered to patients, as well as the quality of this care.

MQD contracts with five Managed Care Organization (MCO) health plans to administer benefits for 99% of all Medicaid beneficiaries in Hawai‘i. Historically, four out of five QI health plans financed providers through Fee-For-Service contracts. Building on this, the 2025-2029 Demonstration promotes the advancement and evaluation of APMs within Hawai‘i’s Medicaid programs, extending the progress from previous Demonstration periods.

To realize a value-based purchasing philosophy, MQD aims to implement purchasing strategies that incentivize quality and whole-person care. Both state-initiated purchasing strategies to QI health plans and the APMs implemented by QI health plans with providers hold health plans and providers accountable for both the costs and quality of care provided (MQD, 2017; MQD, 2023). MQD’s HOPE Initiative and the State’s quality strategy continuously endorse a transformation roadmap, aiming to reshape healthcare delivery by implementing new value-based purchasing models (MQD, 2017; 2023).

MQD’s plans to advance value-based care in Hawai‘i include steps to evolve current QI health plan requirements to reflect the Health Care Payment Learning and Action Network (HCP-LAN) APM Framework (HCP-LAN, 2025). This involves requiring QI health plans to progressively adopt more sophisticated APMs across various provider types, including primary care providers (PCPs), hospitals, specialists, LTSS providers, and other provider types.

Understanding (APMs)

The APM Framework, initially developed by CMS and refined by HCP-LAN, classifies payment models to monitor progress toward person-centered care and health payment reform, moving away from Fee-For-Service. This shift is intended to reduce expenditure growth and improve quality of care. HCP-LAN recently communicated that priorities and initiatives will evolve following State and Federal developments in line with the CMMI strategy to "Make America Healthy Again" (HCP-LAN, [HCPLAN reaffirms commitment to value-based care, May 19, 2025]). Any changes will inform Hawai'i's ongoing evaluation of its value-based healthcare transformation.

Box 1. Key Terminology: State value-based purchasing strategies and APMs
Value-Based Health Care Transformation is assessed from two perspectives:

- **State value-based purchasing strategies:** The incentives and mechanisms the State uses to encourage QI health plans to focus on high-quality, lower-cost care. These include:
  - Capitated payments to QI health plans within the managed care population;
  - Withholds and payback for meeting quality metrics; and
  - Auto-assignment of new beneficiaries to QI health plans based on quality performance.

- **Alternative Payment Models (APMs):** The models QI health plans implement to incentivize providers to deliver value-based care, aligning with the HCP-LAN APM framework. These models include:
  1. Fee-for-service only;
  2. Fee-for-service plus payments for infrastructure, quality reporting, and performance;
  3. Fee-for-service with risk sharing; and
  4. Population-based payments.

Tracking Progress and Lessons Learned

In 2019, MQD, in collaboration with the evaluation team, developed a reporting framework to track QI health plans' advancement toward payment transformation alongside the implementation of these incentives. Today, QI health plans provide qualitative information on implemented APMs, and quantitative information on provider participation in these models, beneficiary attribution to providers who participate in APM models, and financial outcomes of the implemented models. Reports provide data in line with the HCP-LAN annual inquiry (HCP-LAN, 2025).
The 2019-2024 Hawai'i's Section 1115 Demonstration evaluation indicates a positive trend in QI

health plans' achievement of Pay-for-Performance benchmarks set by MQD, directly reflecting progress aligned with the State's quality strategy. In 2016, QI health plans achieved an average of 46.3% of these benchmarks, a figure that rose to 63.5% by 2021. This improvement demonstrates QI health plans' success in implementing various programs specifically designed in accordance with MQD's objectives. Notably, the majority of QI health plan APMs are concentrated on primary care, underscoring a strategic focus on high-value services.
The previous Demonstration evaluation led to several recommendations for future evaluation and APM implementation:

1. Include QI Health Plan Reports from additional calendar years for trend analysis of APMs and spending;
2. Conduct more detailed investigations into the intended effects of existing APMs; and
3. Refine and expand APM models to higher levels of the APM Framework among QI health plans, providers, and MQD, aligning with existing quality programs, the HOPE Initiative, and the State's quality strategy. This specifically involves expanding risk-sharing and population-based payment arrangements beyond current Pay-for-Performance models, while considering provider perceptions.

In line with these recommendations, this evaluation aims to explore developments in MQD's payment strategies at the QI health plan level and QI health plans' APMs at the provider level in Hawai‘i from 2025 onward.
Project 3: Health-Related Social Needs (HRSN) Interventions–Housing Interventions, Nutrition Interventions, Cooking Supplies, and Non-Medical Transportation (NMT)

Evidence has indicated that HRSN benefits are critical drivers of an individual's access to health services that keep them well (Kreuter, et al., 2021). Under this Demonstration, the state will cover housing and nutrition interventions to address the HRSNs of eligible beneficiaries, help beneficiaries stay connected to coverage, and improve their access to needed health care. Particularly, the housing and nutritional support services aim to stabilize the housing and nutritional situations of eligible beneficiaries, provide a regular source of care to meet individuals' comprehensive health needs, improve health outcomes directly, and support use of other appropriate clinical services.
HRSN Housing Interventions

During the previous Demonstration period (2019-2024), MQD developed Community Integration Services (CIS), a program that provides outreach, pre-tenancy supports, and tenancy sustaining services for beneficiaries who meet health needs-based criteria and are experiencing homelessness or are at risk for experiencing homelessness. Under this Demonstration, MQD plans to expand the CIS program by providing additional housing-related services that can support sustainable transitions into permanent housing. Leveraging existing infrastructure and partnerships established through the original CIS benefit rollout, "CIS Plus" (CIS+) will add increased supports, including short-term rental assistance, utility payments, and medical respite, to the existing housing navigation services for homeless and at-risk beneficiaries. Through this assortment of housing services, CIS+ aims to improve beneficiary health through housing stability, and ultimately to:

1. decrease utilization of acute services (emergency and inpatient utilization),
2. increase engagement in outpatient care services, and

3. decrease the total cost of care.

CIS+ services include:

- **Pre-Tenancy Supports**: Supports include housing navigation services that help beneficiaries find and obtain housing. Services include linking the beneficiary to services and service providers.
- **Tenancy Supports**: Services that assist beneficiaries in maintaining their housing. Services include referrals to expert community resources, ongoing support with household management, housing support and crisis plan development, and independent living skills development.
- **Rental Assistance**: Provides funds for rent and/or short-term temporary stays for up to six months for eligible housing arrangements (e.g., apartments, single room occupancy (SRO) units; manufactured home lots, motel, or hotel when it is serving as the primary residence; transitional and recovery housing; and community living programs).
- **One-Time Transition and Moving Costs and Housing Deposits**: Covers housing application costs, relocation expenses, and basic household goods and furniture costs.
- **Utility Costs**: Available for up to six months per Demonstration period for total prospective/retrospective payments.
- **Medically Necessary Repairs, Remediation, and Home Accessibility Modifications**: Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) are covered when they are necessary to ensure occupant's health, and when the modification(s) are not covered under any other provision such as the Americans with Disabilities Act.
- **Medical Respite**: Short-term housing interventions that include clinical services along with room and board, including:
    - *Pre-Procedure Housing:* short-term housing provided to CIS+ beneficiaries who have a planned medical treatment requiring care prior to treatment.
    - *Recuperative Care:* short-term residential care for up to 90 days provided to CIS+ beneficiaries with ongoing medical and psychiatric needs following discharge or exit from an institution.
    - *Short-Term Post-Hospitalization Housing:* short-term housing provided for up to six months to CIS+ beneficiaries who are recovering from physical, psychiatric, or substance use conditions following discharge or exit from an institution.

Under CIS+, QI health plans will identify potentially eligible beneficiaries and authorize homeless service providers to conduct engagement activities to collect information needed to confirm eligibility and obtain consent. After consent is obtained, providers will conduct an initial CIS assessment and develop a beneficiary-driven housing action plan to determine beneficiary needs. Based on these needs and plans, providers will provide housing navigation, housing supports, and/or medical respite services. They will also connect beneficiaries to other social services and QI health plan benefits as needed.

These services are theorized to lead to increased housing stability, improved access to health care, and increased connection to other services for beneficiaries. These outcomes will lead to improved physical and mental well-being, increased community integration, increased use of outpatient services, a stabilization of health needs, and a reduction in acute emergency services usage. Together, these outcomes are theorized to lead to a reduction in statewide homelessness,

decreased total cost of care for Medicaid beneficiaries, and a slowed expenditure growth rate. A key component of CIS+ includes its medical respite benefit that allows for pre- and post-procedure care. In addition to improving patient outcomes, this benefit aims to reduce costs and overcrowding of hospitals by reducing hospital readmissions and unnecessary extended hospital stays. MQD will work with QI health plans and providers to establish a closed-loop referral system to ensure access to care and to reduce gaps in services.

HRSN Nutrition Interventions

HRSN nutrition interventions under this Demonstration include coverage of nutrition instruction, home delivered meals or pantry stocking, medically tailored meals, and nutrition prescriptions. Details of each benefit are described below:

- **Nutrition Instruction:** Individuals may receive 12 sessions per six-month period of any combination of instructional and educational strategies designed to motivate and facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being.
- **Provision of Food:** HRSN nutrition interventions with provision of food are limited to a maximum of 3 meals/day or any other complete nutritional regimen (e.g., 2 meals/day) and are limited to a duration of 6 months, renewable while the beneficiary continues to meet qualifying criteria.
    - *Home Delivered Meals or Pantry Stocking:* Also referred to as grocery provisions, this benefit provides meals appropriate for the beneficiary's health condition or status as a child or pregnant person.
    - *Medically Tailored Meals:* Individuals with nutrition-sensitive conditions (e.g., pregnant individuals, individuals with diabetes) may receive medically tailored meals as specified in STC 8.6.
    - *Nutrition Prescriptions:* Individuals may receive fruit and vegetable prescriptions, protein boxes, food pharmacies, and/or healthy food vouchers appropriate for the beneficiary's health condition or status as a child or pregnant person.
- **Cooking Supplies:** Individuals may receive supplies outside of HRSN services and covered under separate expenditure authority that are necessary for meal preparation and nutritional welfare of a beneficiary when not covered as an HRSN one-time transition and moving cost or available through other programs (e.g., pots and pans, utensils, refrigerator).

NMT for HRSN Services

The State will provide NMT to Medicaid beneficiaries to and from HRSN services authorized under this Demonstration as described below:

- NMT services may be provided to Medicaid beneficiaries eligible for HRSN services to and from HRSN services authorized under this Demonstration. The HRSN services must be described in the beneficiary's care plan.
- All NMT must be provided in alignment with the technical specifications, and safeguards required for NMT authorized under 1915(c) waiver or under 1915(i) state plan authorities.

HRSN Infrastructure

Infrastructure to support the development and implementation of HRSN services includes the following activities:

- **Technology**: – e.g., electronic referral systems, shared data platforms, electronic health record (EHR) modifications or integrations, screening tools and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, and accounting and billing systems.
- **Development of Business or Operational Practices:** – e.g., Developing policies, procedures and workflows, training and technical assistance, and administrative activities to support or expand HRSN operations.
- **Workforce Development:** – e.g., Recruiting and hiring, salary and fringe benefits for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies and procedures, and training materials.
- **Outreach, Education, and Interested Parties Convening:** – e.g., Designing and producing outreach and education materials, translation, obtaining community input, and interested parties convening and community engagement activities.

II. Evaluation Questions and Hypotheses

The evaluation is designed to assess the effectiveness of the Demonstration in achieving its overall goals to improve health outcomes, reduce the rate of expenditure growth, strengthen the managed care delivery system, and address social drivers of health. During initial planning of the HOPE Initiative, MQD worked extensively with internal and external stakeholders to develop a comprehensive plan for measurement and evaluation.

Table II.1 summarizes key evaluation hypotheses and projects to support each Demonstration objective. Project-level details for each hypothesis, including information on specific target populations, research questions, data strategy, sources and collection frequency, measures, statistical framework, and subgroup analyses (if applicable) are described in detail in Section V: Project-Level Detail.

All evaluation questions and hypotheses promote the objectives of *Title XIX* by assessing whether providing high-quality, accessible services to individuals with low income improve their health outcomes during the Demonstration. In addition, these hypotheses collectively assess progress toward the Institute for Healthcare Improvement's Triple Aims: improved health, improved quality of care, and reduced costs–the primary focus of the Demonstration as well as a core tenet of the HOPE Initiative.

Table II.1. Overview of Evaluation Projects by Demonstration Objectives, Hypotheses, and Research Questions

Evaluation Projects	Demonstration Hypotheses	Research Questions (RQ)
Demonstration Objective 1: Improve health outcomes for Medicaid-enrolled individuals covered under the Demonstration		
Project 1A: Pre-Release Services under the Reentry Demonstration Initiative	**Hypotheses 1A.1** The Reentry Demonstration Initiative will result in improved cross-system communication and coordination between stakeholders. **Hypotheses 1A.2** Pre-release services will increase enrollment of eligible Individuals and improve access to high-quality services and services uptake in carceral settings. **Hypotheses 1A.3** Pre-release services will improve connections between correctional and community	**Research question 1A.1** How does the Reentry Demonstration Initiative improve cross-system communication and coordination, and connection between correctional and community services? **Research question 1A.2a** How are beneficiaries identified and enrolled in pre-release services? **Research question 1A.2b** Does the implementation of pre-release services improve access to services and services uptake among beneficiaries in the carceral setting? **Research question 1A.3a** Are pre-release services beneficiaries with

	services, access to and quality of care in community settings after release, resulting in improved continuity of care into the community. **Hypothesis 1A.4** Providing re-release services for up to 90-days coverage period before the individual's expected date of release will improve the state's ability to plan for and provide pre-release services. **Hypothesis 1A.5** Pre-release services will increase preventive and routine physical and behavioral health care use, reduce non-emergent ED visits and inpatient hospitalizations visits and associated costs, and decrease all-cause deaths in the near-term post-release.	identified physical and behavioral health needs and HRSNs connected to supports after release? **Research question 1A.3b** What are the experiences among beneficiaries and providers related to continuity of care into the community after release? **Research question 1A.4** Are pre-release eligible beneficiaries who have a longer length of days incarcerated before expected release date more likely to be enrolled in Medicaid and receive pre-release services compared to those with shorter durations? **Research question 1A.5a** Is receiving pre-release services associated with increased preventive and routine physical and behavioral health care use among beneficiaries? **Research question 1A.5b** Is receiving pre-release services associated with reduced non-emergent ED visits and inpatient hospitalization visits and their associated costs among beneficiaries? **Research question 1A.5c** Is receiving pre-release services associated with reducing all-cause deaths in the near-term post-release?
Project 1B: CM Services for Eligible Beneficiaries with a StimUD and/or OUD	**Hypothesis 1B.1** Increasing the availability of CM will increase the number of Medicaid beneficiaries engaged in treatment for SUDs. **Hypothesis 1B.2** Participation in CM among Medicaid beneficiaries with SUDs will increase adherence to and retention in SUD treatment.	**RQ 1B.1a** Does CM increase engagement in substance use treatment? **RQ 1B.2a** Does CM increase adherence to or retention in substance use treatment? **RQ 1B.2b** What is the cost of providing CM incentives? **RQ 1B.2c** What is the cost of services associated with the CM program?

Project 1C: Continuous Eligibility for Medicaid Children and Coverage for FFCY and Youth Aged Out from Adoption System/Kinship Guardianship System	**Hypothesis 1C.1** Continuous eligibility will improve enrollment continuity, reduce the quantity of redeterminations and churn among beneficiaries, including for racial and ethnic minorities with disproportionately high rates of churn, resulting in lower administrative burden for eligibility workers and associated costs. **Hypothesis 1C.2** By improving enrollment continuity, continuous eligibility will increase the utilization of preventive care, reduce the utilization of avoidable inpatient admissions and emergency care, and slow down the expenditure growth among beneficiaries.	**RQ 1C.1a** How does continuous eligibility streamline eligibility determination/redetermination and enrollment for beneficiaries? **RQ 1C.1b** Does continuous eligibility improve enrollment continuity and reduce churning among beneficiaries, including for racial and ethnic minorities with disproportionately high rates of churn? **RQ 1C.1c** Does continuous eligibility lower administrative burden and results from interviewing associated costs for eligibility workers? **RQ 1C.2** How does continuous eligibility affect beneficiaries' utilization of preventive care, avoidable inpatient admissions and emergency care, and the expenditure growth among beneficiaries?
Demonstration Objective 2: Maintain a managed care delivery system that leads to more appropriate utilization of the healthcare system and a slower rate of expenditure growth		
Project 2: Value-Based Purchasing and APMs	**Hypotheses 2.1** Increased beneficiary coverage under QI health plan advanced APMs is related to improved outcomes, care utilization and spending.	**RQ 2.1a** What changes were made by QI health plans to their APMs? **RQ 2.1b** Are MQD's articulated expectations and requirements associated with an expansion of APMs implemented by QI health plans? **RQ 2.1c** How does attribution to an advanced APM affect beneficiaries' utilization of preventive care, avoidable inpatient admissions and emergency care, and expenditure?
Demonstration Objective 3: Address social drivers of health to improve health outcomes and lower healthcare costs		

Project 3: HRSN ● Housing interventions ● Nutrition interventions ● Cooking supplies ● NMT to HRSN benefits	**Hypothesis 3.1** HRSN interventions will promote the development of HRSN infrastructure to support HRSN implementation and increase local investments in housing supports and nutrition services over time. **Hypothesis 3.2** HRSN interventions will improve access to HRSN services and mitigate the identified HRSN among beneficiaries. **Hypothesis 3.3** HRSN interventions will improve beneficiaries' health status, the use of preventive and routine care, and reduce the use and costs associated with potentially avoidable, high-acuity health care, and the use of hospital and institutional care, leading to reduced health care spending over time.	**RQ 3.1a** Who are the key actors collaborating to implement and operationalize the interventions, what are their main roles, and how are they related to each other? **RQ 3.1b** How does the Demonstration change the way key actors form and maintain partnerships to implement HRSN services? **RQ 3.1c** What infrastructure is developed to support the implementation of HRSN interventions and what is the cost? **RQ 3.2a** How do key actors identify beneficiaries with social risk factors related to housing and nutrition and facilitate their participation in the interventions? What facilitators and barriers to participation do key actors and beneficiaries experience? **RQ 3.2b** How do HRSN interventions impact the use of housing and nutrition services and the rate of housing stability and nutrition security among beneficiaries? **RQ 3.3** How do HRSN interventions impact beneficiaries' physical and mental health status, the use of preventive and routine care, the use of potentially avoidable, high-acuity health care, hospital and institutional care, and health care spending?
Cross-Cutting Evaluation		
Cross-Cutting Hypothesis	**Hypotheses 4.1** Beneficiaries receiving multiple services will have higher use of preventive and routine care, and lower use of potentially avoidable, high-acuity health care, and hospital and institutional care than beneficiaries receiving only one or no services.	**RQ 4.1a** What are the characteristics of beneficiaries receiving multiple services compared to beneficiaries receiving one service or none. **RQ 4.1b** How receiving multiple services impact beneficiaries' use of preventive and routine care, and potentially avoidable, high-acuity health care, and hospital and institutional care.

Overarching Demonstration Logic Model

The logic model represented in **Figure II.1** outlines a comprehensive strategy encompassing five distinct program areas (Inputs) designed to achieve the Demonstration objectives of improving health outcomes, promoting more appropriate utilization of services, slowing the rate of expenditure growth, and addressing social drivers of health. Each input is linked to a series of activities, which generate measurable outputs. These outputs then contribute to various short-term outcomes and subsequently lead to overarching intermediate outcomes, all working towards the State Demonstration objectives.

The five programmatic areas (Inputs) each lead to specific outcomes as detailed in Section V. Project-Level Detail. The model illustrates a systematic pathway from foundational programmatic interventions to significant, long-lasting improvements in public health and healthcare system sustainability.

The program's initiatives are designed to yield several short-term outcomes. These include a decrease in coverage gaps for MQD beneficiaries, specifically continuous eligibility for children and youth, and pre-release services for incarcerated individuals. These efforts are intended to reduce inequities in access to care for these populations. Continuous eligibility and State value-based purchasing strategies are intended to decrease administrative burden for MQD, QI health plans and providers, resulting from lower rates of redeterminations and the evolution of the managed care system to promote value over volume.

The short-term outcome of increased and improved coordination across initiatives and between stakeholders is central to the Section 1115 Demonstration. All initiatives included in this evaluation support systematic strengthening of communication between MQD, QI health plans, providers, and beneficiaries. The value-based purchasing strategies implemented by the State are specifically aimed at incentivizing cross-cutting APMs by QI health plans that cover a wide range of providers and services. All programs invest in cross-stakeholder collaboration to achieve optimal outcomes.

Another short-term outcome of the Demonstration across all programmatic efforts is the increased and timely delivery of high-value services. Measures implemented by one program, for instance the implementation of pre-release services, are intended to support the adequate and timely access to all Medicaid services, including CM, nutrition or housing support upon release. Finally, directly addressing non-medical factors that impact health, such as housing, transportation, and nutrition, is achieved through the HRSN interventions specifically.

Figure II.1 Overarching Demonstration Logic Model

These short-term outcomes support the provision of care and then converge into a set of broader, intermediate outcomes. The primary intermediate outcome to be achieved by all programs combined is a higher performance on various outcome measures defined by the State Quality Strategy (MQD, 2023). This encompasses a range of improvements including, but not limited to, better self-reported health outcomes by beneficiaries, a reduction in hospital readmissions, and fewer ED visits. Other intermediate outcomes include increased medication adherence which is vital for chronic condition management, and a greater emphasis on preventive and primary care services. The model reflects enhanced overall health management and efficiency (timeliness) resulting in reductions in frequency and duration of inpatient stays and all-cause mortality rates. Financially, the intermediate outcomes include a lower rate of expenditure growth on low-value services, indicating optimized resource allocation, and conversely, a higher rate of expenditure growth on high-value services, as a result of strategic investment in impactful care, such as preventive and primary care services.

These collective short-term and intermediate outcomes are strategically designed to achieve the overarching Demonstration objectives: Improve health outcomes for Medicaid-enrolled individuals covered under the Demonstration; maintain a managed care delivery system that leads to more appropriate utilization of the healthcare system and a slower rate of expenditure growth; and address social drivers of health to improve health outcomes and lower healthcare costs**.**

While this logic model details specific programs for evaluation aligned with CMS STC 17.6 requirements, it's important to note that other 1115 Demonstration authorities not included in this evaluation design may also contribute significantly to achieving the overall objectives. These additional mechanisms are not explicitly detailed here.

III. Methodology

The Demonstration includes a wide range of strategies and interventions to promote improved health outcomes, reduce costs, and address social drivers of health. Accordingly, the evaluation will utilize a variety of research and statistical approaches to assess the impacts and outcomes of the Demonstration strategies and interventions. This section outlines overarching elements of the evaluation design that cut across several of the research questions and evaluation priorities.

Methodological Design

Many of the in-depth studies in the evaluation will employ a mixed-methods approach. A qualitative process evaluation will be conducted to track the implementation progress of a new initiative and/or to assess program fidelity based on input from key stakeholders or review of program documents. A quantitative outcome study using administrative data and applying modeling techniques or multivariate data analyses will be conducted to assess impacts of the Demonstration on access, utilization, quality, health status, and costs (among other outcomes).

Comparison Populations and Subgroup Analyses

Given the nature of the population, random assignment of participants (Medicaid beneficiaries) to programs to establish control and treatment groups is not feasible and generally not ethical. Instead, a variety of quasi-experimental statistical methods will be used to assess program impacts, such as difference-in-differences (DiD) and interrupted time series (ITS). These methods are discussed in further detail below and in Section V Project-Level Details.

Some of the evaluation questions will involve analyzing costs or outcomes for all Medicaid beneficiaries, e.g., assessing expenditure growth. Most of the in-depth studies, however, target specific subgroups of beneficiaries, such as individuals who are homeless, the FFCY population, or individuals who are incarcerated. Therefore, comparison populations will be chosen for each analysis and are described in greater detail for each project.

In order to provide a fuller understanding of access to and quality of care and health outcomes among different subgroups, analyses will be stratified by key subpopulations of interest, where feasible, including sex, age, race/ethnicity, English language as a second language, and geography (rural/urban, county, island).

Evaluation Period

The first year of the evaluation will focus primarily on designing, modifying, and refining the evaluation plan to ensure that the final plan is feasible yet sufficiently rigorous, and comprehensively addresses all of the Demonstration objectives and hypotheses. Additionally, a major part of our efforts will involve working with MQD to obtain the data required for the evaluation, when needed and in the required format.

Primary data collection in the form of interviews and focus groups will occur in years 2-3. Years 2-3 will also focus on preparing and accessing administrative data and conducting preliminary analyses or statistical modeling with small samples of data to determine whether the proposed models and analytic strategies can be accurately applied and tested. Additionally, preliminary findings will be shared with MQD and other stakeholders to actively inform practice and policy. Year 4 will focus on drafting an interim report with preliminary findings and specifying and estimating models, testing hypotheses, and addressing all research questions. Year 5 will focus on finalizing the summative report.

Evaluation Measures

A variety of quantitative and qualitative measures will be used. Quantitative measures will be derived from existing databases or generated from periodic QI health plan reports. New initiatives and modified initiatives may require the development of new data sources. Quantitative measures include both process measures and outcome measures. Process measures include numbers of beneficiaries who are identified, authorized, and receive the Demonstration services (e.g., pre-release services, CM services, or HRSN services). Outcome measures include self-reported physical and mental health status, downstream services utilization (e.g., use of preventive and routine care, use of hospital and institutional care), quality of care measurement (e.g., potentially avoidable, high-acuity health care), and costs associated with both Demonstration services and other services utilization.
Qualitative measures are developed to gain in-depth understanding of the program implementation and beneficiary and provider experience with the Demonstration. Particularly, the qualitative measures will include a description of the program implementation process, a map of key actors' roles and their collaboration in the implementation, facilitators and barriers to implementation identified by key actors and beneficiaries, and changes brought by the Demonstration.
Data Sources

The evaluation may include assessment of quantitative or qualitative process and outcome measures from various sources including the Hawai‘i Health Analytics Program (HAP), relevant documents and meeting notes related to the Demonstration, and primary data collection.
HAP is an integrated data analytic platform that documents and standardizes Hawai‘i health care data sources including Medicaid, Medicare, and Commercial Insurance for state employees and retirees. The Medicaid data sources housed in HAP include the Medicaid Administrative Claims and Encounter Data, the Medicaid eligibility determination system (Kauhale On-Line Eligibility Assistance [KOLEA]), QI Health Plan Reports, Milliman Actuarial Risk Score Data, QI Health Plan Quality Data, and other existing and new Medicaid data sources.
HAP-integrated Data Sources:

- **Hawai‘i Medicaid (MQD) Administrative Claims and Encounter Data**: QI health plans in Hawai‘i are contractually required to submit complete, accurate, and timely encounter data. Encounter and claims data will be used by the evaluation team to access information on diagnoses, utilization of services, and cost of care over time for a variety of analyses requiring these parameters.
- **KOLEA Eligibility and Enrollment Data**: KOLEA is the Hawai‘i Medicaid eligibility determination system. Applicants submit applications through the KOLEA system. Once approved, beneficiaries eligible for Medicaid are enrolled in a QI health plan and the managed care plan begins to receive capitation payments as of the date of enrollment. KOLEA data includes Medicaid application records, beneficiaries' demographics extracted from the beneficiary's application (age, sex, race, geography, ethnicity, etc.), eligibility category (Aged, Blind, Disabled; Low Income Adult, etc.), enrollment in special programs (LTSS, "at risk", CIS, etc.), and capitation payment amounts.
- **QI Health Plan Reports (as dictated by QI health plan contract requirements)**: Independent of administrative claims or encounter data, the QI Health Plan Reports

include clinical information to support the evaluation (such as a beneficiary's functional limitations, self-reported physical and mental health status), beneficiary housing situations, and implementation of APMs and included providers. MQD implemented new reporting requirements at the start of the last Demonstration period (2019-2024) for QI health plans to provide information that would otherwise not be available through other standardized data sources. The evaluation team used reports developed by MQD for value-based care, primary care, CIS, Special Health Care Needs / Expanded Health Care Needs, LTSS and Quality Assessment and Performance Improvement for the evaluation during the last Demonstration period (2019-2024). To construct the existing reports, QI health plans retrieved standardized information from EHRs, case management systems, etc., and provided this information in MQD's standardized reporting format. New reports will be constructed to monitor the initiatives started for the 2025-2029 Demonstration period (e.g., pre-release services, CM, and nutrition interventions). The new reports will be under development for the duration of the Demonstration; therefore, potential data accuracy and other limitations could exist for the incoming data and will be assessed as part of the evaluation.

- **Milliman Actuarial Risk Score Data**: Using the Chronic Illness and Disability Payment System model, the Milliman Actuarial Risk Score data calculates Medicaid beneficiary-level risk scores that quantify individuals' relative risk burden. An individual risk score is calculated based on age and sex, and diagnosis categories, with multiple diagnoses for different categories leading to higher risk scores. Risk scores are developed for rate-setting purposes and are considered predictors of costs. Scores provide insight into multimorbidity and are a predictor for care utilization. The scores will therefore be used by the evaluation team to control for health status across population groups under study. Dual-eligible beneficiaries are excluded from the dataset. These beneficiaries are not risk-adjusted since the majority of their medical expenses are paid by Medicare. All other beneficiaries are included in the data set regardless of how many months of exposure they have in the base year. However, six months of data is considered as a threshold for "credible" risk score. The months of exposure in the base year is included as a field for reference. When using the data as a proxy for health status, the evaluation team only includes beneficiaries with at least 6 months of exposure within a year to ensure a credible risk score.
- **QI Health Plan Quality Data**: MQD has historically collected CMS Core Set of Children and Adult Health Care Quality Measures for Medicaid as well as HEDIS quality measures, and other nationally standardized performance measures, from QI health plans in an aggregate format. Beginning in 2021, MQD implemented a patient-level data file requirement that allows for more granular data collection. This file includes identifiers that allow for linking quality-based outcomes with other beneficiary-level information including demographics, utilization, cost of care, and other metrics.

Other Secondary Data Sources

- **State of Hawai'i Department of Health Office of Health Status Monitoring (OHSM) Vital Statistics Data: "**The Death Data is composed of information extracted from death certificates. State laws require death certificates to be issued for all deaths. Data for death certificates are the most comprehensive source of information on mortality, including cause of death. The information is captured by the Hawai'i State Department of Health, Office of Health Status

Monitoring as part of the National Vital Statistics System in collaboration with the National Center for Health Statistics (NCHS)." (Hawai'i Data Warehouse, n.d.).

- **Relevant Policy Documents and Meeting Notes:** For insights into the implementation of Demonstration interventions, relevant documents and meeting notes are included in qualitative analyses. This includes policy documents (e.g., the State Quality Strategy [MQD, 2023]), along with policy memoranda, detailed implementation scope documents, and official guidance. Furthermore, the evaluation team uses recorded meeting notes and transcriptions from all implementation meetings and stakeholder engagements, offering a direct record of critical decisions and analysis throughout the implementation process.

Primary Data Collection

Data that cannot be gained through the aforementioned data sources will be collected by the evaluators. Particularly, the evaluators will collect qualitative data to gain understanding of the program implementation and beneficiary and provider experience with the Demonstration, through individual interviews and focus groups with beneficiaries, providers, and other stakeholders.

Evaluation Data Sources and Illustrative Measures

Relevant illustrative measures used in this evaluation design by data source are described in **Table III.1.**

Table III.1 Evaluation Data Sources and Illustrative Measures

Data Source	Illustrative Measures	Time period included
Data Sources Housed in the Hawai'i Health Analytics Program (HAP)		
Hawai'i Medicaid (MQD) Administrative Claims and Encounter Data	• Diagnoses • Utilization of services • Cost of care	● Previous demonstration period 2019-2024 and Demonstration period 2025-2029
KOLEA Eligibility and Enrollment Data	• Medicaid application records • Demographics (age, sex, race, ethnicity, geography, etc.) • Eligibility category (Aged, Blind, Disabled; Low Income Adult, etc.) • Enrollment in special programs (LTSS, "at risk," CIS, etc.) • Capitation payment amounts	● Previous demonstration period 2019-2024 and Demonstration period 2025-2029

QI Health Plan Reports	• QI Health Plan Health Care Coordination Services (HCS) Reports (Existing) ○ Functional limitations ○ Self-reported mental and physical health outcomes	● Report implementation year 2024 and Demonstration period 2025-2029
	• QI Health Plan Re-Entry Reports (Needs to be constructed) ○ Pre-release services eligibility and potential eligibility status ○ Pre-release services enrollment and services utilization ○ Post-release services and access	● Demonstration period 2025-2029
	• QI Health Plan CM Reports (Needs to be constructed) ○ CM eligibility and potential eligibility status ○ CM enrollment and services utilization	● Demonstration period 2025-2029
	• QI Health Plan Value-Based Health (VHC) Care Reports (Existing) ○ Implementation of APMs and included providers ○ Beneficiaries' attribution to VHC providers	● Previous demonstration period 2019-2024 and Demonstration period 2025-2029
	• QI Health Plan CIS+ Reports (Existing and revised to reflect new services) ○ CIS+ eligibility and potential eligibility status ○ CIS+ enrollment and services utilization ○ Housing status	● Previous demonstration period 2019-2024 and Demonstration period 2025-2029
	• QI Health Plan Nutrition Intervention Reports (Needs to be constructed) ○ Nutrition intervention eligibility and potential eligibility status ○ Nutrition intervention enrollment and services utilization ○ Nutritional and food security status	● Demonstration period 2025-2029

	• Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report ○ EPSDT visits for Medicaid-eligible infants, youth and participants up to the age of 21	● Demonstration period 2025-2029
Milliman Actuarial Risk Score Data	Risk score that quantifies individuals' relative risk burden	● Demonstration period 2025-2029
QI Health Plan Quality Data	Quality-based outcomes such as the Prevention Quality Indicators in Inpatient Settings (PQI), Plan All-Cause Readmission (PCR), etc.	● Demonstration period 2025-2029
Other Secondary Data		
Death Data	State of Hawai'i Department of Health Office of Health Status Monitoring (OHSM) Vital Statistics Data:	● Demonstration period 2025-2029
Relevant Policy Documents and Meeting Notes	• Policy documents • Policy memoranda • Detailed implementation scope documents • Guidance documents • Meeting notes and transcriptions	● Demonstration period 2025-2029
Primary Data collection		
Qualitative Primary Data Collection	Data on program implementation and beneficiary and provider experience with the Demonstration, including: • Individual (in-depth and semi-structured) interviews • Focus groups	● Demonstration period 2025-2029

Primary Data collection methods

In addition to administrative data this evaluation will conduct primary data collection. Methods of primary data collection will be adapted according to the stage of existing benefits and the emerging implementation of new benefits under the 1115 demonstration. The design of each data collection will be tailored to each project depending on collaboration with stakeholders and the project phase.

Qualitative data collection

Qualitative data will be collected through interviews and focus groups with various stakeholders.

- **Focus groups** are ideal for capturing collective narratives, generating consensus on shared barriers, and exploring group dynamics.

- **In-depth and semi-structured interviews** allow participants to explain their experiences and perceptions in their own words. This method is specifically helpful in including those from hard to reach and vulnerable populations. In depth interviews provide the participant freedom to determine the content of the conversation, while semi-structured interviews generally follow an interview-guide with prompts.

Focus group and interview set-up

- For each interview participant 'type' (e.g. QI health plan representative, MQD staff, provider, beneficiary) an interview guide or focus group guide will be developed. Interview guides and focus group guides provide a structured roadmap of open-ended questions to help facilitators cover key topics while allowing for a natural, deep-dive conversation. They are used to maintain consistency, therefore ensuring that qualitative data is gathered systematically from every participant or group.
- The evaluation team generally conducts interviews and focus groups through video conferencing. Where feasible, in person interviews will be held to promote open interaction. Each interview will be recorded and transcribed verbatim. In cases where recording is not feasible, a note taker will keep records.

Sampling

- **Purposeful sampling** will be used to select participants with the knowledge needed to answer process and content questions involved with the different implementation areas, such as the leads of specific MQD departments or QI Health Plan representatives.
- **Snowball sampling** will be used to include hard to reach populations. For instance, we may ask a provider to put us in touch with other providers. Additionally, the evaluation team may identify potential participants through connections with stakeholders.

Consent

- **All primary data collection methods will include standard consent procedures.** This ensures participants are informed of the study's purpose, their right to withdraw at any time, and the confidentiality of their responses before data collection begins.

Analytic Methods

This evaluation uses a mixed-methods design, thus analytic methods for quantitative and qualitative data will be applied where feasible and appropriate. The analytic methods will be tailored to each project to address the hypotheses and answer the research questions.
Qualitative analytic approaches include content analysis, thematic analysis, context–mechanism–outcome configurations, and implementation mapping. Choice for qualitative analytic methods will vary by research question. The suitable analytic approach will be selected to analyze data from documents, interviews, and focus groups.

- **Content Analysis** (Hsieh & Shannon, 2005)**:** Systematically describes the meaning of qualitative data by categorization. Approaches include conventional (meaning derived directly from the text), directed (starts with theory or framework as a guide for codes), or summative analysis (involves counting and comparisons of codes). All three approaches will be used to interpret the underlying meaning from text.
- **Thematic Analysis** (Braun & Clarke, 2006): Used to identify, analyze, and report patterns (themes) within the data. After initial open coding, related codes are grouped

into broader themes that capture significant aspects of the data relevant to the research questions.

- **Context-Mechanism-Outcome Configurations** (De Weger et al., 2020)**:** Drawing from Realist Evaluation, context–mechanism–outcome configurations are used to explain "what works, how, why, in which contexts, for whom, and to what extent" a program works (or doesn't). It involves identifying the specific Contexts (circumstances, conditions) in which interventions operate, the underlying Mechanisms (resources, reasoning, reactions) that are activated by the intervention, and the resulting outcomes.
- **Implementation Mapping** (Fernandez et al., 2019)**:** A systematic iterative process for developing strategies to improve the adoption, implementation, and maintenance of evidence-based interventions in real-world settings.

Quantitative analytic approaches include descriptive analysis (including trend analysis) to describe the program implementation (over time) and advanced statistical analysis to examine the program impact. For example, logistic regression analysis and Poisson regression analysis will be used to control for factors that could be associated with the outcome, independent of the interventions. In the absence of adequate control groups (and in some cases, comparison groups), the evaluation will rely on quasi-experimental methods, such as difference-in-differences and Interrupted Time Series.

- **Descriptive Analysis** (including Trend Analysis): Summarizes and describes data. It includes calculating measures like means, medians, frequencies, and percentages to describe program implementation. Significance differences of findings between groups are often derived from t-tests.
    - **Trend Analysis:** Specifically looks at how these descriptive statistics change over time, showing patterns or shifts in program activity or beneficiary characteristics.
- **Regression Analysis:** Used to estimate the relationship between a dependent variable and one or more independent variables. Various types of regression analysis are used to account for differences in data type.
    - **Logistic Regression Analysis:** Used when the outcome variable is binary (e.g., enrolled/not enrolled, utilized service/did not utilize). It estimates the probability of an event occurring based on one or more predictor variables, controlling for other factors.
    - **Poisson Regression Analysis:** Used when the outcome variable is a count (e.g., number of ED visits, number of medications filled). It models the relationship between a count outcome and predictor variables.
- **Quasi-experimental Methods:** Used when experimental designs are not feasible. Includes difference-in-differences and interrupted time series.
    - **Difference-in-Differences (DiD):** Compares the change in outcomes over time between a group that participated in a program and a control or comparison group that did not. By accounting for pre-existing trends, the effect of program participation is isolated.
    - **Interrupted Time Series (ITS):** Analyzes a single group (or multiple groups) over a period of time, looking for a significant change in the outcome trend after

the intervention is introduced. It is a robust method for identifying changes in level or slope following an intervention.

For both qualitative and quantitative data analysis, several of the in-depth studies will focus on subgroup analyses to understand in greater depth how beneficiaries from different subgroups (e.g., defined by age, sex, race/ethnicity, language, geography) respond to the initiatives in the Demonstration.

IV. Methodological Limitations

This evaluation aims to assess the program impact of the 2025-2029 Demonstration on improving health outcomes, slowing the rate of health care expenditure growth, reducing costs, and addressing social drivers of health. Several methodological limitations are noted for this evaluation due to the nature of policy evaluation.

One limitation common to policy evaluations is the strength of the statistical comparison. As eligible beneficiaries will be naturally exposed to policies (both under and beyond the Demonstration), the confounding impact from other policies that may affect the outcomes is unavoidable. For example, for beneficiaries eligible and receiving multiple services concurrently (e.g., CM, housing, and nutrition interventions), it's challenging to establish a statistically strong comparison group in order to determine which specific intervention or intervention component leads to observed changes in some outcome measures. For example, beneficiaries eligible and receiving nutrition interventions might also have participated in non-Medicaid support programs, which creates difficulties in identifying causal inference of the impact of HRSN nutrition interventions. In light of this limitation, the evaluator will use quasi-experimental designs to study the effects of real-world practice and implementation. This approach prioritizes understanding what happens in natural settings over creating artificial conditions that would be needed to prove direct cause and effect.

A second limitation is the ability to evaluate the long-term impacts of the Demonstration, such as improving health outcomes and reducing healthcare cost. The timeline of the program implementation might not give enough time to observe these long-term impacts, especially for HRSN interventions that address social needs and the lag time required to observe clinical health outcomes. In order to comprehensively assess the Demonstration impact, the evaluators will incorporate short-term and intermediate outcomes (e.g., access to health care, access to appropriate social services, self-reported health outcomes, etc.), which are hypothesized to lead to the desired long-term impacts.

A third limitation includes limited sample sizes for HRSN and re-entry due to small, dispersed populations. For instance, the re-entry services are implemented through a staggered rollout across nine facilities which means fewer released individuals per facility-quarter than continental states, limiting statistical power for detecting modest effect sizes.

V. Project-Level Detail

The Project-Level Detail section further elaborates on the evaluation design for our Section 1115 Demonstration, breaking down the methodology by distinct programmatic areas. For each program, the evaluation will clearly define the specific research questions and hypotheses that guide our assessment of the Demonstration's effectiveness and impact. This includes identifying the primary outcomes of interest, such as changes in access to care, quality of services, population differences and healthcare costs, as well as process measures related to implementation of the program. The evaluation will outline the chosen data sources and selected analytic approaches.
Each section is structured by first providing a logic model detailing the theory of change, followed by a project-level detail table, providing insight into approaches by hypothesis and research question.
Demonstration Objective 1. Improve Health Outcomes for Medicaid-enrolled Individuals Covered under the Demonstration

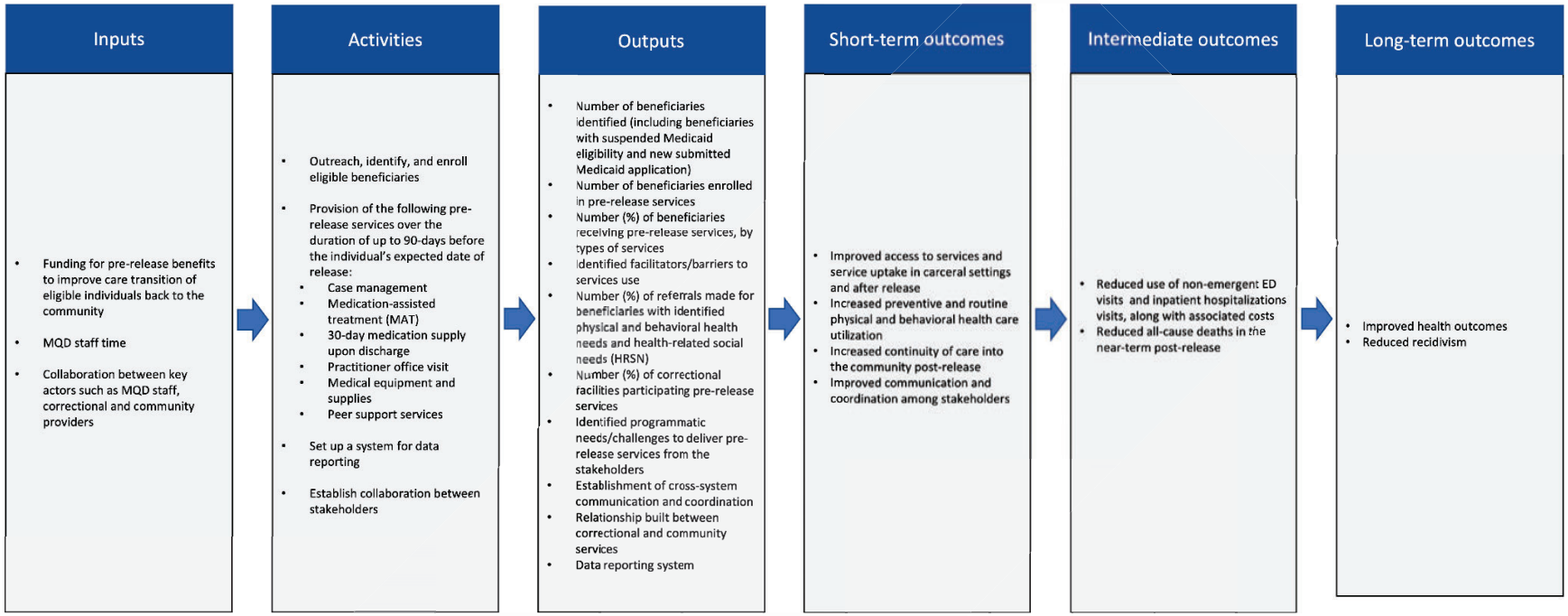
Project 1A: Pre-Release Services under the Reentry Demonstration Initiative

Logic Model

Figure V.1A presents a logic model that details Medicaid program enrollment for incarcerated individuals in a youth correctional facility, jails, and prisons, aiming to improve their health and social outcomes upon reentry into the community. Inputs include setting up funding for Medicaid coverage of pre-release services, MQD staff time, and collaboration among key partners including MQD staff, correctional staff (i.e., jails, prisons, correctional case managers), and community-based provider organizations. Activities involve outreach, identifying eligible beneficiaries, conducting screening and enrollment for pre-release services; provision of pre-release services; setting up a data reporting system; and establishing collaboration between stakeholders. Provision of pre-release services over the duration of up to 90 days prior to release include the following reentry program services, at minimum: case management to assess and address physical and behavioral health needs and health-related social needs (HSRN), medication-assisted treatment (MAT) for substance use disorder as clinically appropriate with accompanying counseling, and a 30-day medication supply provided immediately upon discharge. Additional, optional services that may be provided include: medical equipment and supplies (DME), peer support services, practitioner office visits, and lab and radiology services. Outputs include both quantitative and qualitative measures. Quantitative outputs include the number and percentage of eligible incarcerated individuals identified and enrolled in the reentry program (including beneficiaries with suspended Medicaid eligibility and new submitted Medicaid application), the number and percentage of beneficiaries receiving pre-release services by service type, the number and percentage of referrals made for beneficiaries with identified physical and behavioral health need and HRSNs, and the number and percentage of correctional facilities providing services included in the program. Qualitative outputs include identified facilitators and barriers to service use, identified programmatic needs and challenges to deliver pre-release services from the stakeholders, establishment of cross-system communication and coordination, relationship building between correctional and community services, and components of the data reporting system. Short-term outcomes are expected to include improved

access to services and service uptake in carceral settings and after release, increased preventive and routine physical and behavioral health care utilization, increased continuity of care into the community post-release, and improved communication and coordination among stakeholders. Building upon these short-term gains, intermediate outcomes including decreased use of non-emergent ED visits and inpatient hospitalizations visits and their associated costs and reduced all-cause deaths in the near-term post-release are expected. Ultimately, all components of this reentry Medicaid Enrollment program are designed to achieve the overarching programmatic objectives: improved health outcomes for justice-involved individuals and reduced recidivism.

Figure V.1A Pre-Release Services under the Reentry Demonstration Initiative Logic Model



Analytic Approach

Hawai'i's Medicaid Reentry Program will be implemented across nine correctional facilities (four state jails, four state prisons, and one youth correctional facility) on a staggered schedule contingent on facility readiness, beginning in early 2026 and extending through 2028. Calendar year 2025 serves as a full pre-implementation baseline year during which no facilities delivered Medicaid-funded pre-release services. Thereafter, facilities go live sequentially, after each facility satisfies defined readiness criteria (beginning with at Hawai'i Youth Correctional Facility in 2026, followed by selected prisons and then jails). This phased rollout creates a natural experiment that supports quasi-experimental impact evaluation by providing both within-facility before/after contrasts and between-facility contrasts between early- and later-implementing sites.

As shown in Table V.1A, the impact of pre-release services under the Reentry Demonstration Initiative will be analyzed using both quantitative and qualitative analytic methods. Quantitative approaches will include descriptive statistics and quasi-experimental methods such as DiD and ITS analysis, as data allows. Qualitative analysis will include context-mechanism-outcome

configurations and iterative reflection sessions to study the quality of collaboration, identify facilitators and barriers to service use, ascertain programmatic needs, and understand cross-system communication and coordination, as data allows.

Research question 1A.1 How does the Reentry Demonstration Initiative improve cross-system communication and coordination, and connection between correctional and community services? We will conduct a minimum of 6 semi-structured interviews with correctional staff and community providers, and 3 interviews with MQD staff to probe perceived collaboration and ongoing coordination, such as joint protocols and referral efficiency and existing connections between correctional and community services. Interviews will be conducted in the first year of implementation and the final year of implementation. Interviews will capture individual perspectives on sensitive topics over time. Additional interviews or focus groups with stakeholders will be conducted to achieve saturation if needed. We will explore context–mechanism–outcome explanations across urban and rural settings as well as jails and prisons. The evaluation team will use purposive sampling for the inclusion of interview participants. Coordination and collaboration documents will be collected through MQD staff, stakeholder meetings and snowball sampling.

Research question 1A.2a How are beneficiaries identified and enrolled in pre-release services? We include both qualitative measures and quantitative measures to examine how beneficiaries are identified and enrolled in pre-release services. At least one interview per correctional facility (9 interviews in total) will be conducted with correctional facility staff and pre-release case managers to identify strategies and tools developed during the demonstration to identify and enroll beneficiaries in pre-release services and explore barriers, facilitators, and contextual factors during the process. KOLEA Eligibility and enrollment data will be used to determine identification and enrollment. QI Health Plan Re-Entry Reports will be used to extract and describe the number of beneficiaries outreached, number of beneficiaries with suspended Medicaid coverage, number of Medicaid application support for newly eligible individuals, percentage of individuals found eligible for Medicaid among the incarcerated population and number of beneficiaries enrolled in pre-release services. Quantitative results will be stratified by facility type, geography, race/ethnicity, length of days (under 30 days, 30 to 59 days, or 60 to 89, and 90 days) before expected release date.

Research question 1A.2b Does the implementation of pre-release services improve access to services and services uptake among beneficiaries in the carceral setting?
Quantitative analysis of MQD Administrative Claims and Encounter Data and KOLEA Eligibility and Enrollment Data will describe the number and percentage of enrolled beneficiaries who receive pre-release services prior to release, including diagnostic/lab and radiology services, case management, medication-assisted treatment (MAT), practitioner office visits, medical equipment and supplies, and peer support services. Through QI Health Plan Reentry reports we will also assess the number of beneficiaries with identified physical and behavioral health needs and health-related social needs (HRSNs), the number and percentage of referrals made to address those needs. Outcomes for participating beneficiaries will be compared with individuals released from similar facilities that are not yet participating in the reentry demonstration initiative. Findings will be stratified by facility type (jail, prison, or youth facility), geography (O‘ahu compared with neighbor islands), race and ethnicity, and time

between service initiation and expected release date.
Depending on data availability and sample sizes, we will use ITS analysis, a quasi-experimental method, to examine changes in access to services and services uptake. Monthly counts of individuals accessing services (e.g., screenings, enrollments, care plans) are identified from MQD Administrative Claims and Encounter Data establishing using pre-implementation trends as the baseline. The waiver rollout will be treated as the "interruption," or key change point, examining whether access increases right away and whether it continues to grow over time. If the available data do not permit this type of analysis (i.e., due to low sample sizes), descriptive statistics will be used to demonstrate access for pre-and post-waiver rollout. Qualitative interviews with correctional facility staff and case managers described above will explore key facilitators and barriers influencing service use among pre-release service beneficiaries.

Research question 1A.3a Are pre-release services beneficiaries with identified physical and behavioral health needs and HRSNs connected to supports after release?

A quantitative approach will be used to determine whether pre-release services beneficiaries with identified physical and behavioral health needs and HRSNs are connected to supports after release. Key outcomes include the number and percentage of enrolled beneficiaries who receive a 30-day medication supply at discharge; the number and percentage of beneficiaries referred for HRSNs who receive corresponding services within 30 days, 3 months, and 6 months post-release; continuity of medication-assisted treatment (MAT) among beneficiaries who received MAT prior to release within the same post-release timeframes; and the number and percentage of beneficiaries with a scheduled post-release appointment documented prior to release. Outcomes for pre-release services beneficiaries will be compared with individuals released from comparable facilities that are not, or not yet, participating in the reentry demonstration initiative. Analyses will be stratified by facility type, geography, race and ethnicity, and the length of time between service initiation and expected release date. Data will be drawn from MQD Administrative Claims and Encounter Data, KOLEA Eligibility and Enrollment Data, and QI Health Plan Re-Entry Reports, and analyzed using DiD models, with ITS and subgroup models incorporating interaction terms implemented as appropriate.

Research question 1A.3b What are the experiences among beneficiaries and providers related to continuity of care into the community after release?

We will use a qualitative approach to explore the experiences of beneficiaries and providers related to continuity of care as individuals transition from carceral settings into the community following release. Semi-structured interviews with pre-release services beneficiaries will examine perceived experiences with care coordination, including their sense of connection to services, providers, and support in the community. Interviews with correctional and community-based providers will focus on their perspectives on the processes, challenges, and facilitators involved in transitioning beneficiaries to community-based care. We are not yet able to determine the number of community-based providers. We will use a snowballing sampling strategy, identifying community-based providers for interviews through the case managers involved in pre-release services. Analyses will consider variations by facility type, geography, and race and ethnicity. Interview data will be analyzed using thematic analysis guided by a framework approach to identify common themes and contextual factors influencing continuity of

care after release.

Research question 1A.4 Are pre-release eligible beneficiaries who have a longer length of days incarcerated before expected release date more likely to be enrolled in Medicaid and receive pre-release services compared to those with shorter durations?

We will assess the likelihood of Medicaid enrollment and receipt of pre-release services among beneficiaries with the maximum enrollment of 90 days before release compared with those whose expected release dates fall under 30 days, 30–59 days, or 60–90 days through analyses drawing on MQD Administrative Claims and Encounter Data, QI Health Plan Re-Entry Reports and KOLEA Eligibility and Enrollment Data. Analyses will include descriptive statistics and multivariate regression models controlling for demographics, facility type, and prior Medicaid eligibility to assess the association between length of time before release and enrollment and service receipt.

Research question 1A.5a Is receiving pre-release services associated with increased preventive and routine physical and behavioral health care use among beneficiaries?
Research question 1A.5b Is receiving pre-release services associated with reduced non-emergent ED visits and inpatient hospitalization visits and their associated costs among beneficiaries?
Research question 1A.5c Is receiving pre-release services associated with reducing all-cause deaths in the near-term post-release?

This set of research questions will be answered through a quantitative approach. Analyses will assess whether pre-release services are associated with increased use of preventive and routine physical and behavioral health care, measured by follow-up primary care visits and continuity of behavioral health services within 30, 90 and 180 days post-release; reduced non-emergent emergency department visits, inpatient hospitalizations for preventable or ambulatory care–sensitive conditions, and related costs; and reductions in all-cause mortality in the near-term post-release period (0–30 days, 30–90 days, and within 365 days). Outcomes for pre-release services beneficiaries released from participating facilities will be compared with individuals released from comparable facilities not yet participating in the reentry demonstration initiative. Analyses will be stratified by facility type, geography, race and ethnicity, and time before expected release date, using data from MQD Administrative Claims and Encounter Data, KOLEA Eligibility and Enrollment Data, QI Health Plan Re-Entry Reports, and state death records. DiD models will be employed, with subgroup analyses incorporating interaction terms and ITS analyses conducted as needed to assess temporal effects.

Table V.1A Pre-Release Services under the Reentry Demonstration Initiative

Project 1A Pre-Release Services under the Reentry Demonstration Initiative				
Research Question	**Outcome Measures Used to Address the Research Question**	**Sample or Population Subgroups to Be Compared**	**Data Sources**	**Analytic Methods**
Hypotheses 1A.1 The Reentry Demonstration Initiative will result in improved cross-system communication and coordination between stakeholders.				
Research question 1A.1 How does the Reentry Demonstration Initiative improve cross-system communication and coordination, and connection between correctional and community services?	• MQD's engagement with stakeholders, including correctional and community services providers • Description of mechanisms for communication, collaboration, and coordination between stakeholders operate in different contexts • Changes in collaborative structures over time	• Stakeholders involved pre-release services implementation, including MQD, correctional facilities, community services providers, and health plans. Subgroup analyses by urban/rural; facility types	• Minimum of 6 semi-structured interviews with correctional facility staff and community service providers, and 3 MQD staff at the beginning and end of the implementation • Documents on collaboration and coordination	• Thematic analysis of qualitative interviews using framework approach • Context-mechanism-outcome configurations
Hypotheses 1A.2 Pre-release services will increase enrollment of eligible Individuals and improve access to high-quality services and services uptake in carceral settings.				
Research question 1A.2a How are beneficiaries identified and enrolled in pre-release services?	• Strategies and tools developed to identify and enroll beneficiaries • Screening barriers and facilitators	• Correctional facility staff • Pre-release services case managers • Eligible beneficiaries Subgroups: Facility type (jail	• Interviews with correctional facility staff and case managers	• Descriptive analysis • Thematic analysis of qualitative interviews

	• Contextual factors (e.g., staff training, screening tools) that trigger mechanisms (e.g., participant disclosure of needs) • Number of beneficiaries outreached • Number of beneficiaries with suspended Medicaid coverage • Number of Medicaid application support for newly eligible • % of individuals found eligible for Medicaid among incarcerated population • Number of beneficiaries enrolled in pre-release services	vs. prison vs. youth); geography (Oahu vs. neighbor islands); race/ethnicity; length of days before expected release date under 30 days, 30 to 59 days, or 60 to 90 days	• QI Health Plan Re-Entry Reports • KOLEA Eligibility and Enrollment Data	using framework approach

Research question 1A.2b Does the implementation of pre-release services improve access to services and services uptake among beneficiaries in the carceral setting?	• Number (%) of enrolled beneficiaries receiving pre-release services before release, by types of services
	  ○ Diagnostics/lab and Radiology services
	  ○ Case management
	  ○ Medication-assisted treatment (MAT)
	  ○ Practitioner office visit
	  ○ Medical equipment and supplies
	  ○ Peer support services
	• Number of beneficiaries with identified physical and behavioral health needs and HRSNs
	• Number (%) of referrals made for beneficiaries with identified physical and behavioral health needs and HRSNs
	• Identified facilitators/barriers to services use
		Pre-release services beneficiaries
		
		Comparison groups: Individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration initiative.
		
		Subgroups: Facility type (jail vs. prison vs. youth); geography (Oahu vs. neighbor islands); race/ethnicity; different length of days before expected release date under 30 days, 30 to 59 days, or 60 to 90 days
			• QI Health Plan Re-Entry Reports
			• MQD Administrative Claims and Encounter Data
			• Semi-structured interviews with eligible beneficiaries
			• Semi-structured provider interviews
				• Descriptive analysis
				• ITS to examine changes in access to services and services uptake before and after pre-releases services implementation
				• Thematic analysis of qualitative interviews using framework approach

Hypotheses 1A.3 Pre-release services will improve connections between correctional and community services, access to and quality of care in community settings after release, resulting in improved continuity of care into the community.				

Research question 1A.3a Are pre-release services beneficiaries with identified physical and behavioral health needs and HRSNs connected to supports after release?	• Number (%) of enrolled beneficiaries receiving 30-day medication supply upon discharge • Number (%) of beneficiaries referred to HRSNs receiving HRSNs services within 30, 90 and 180 days post-release • Number (%) of beneficiaries who received MAT before release receiving MAT within 30, 90 and 180 days post-release; • Number (%) beneficiaries with scheduled post-release appointment documented pre-release;	Pre-release services beneficiaries released from facilities **Comparison groups**: individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration initiative. Subgroups: Facility type (jail vs. prison vs. youth); geography (Oahu vs. neighbor islands); race/ethnicity; different length of days before expected release date under 30 days, 30 to 59 days, or 60 to 90 days	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • QI Health Plan Re-Entry Reports	• DiD models, as described above ITS models will also be implemented as needed • Subgroup DiD models with interactional terms
Research question 1A.3b What are the experiences among beneficiaries and providers related to continuity of care into the community after release?	• Beneficiaries' perceived experience with care coordination, sense of connection and support • Correctional and community providers' perceived experience in transitioning beneficiaries into the community	Pre-release services beneficiaries released from facilities Correctional and community providers Subgroups: Facility type (jail vs. prison vs. youth); geography (Oahu vs. neighbor islands); race/ethnicity	• Semi-structured interviews with beneficiaries and provider interviews	• Thematic analysis of qualitative interviews using framework approach
Hypothesis 1A.4 Providing re-release services for up to 90-days coverage period before the individual's expected date of release will improve the state's ability to plan for and provide pre-release services.				

Research question 1A.4 Are pre-release eligible beneficiaries who have a longer length of days incarcerated before expected release date more likely to be enrolled in Medicaid and receive pre-release services compared to those with shorter durations?	• Number (%) of enrolled pre-release beneficiaries among all incarcerated population • Number of pre-release services received by beneficiaries • Number (%) of Medicaid enrollment following release	Pre-release services beneficiaries with the maximum 90 days of enrollment **Comparison group**: Pre-release services beneficiaries with length of days before expected release date under 30 days, 30 to 59 days, or 60 to 90 days	• MQD Administrative Claims and Encounter Data • QI Health Plan Re-Entry Reports • KOLEA Eligibility and Enrollment Data	• Descriptive analysis • Multivariate regression analysis controlling demographics, facility type, and previous Medicaid eligibility
Hypothesis 1A.5 Pre-release services will increase preventive and routine physical and behavioral health care use, reduce non-emergent ED visits and inpatient hospitalizations visits and associated costs, and decrease all-cause deaths in the near-term post-release.				
Research question 1A.5a Is receiving pre-release services associated with increased preventive and routine physical and behavioral health care use among beneficiaries?	• Number (%) of beneficiaries with follow-up primary care visit within 30, 90 and 180 days post-release • Among beneficiaries receiving behavioral care services pre-release, number (%) of beneficiaries receiving behavioral health care services within 30, 90 and 180 days post-release	Pre-release services beneficiaries released from facilities **Comparison groups**: individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration initiative. Subgroups: Facility type (jail vs. prison vs. youth); geography (Oahu vs. neighbor islands); race/ethnicity; different length of days before expected release date under 30 days, 30 to 59	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • QI Health Plan Re-Entry Reports	• DiD • Subgroup analysis using Interaction terms in DiD models • If needed ITS

		days, or 60 to 90 days		
Research question 1A.5b Is receiving pre-release services associated with reduced non-emergent ED visits and inpatient hospitalization visits and their associated costs among beneficiaries?	• ED visit count/rate per 100 releases (30-90 days); hospitalization count/rate, focusing on preventable/ambulatory-care sensitive conditions; • Cost of care for ED visits • Cost of care for hospitalizations	Pre-release services beneficiaries released from facilities **Comparison groups**: individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration initiative. Subgroups: Facility type (jail vs. prison vs. youth); geography (Oahu vs. neighbor islands); race/ethnicity; different length of days before expected release date under 30 days, 30 to 59 days, or 60 to 90 days		• DiD • Subgroup analysis using Interaction terms in DiD models • If needed ITS
Research question 1A.5c Is receiving pre-release services associated with reducing all-cause deaths in the near-term post-release?	• All-cause death post-release (0-30, 30-90, 365-day windows)	Pre-release services beneficiaries released from facilities **Comparison groups**: individuals released from comparable facilities that are not, or not yet participating in the in the reentry demonstration initiative. Subgroups: Facility type (jail vs. prison vs. youth); geography (Oahu vs. neighbor islands); race/ethnicity; length of days	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • QI Health Plan Re-Entry Reports • State death data	• DiD • Subgroup analysis using Interaction terms in DiD models • If needed ITS

		before expected release date under 30 days, 30 to 59 days, or 60 to 90 days		

Project 1B: Contingency Management (CM) Services

Logic Model

Figure V.1B presents a logic model that illustrates a program delivering CM services for OUD and StimUD, moving from initial resources to improved health outcomes. The inputs include the MQD as the provider of essential resources and incentives for CM implementation. Activities detail the initiative's operational steps: recruiting and training CM providers, hiring a provider for beneficiary tracking and payments, and identifying eligible individuals.

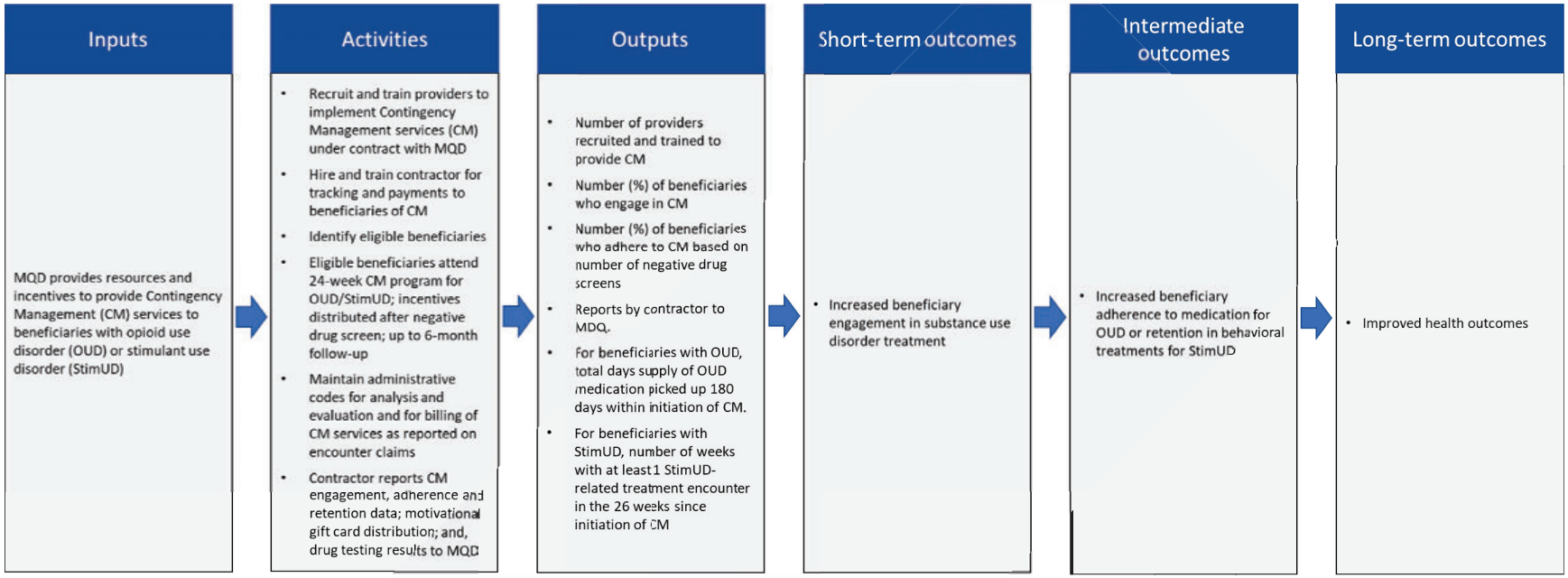
The core intervention involves a 24-week CM program for beneficiaries. The evaluation will be conducted on a sample of beneficiaries who meet the eligibility criteria for CM services and received services, vs. those that met eligibility criteria and did not receive services. The eligibility criteria for CM services are:

- Be assessed and determined by qualifying providers to have a qualifying SUD for which CM is medically necessary and appropriate based on the fidelity of treatment to the evidence-based intervention.
- The presence of additional substance disorders and/or diagnoses shall not disqualify an individual from receiving CM;
- Not be enrolled in another CM program for SUD; and
- Receive services from an eligible provider that offers CM in accordance with the State laws, policies, procedures, and guidance.

Among those enrolled in the program, incentives are distributed after negative drug screens, followed by up to six months of follow-up. Administrative codes are maintained for analysis, evaluation, and billing. The provider provides regular reports to MQD, covering engagement, adherence, retention data, gift card distribution, and drug test results. The outputs include the number of recruited and trained CM providers, and the number and percentage of beneficiaries who engage in CM. Adherence rates are measured by the number and percentage of beneficiaries with negative drug screens. The provider's reports to MQD are necessary to measure results and serve as a key output. For OUD beneficiaries, the total days' supply of medication for OUD treatment picked up within 180 days is tracked. For StimUD beneficiaries, number of weeks with at least one treatment encounter over the 24-week CM service provision and a subsequent 2-week monitoring period.

These outputs are expected to lead to short-term outcomes, specifically increased beneficiary engagement in SUD treatment. Further along the chain, intermediate outcomes represent sustained changes. For OUD, this means increased beneficiary adherence to medication. For StimUD, it translates to improved retention in behavioral treatments. Both outcomes signify sustained commitment to treatment. Long-term outcomes aligned with the 1115 Demonstration objectives are improved health outcomes for beneficiaries, encompassing reduced substance use and enhanced overall well-being.

Figure V.1B CM Services



Analytic Approach:

Table V.1B describes the analytic methods used to test the hypothesized relationship between the provision of Contingency Management (CM) to beneficiaries with Substance Use Disorders (SUDs) and health and services outcomes. These relationships will be analyzed using descriptive statistics, logistic regression analysis, and regression analysis. Appropriate statistical techniques, such as propensity score matching, will be applied to address potential selection bias.

Research Question 1B.1a Does CM increase engagement in substance use treatment?

The short-term outcome of SUD treatment engagement will be examined to assess whether CM increases individual treatment engagement. The analysis will utilize descriptive statistics and logistic regression analysis to compare rates of engagement (yes/no) between beneficiaries who enrolled in CM and those who were eligible but did not enroll. Appropriate statistical techniques will be applied to address potential selection bias.

Research Question 1B.2a Does CM increase adherence to or retention in substance use treatment?

Intermediate outcomes of adherence and retention to treatment will be used to evaluate Research Question 1B.2a. Adherence and retention are operationalized according to the type of SUD, specifically Opioid Use Disorder (OUD) versus Stimulant Use Disorder (StimUD). The analysis will involve descriptive statistics and regression analysis comparing the Proportion of Days Covered (PDC) or Proportion of Weeks Treated (PWT) between beneficiaries who enrolled in CM and those who were eligible but did not enroll. Appropriate statistical techniques will be applied to address potential selection bias.

Research Questions 1B.2b and 2c What is the cost of services associated with the CM program?; What is the cost of services associated with the CM program?

The cost of CM incentives will be quantified as the cost of drug tests administered to determine incentive eligibility and the cost of incentives paid out for negative drug tests. For each month of the evaluation period, descriptive statistics will be used to calculate the total cost and per-beneficiary cost of the CM incentives, including a $10 administrative fee per test. Additionally, the cost of services associated with the CM program will be quantified as the cost of services delivered in encounters involving the treatment of SUD. Descriptive statistics will be used to calculate the total cost of treatment services related to an SUD diagnosis.

Table V.1B CM Services

Project 1B CM Services				
Research Question	**Outcome Measures Used to Address the Research Question**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Hypotheses 1B.1 Increasing the availability of CM will increase the number of Medicaid beneficiaries engaged in treatment for SUDs.				
Research question 1B.1a Does CM increase engagement in substance use treatment?	• The outcome is Engagement (yes/no), defined as two or more services related to OUD/ StimUD diagnosis within 30 days of the initial CM program visit	• Beneficiaries who meet the eligibility criteria for the CM program during the Demonstration	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data	• Descriptive statistics • Logistic regression analysis comparing rates of engagement (yes/no) between beneficiaries who enrolled in CM and those who were eligible but did not enroll in CM. Appropriate

		period (2025-2029)	• QI Health Plan HCS reports • QI Health Plan CM reports I	statistical techniques will be applied to address potential selection bias (e.g., propensity score matching)
Hypothesis 1B.2 Participation in CM among Medicaid beneficiaries with SUDs will increase adherence to and retention in SUD treatment.				
Research question 1B.2a Does CM increase adherence to or retention in substance use treatment?	• Adherence to OUD treatment will be quantified as Proportion of Days Covered (PDC) = total days supply of medication picked up/180-day follow-up period • Retention in StimUD treatment will be quantified as the Proportion of Weeks in Treatment (PWT) = number of weeks with at least 1 StimUD-related treatment encounter/26 weeks of follow-up. If the patient's diagnosis is updated to "in remission" the follow-up period will be adjusted accordingly	• Beneficiaries who meet the eligibility criteria for CM during the Demonstration period (2025-2029)	• MQD Administrative Claims and Encounter Data • MQD Administrative KOLEA Eligibility and Enrollment Data • QI Health Plan HCS reports • QI Health Plan CM reports	• Descriptive statistics • Regression analysis comparing PDC/PWT between beneficiaries who enrolled in CM and those who were eligible but did not enroll in CM. Appropriate statistical techniques will be applied to address potential selection bias (e.g., propensity score matching)
Research question 1B.2b What is the cost of providing CM incentives?	• The cost of CM incentives will be quantified as the cost of drug tests administered to determine incentive eligibility and the cost of incentives paid out for negative drug tests.	• Beneficiaries enrolled in the CM program during the Demonstration period (2025-2029)	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data	• Descriptive statistics: for each month of the evaluation period the total cost and per/beneficiary cost of the CM incentives (+ admin fee of $10/test) will be calculated.
Research question 1B.2c What is the cost	• The cost of services associated with the CM program will be quantified as the cost of services	• Beneficiaries enrolled in the CM program	• MQD Administrative	• Descriptive statistics: the total cost of treatment services related

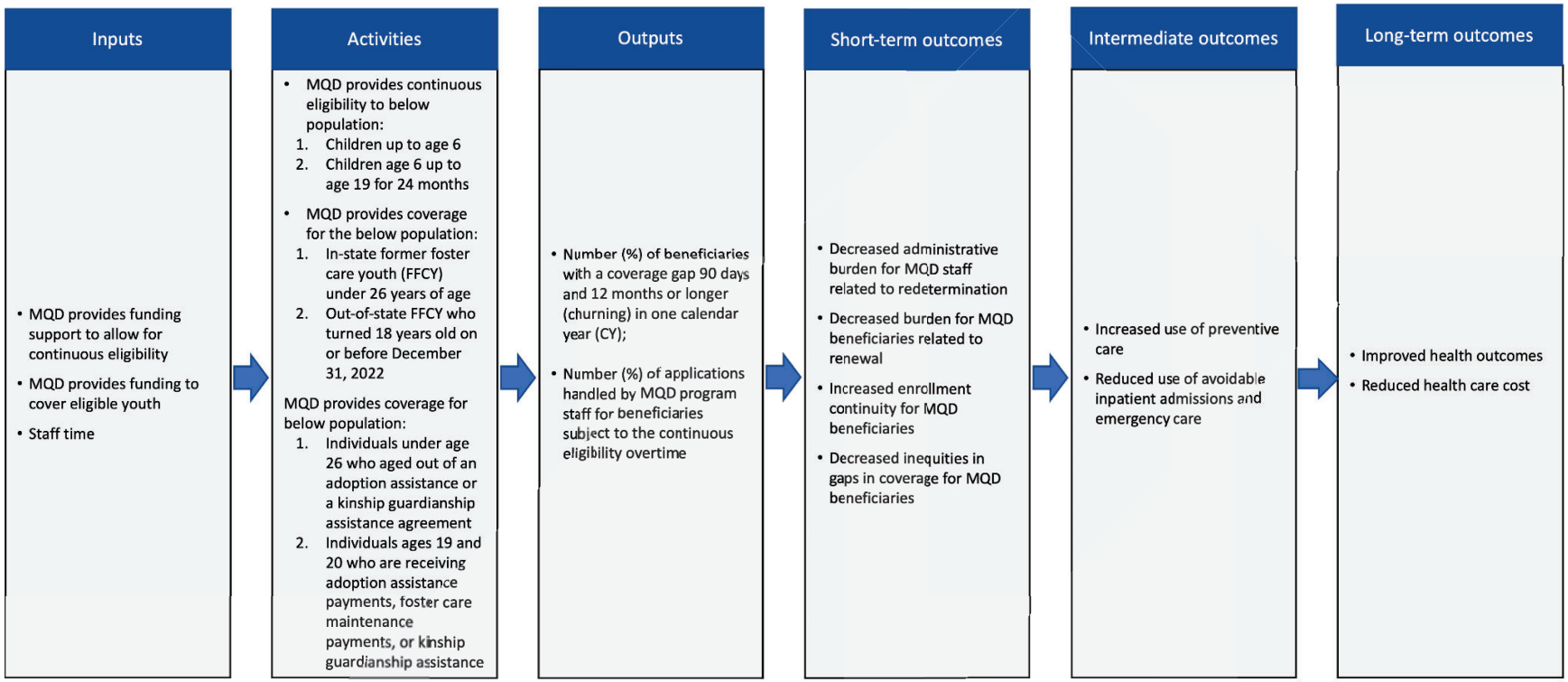
of services associated with the CM program?	delivered in encounters that involved treatment of SUD	during the Demonstration period (2025-2029)	Claims and Encounter Data • KOLEA Eligibility and Enrollment Data	to SUD diagnosis will be calculated.

Project 1C: Continuous Eligibility for Medicaid Children and Coverage for Former Foster Care Youth (FFCY) and Youth Aged Out from Adoption System/Kinship Guardianship System

Logic Model

Figure V.1C presents a logic model that outlines the Continuous Eligibility program's aim to provide stable Medicaid coverage. Inputs include funding for continuous eligibility for children, coverage for eligible youth and staff time. Key Activities involve MQD extending continuous eligibility for children (up to age 6, and 6-19 for 24 months), and to specific FFCY (under 26, both in-state and out-of-state), as well as young adults (under age 26) who aged out of adoption/kinship guardianship or are currently receiving related payments. The output is that eligible children and youth are successfully enrolled under this policy. These efforts are expected to result in short-term outcomes: a reduced administrative burden for MQD staff and beneficiaries related to redeterminations, leading to increased enrollment continuity for beneficiaries. This is also expected to translate to decreased inequities in healthcare coverage gaps. Intermediate outcomes include an increased use of preventive care and a reduction in potentially avoidable inpatient admissions and emergency room visits, indicating more efficient and appropriate healthcare utilization. Long-term outcomes contribute to the objectives of improved overall health outcomes for the covered populations, and a reduction in associated healthcare costs while reducing inequities.

Figure V.1C Continuous Eligibility for Medicaid Children and Coverage for Former Foster Care Youth (FFCY) and Youth Aged Out from Adoption System/Kinship Guardianship System



Analytic Approach

As shown in **Table V.1C,** the relationship between the implementation of continuous eligibility and outputs of churn and administrative burden for MQD staff will be analyzed quantitatively through descriptive statistics, trend analysis, and ITS. Appropriate statistical techniques will be applied to address potential selection bias (e.g., trend analysis, ITS analysis).

Research question 1C.1a How does continuous eligibility streamline eligibility determination/ redetermination and enrollment for beneficiaries?

We will conduct semi-structured interviews or focus groups with MQD program staff and vendors who are involved in eligibility determination and redetermination, to understand policy change and its influence on determination/ redetermination and enrollment for beneficiaries. We will use a snowball sampling methodology to recruit participants. In total, six to eight interviews or focus groups will be conducted in 2027. The interviews will be analyzed using thematic analysis method.

Research question 1C.1b Does continuous eligibility improve enrollment continuity and reduce churning among beneficiaries?

Research question 1C.1c Does continuous eligibility lower administrative burden and associated costs for eligibility workers?

Research question 1C.2 How does continuous eligibility affect beneficiaries' utilization of preventive care, potentially avoidable inpatient admissions and emergency care, and the expenditure growth among beneficiaries? Particularly, how does 24-month continuous eligibility for children age 6 to 19 affect beneficiaries' utilization of preventive care, compared to 12-month continuous eligibility (federal minimum requirement)?

The above three research questions will be answered through quantitative approaches. The target population will be beneficiaries subject to the continuous eligibility and coverage policy changes, including (1) Medicaid children under 6 years old; (2) Medicaid children ages 6 to 19 years old; (3) FFCY who are under 26 years of age (including out-of-state FFCY who turned 18 years old on or before December 31, 2022); (4) Youth under 26 who aged out from adoption system/kinship guardianship system; and (5) Youth age 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance. For each of the above populations, trend analysis and ITS analysis will be conducted to investigate listed outcome measures below, specifically focusing on the trend before the implementation of continuous eligibility and after. As continuous eligibility policy for each population was implemented at different times, five years of pre- and post-implementation data will be analyzed for each population, respectively.

For subgroup analysis, we will also examine distribution of continuous eligibility among different groups by age, sex, race/ethnicity, region, and language.

Table V. 1C Continuous Eligibility for Medicaid Children and Coverage for Former Foster Care Youth (FFCY) and Youth Aged Out from Adoption System/Kinship Guardianship System

Project 1C Continuous Eligibility for Medicaid Children and Coverage for FFCY and Youth Aged Out from Adoption System/Kinship Guardianship System				
Research Question	**Outcome Measures Used to Address the Research Question**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Hypotheses 1C. Continuous eligibility will improve enrollment continuity, reduce the quantity of redeterminations and churn among beneficiaries, including for racial and ethnic minorities with disproportionately high rates of churn, resulting in lower administrative burden for eligibility workers and associated costs.				
Research question 1C.1a How does continuous eligibility streamline eligibility determination/ redetermination	• Description of eligibility determination and redetermination process	MQD program staff and other stakeholders involved in eligibility determination and redetermination	• Semi-structured interviews	Qualitative analysis of documents and interviews/focu

and enrollment for beneficiaries?			• Focus groups • State policy documents (e.g., the State Plan Amendments)	s groups (thematic analysis) to understand policy change and its influence
Research question 1C.1b Does continuous eligibility improve enrollment continuity and reduce churning among beneficiaries?	• Number (percent) of beneficiaries with a coverage gap 90 days or longer (churning) in one calendar year (CY) • Number (percent) of beneficiaries who disenrolled and re-enrolled within 12 months • Number (percent) of beneficiaries remaining enrolled at the 12th, 18th, and 24th month	• Beneficiaries subject to continuous eligibility policy • Comparison by demographics (age, sex, race/ethnicity, region, language), before and after implementation of continuous eligibility policy changes	KOLEA Eligibility and Enrollment Data	• Descriptive statistics • Trend analysis to look at the trends of enrollment continuity and churning over time. • ITS to compare the trends of enrollment continuity and churning before and after the Demonstratio n
Research question 1C.1c Does continuous eligibility lower administrative burden and associated costs for eligibility workers?	• Number (percent) of applications handled by MQD program staff for beneficiaries subject to the continuous eligibility policy over time	• Beneficiaries subject to the continuous eligibility policy • Comparison by demographics (age, sex, race/ethnicity, region,	KOLEA Eligibility and Enrollment Data	• Descriptive statistics • Trend analysis to look at the trends of administrative

		language), before and after the implementation of continuous eligibility		burden and associated cost overtime • ITS to compare the trends of administrative burden and associated cost before and after the demonstration
Hypothesis 1C.2 By improving enrollment continuity, continuous eligibility will increase the utilization of preventive care, reduce the utilization of potentially avoidable inpatient admissions and emergency care, and slow down the expenditure growth among beneficiaries.				
Research question 1C.2 How does continuous eligibility affect beneficiaries' utilization of preventive care, potentially avoidable inpatient admissions and emergency care, and the expenditure growth among beneficiaries? • How does 24-month continuous eligibility for children age 6 to 19 affect beneficiaries' utilization of preventive care, compared to 12-month continuous eligibility (federal minimum requirement)?	• Well child visit and adolescent well-care visit rates • EPSDT screening rates • ED visits and rates • Hospitalization visits and rates • Inpatient Prevention Quality Indicators (PQIs) • Total cost of care • Cost of care for ED visits • Cost of care for hospitalizations	• Beneficiaries subject to continuous eligibility policy • Comparison by demographics (age, sex, race/ethnicity, region, language), before and after the implementation of continuous eligibility	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • QI Health Plan EPSDT Report	• Descriptive statistics • Trend analysis of the aggregated outcomes among beneficiaries overtime • ITS to compare the aggregated outcomes before and after the demonstration

Demonstration Objective 2. Maintain a Managed Care Delivery System that Leads to More Appropriate Utilization of the Healthcare System and a Slower Rate of Expenditure Growth

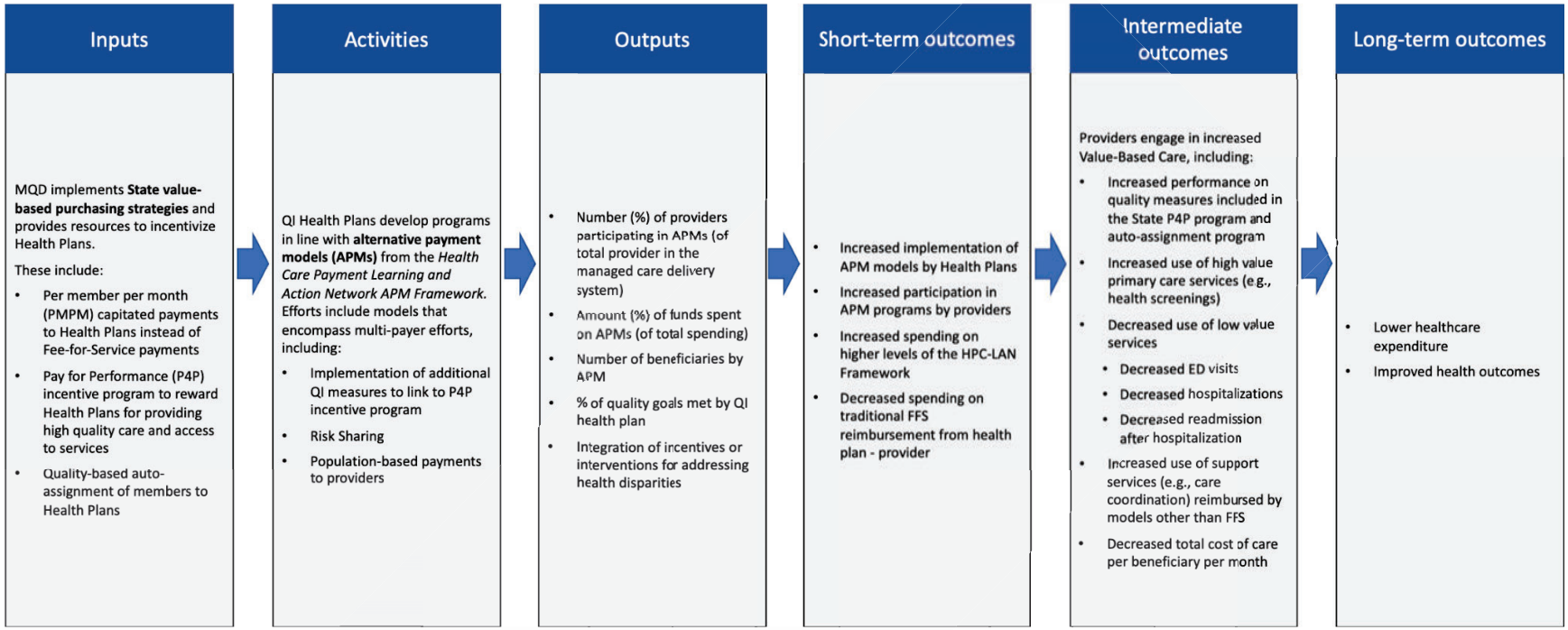
Project 2: Value-Based Purchasing and Alternative Payment Models (APMs)

Logic Model

Figure V.2 presents a logic model that explains the mechanisms through which the State value-based purchasing policy is intended to lead to lower health care expenditure and improved health outcomes. The policy encompasses multiple strategies aimed at incentivizing and supporting the adoption of APMs by QI health plans. Inputs include State value-based purchasing strategies from MQD to develop these APMs, including [1] replacing fee-for-service payments with advanced per member per month capitated payments; [2] providing financial incentives for providing high quality care and access to services by meeting selected quality measure performance goals; and, [3] the auto assignment program assigning new beneficiaries to health plans based on their quality performance. The current auto assignment program contains a 70% quality component and quality measures are focused on primary care, behavioral health, and chronic disease management. These initiatives encourage QI health plans to develop programs and advance providers along the APM continuum.

Inputs and activities are measured by examining outputs including provider participation rates, proportion of funds spent in APMs, number of active programs that correspond to APM initiatives, and identifying programs that integrate interventions or incentives for addressing health disparities. State value-based purchasing strategies should result in short-term outcomes including increased implementation of advanced APMs and a corresponding increase in providers participating in such programs. The goal of the state's value-based payment strategy is to increase provider attribution to advanced HCP-LAN Level 3 and 4 APMs. These advanced APMs are expected to have a stronger impact on multiple healthcare outcomes compared to attribution to a lower level (2 pay-for-performance) APM or no attribution. Care that falls under advance APMs is expected to impact intermediate outcomes such as increasing performance on quality measures such as ED visits, hospitalizations, readmission after hospitalization increasing high value services/decreasing low value services, and increasing the utilization of appropriate services for beneficiaries (as expressed by primary care defined in the 2019-2024 1115 demonstration waiver), ultimately resulting in long-term outcomes including lowering healthcare expenditures and improving health outcomes for beneficiaries.

Figure V.2 Value-Based Purchasing and APMs



Analytic Approach

As shown in **Table V.2**, the relationship between the State value-based purchasing strategies and the expansion of APMs implemented by QI health plans will be qualitatively analyzed through document review of MQD policies and communications, thematic analysis, and implementation mapping of motivations and mechanisms leading up to changes in implemented APMs amongst QI health plans derived from interviews and focus groups. Associations between beneficiary attribution to advanced APMs and healthcare utilization, healthcare outcomes and cost will be tested through regression analysis.

Research question 2.1a What changes were made by QI health plans to their APMs?

To assess changes in QI health plans' APMs over the demonstration period, the evaluation will use a qualitative and trend-based analytic approach. Qualitative descriptors from QI Health Plan Value-Based Health Care (VHC) Reports will be used to describe the

APMs implemented by

each health plan and to examine changes over time with additional insights gained through interviews with healthcare providers participating in APMs. Six semi-structured interviews and/or two focus groups with QI health plan leaders and six semi-structured interviews with Medicaid providers will be used to gain detail on the implemented APMs, as the qualitative descriptive information on APM implementation available in VHC Health Plan reports alone is limited and the previous 1115 demonstration evaluation identified needs for further qualitative insights from QI health plans.

VHC Reports include structured data submissions by health plans that provide attribution of individual beneficiaries to APMs as well as provider attribution to APMs; from these reports we can derive the number of participating providers, attributed beneficiaries, and associated expenditures. Specifically, provider participation, provider and beneficiary attribution, and the distribution of APMs across HCP-LAN framework categories will also be described based on the VHC Health Plan reports.
Information on the percent of quality goals met will be drawn from MQD internal documentation, which includes aggregate results of health plan performance on quality measures. Trend analyses will be conducted to assess whether advancements toward more sophisticated APM arrangements occurred, including the expansion of risk-sharing and population-based payment models and increased inclusion of providers and beneficiaries at higher APM levels. Overall, qualitative content analysis of VHC reports and interviews with key stakeholders will complement quantitative findings by providing detailed descriptions of how APMs evolved over time, the rationale for changes, and perceived facilitators and barriers to advancing value-based payment strategies.

Research question 2.1b Are MQD's articulated expectations and requirements associated with an expansion of APMs implemented by QI health plans?

This research question is aimed at examining policy changes as documented in MQD materials, including the State Quality Strategy, policy memoranda, meeting notes, and other formal or informal communications identified during the demonstration. These findings will be integrated with qualitative insights from six semi-structured interviews with QI health plan leaders[4] and three semi-structured interviews with MQD staff and leadership providers to assess perceptions of MQD's policy direction, the mechanisms through which policy signals influence APM development, and perceived facilitators and barriers to change. Interviews are needed to relate changes in MQD policy to articulated changes in QI health plan implementation of APMs, as health plans are uniquely positioned to explain the reasoning behind internal APM changes. This qualitative input is necessary to answer why changes to APMs were made and whether those changes were directly related to MQD policy shifts or communications. This descriptive information will be used to contextualize these perspectives by examining the timing, type, and scope of APM implementation.

Research question 2.1c How does attribution to an advanced APM affect beneficiaries'

[4] Interview scheduling for research question 2.1a and 2.1b may be combined to reduce participation burden on participants.

utilization of preventive care, avoidable inpatient admissions and emergency care, and expenditure?

To assess the impact of attribution to advanced APMs on beneficiary utilization and expenditures, the evaluation will use multivariable regression analyses comparing adult Medicaid beneficiaries attributed to HCP-LAN Level 3 and 4 APMs with a group of beneficiaries not attributed to advanced APMs. Regression models will control for beneficiary demographic characteristics, enrollment factors, and health status using Milliman Actuarial Risk Scores, drawing on data from QI Health Plan VHC reports,

Medicaid administrative claims and encounter data, and KOLEA eligibility and enrollment data. This approach will allow the evaluation to estimate associations between advanced APM attribution and healthcare outcomes, utilization and cost while accounting for differences in underlying risk and population characteristics. Subgroup analyses will be conducted by beneficiaries' demographics (age, sex, race/ethnicity, region, language). QI health plan leaders will be included through purposeful sampling while providers will be included through outreach by MQD and health plan involvement.

Table V.2 Value-Based Purchasing and APMs

Project 2 Value-Based Purchasing and APMs				
Research Question	**Outcome Measures Used to Address the Research Question**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Hypotheses 2.1 Increased beneficiary coverage under QI health plan advanced APMs is related to improved outcomes, care utilization and spending.				
Research question 2.1a What changes were made by QI health plans to their APMs?	● Qualitative description of implemented APMs ● Number (percent) of providers included in APMs by type ● Number (percent) of beneficiaries included in APMs ● Expenditure by APM ● Percent of quality goals met by QI health plan ● Reported integration of incentives or interventions for	● QI health plans ● Medicaid beneficiaries assigned/attributed to APMs Comparison by demographics (age, sex, race/ethnicity, region, language) ● Medicaid providers attributed to APMs	● QI Health Plan VHC reports ● Minimum of 6 qualitative semi-structured interviews and/or 2 focus groups with QI health plan leaders and a minimum of 6 Medicaid providers ● MQD internal documentation of State value-based purchasing strategies aimed at QI health plan. To be identified.	● Descriptive statistics ● Document review ● Qualitative thematic analysis of changes made to implemented APMs ● Progression and implementation of APMs will be mapped and compared with the previous evaluation period (2019-2024) ● HCP-LAN APM framework will be applied as an analytic framework

	addressing health disparities		• Additional interviews or focus groups will be planned upon need.	
Research question 2.1b Are MQD's articulated expectations and requirements associated with an expansion of APMs implemented by QI health plans?	• Description of MQD's articulated State Value-based purchasing policy • Qualitative description of motivations and mechanisms articulated by QI health plans in relation to MQD's expectations and requirements • Provider perceptions of QI Health Plan APM implementation • MQD perceptions of policy changes and QI Health Plan implementation	• QI health plans • Providers • MQD staff and leadership	• Minimum of 6 Qualitative semi-structured interviews with QI health plan leaders and minimum of 3 MQD staff and leadership • State documents (to be identified, e.g., the state Quality Strategy, Memoranda etc.) • Additional interviews or focus groups will be planned upon need.	• Qualitative thematic analysis and implementation mapping of perceptions, motivations and mechanisms leading up to changes in implemented APMs amongst QI health plans • Document review of MQD's value-based healthcare policies and activities
Research question 2.1c How does attribution to an advanced APM affect beneficiaries' utilization of preventive care, avoidable inpatient admissions and emergency care,	• Use of primary care defined in the 2019-2024 1115 demonstration waiver • ED visits • Hospitalizations • Readmission after hospitalization	• Adult (age18+) Medicaid beneficiaries attributed to HCP-LAN APM level three and four during the Demonstration period (2025-2029).	• QI Health Plan VHC reports • MQD Administrative Claims and Encounter Data	• Regression analysis to identify differences in outcomes between beneficiaries attributed to advanced HCP-LAN APMs (controlling covariates including

and expenditure?	• Total cost of care per beneficiary per month	Comparison group • Adult (age 18+) Medicaid beneficiaries without attribution to APM level 3 and 4. Subgroup analyses by beneficiaries' demographics (age, sex, race/ethnicity, region, language)	• KOLEA Eligibility and Enrollment Data • Milliman Actuarial Risk Score Data	demographics, risk score)

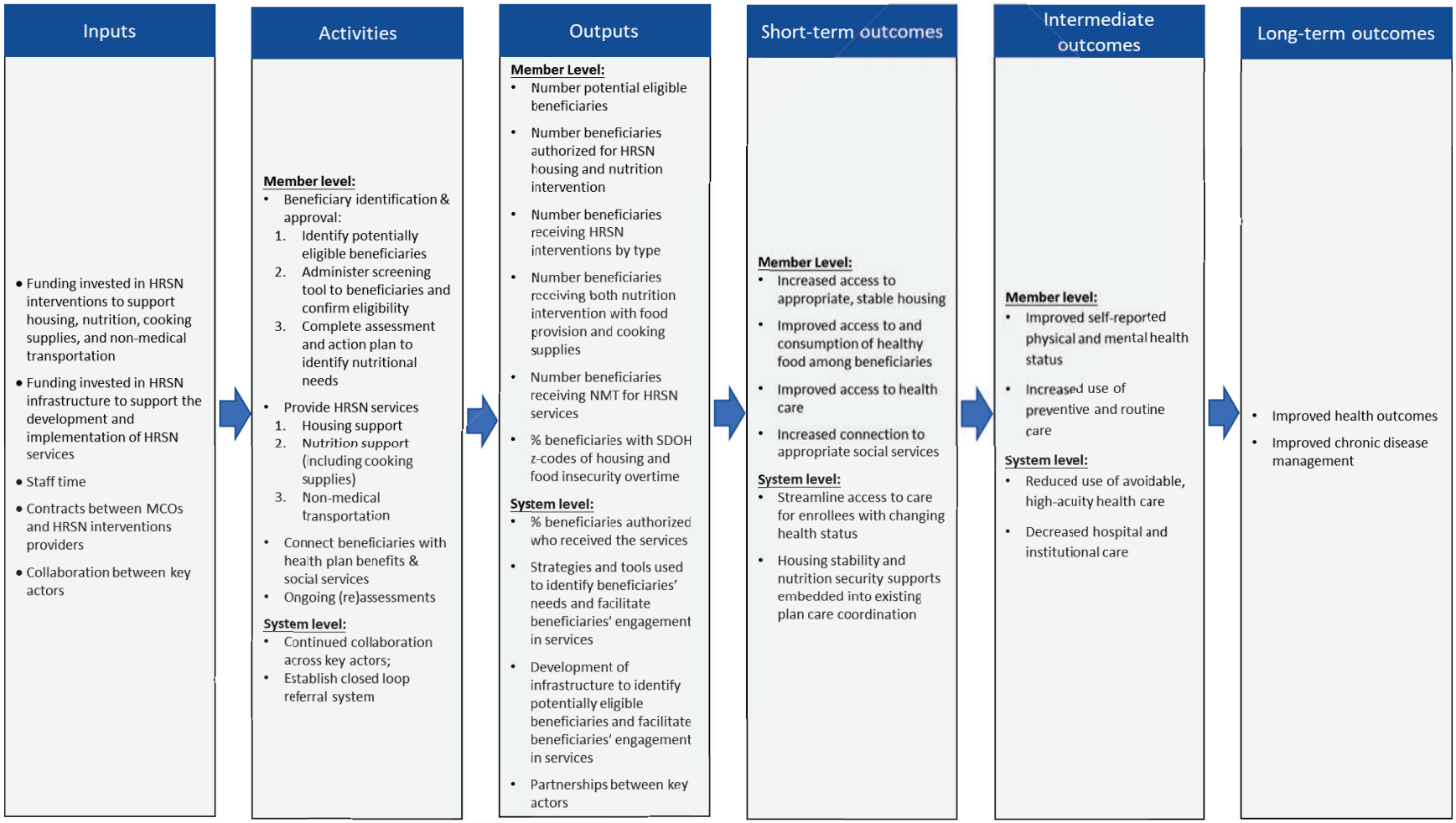
Demonstration Objective 3. Address Social Drivers of Health to Improve Health Outcomes and Lower Healthcare Costs

Project 3: Health-Related Social Needs (HRSN) Interventions–Housing Interventions, Nutrition Interventions, Cooking Supplies, and Non-Medical Transportation (NMT)

Logic Model

Figure V.3 presents a logic model that demonstrates how HRSN interventions are expected to lead to changes in short-term and intermediate outcomes, and eventually impact the ultimate objectives of the Demonstration. The inputs include funding invested in HRSN services (including housing and nutrition support, cooking supplies, and NMT for HRSN services) and infrastructure to support the implementation of HRSN services, staff time, contracts between QI health plans and MQD, and collaboration between key actors. Key activities under the HRSN interventions domains include identifying eligible beneficiaries for HRSN services and approving/authorizing/providing the services on the individual level, and continuing the collaboration between key actors and establishing a closed-loop referral system at the system level. The outputs of HRSN interventions include the number of potential eligible beneficiaries, beneficiaries authorized for HRSN services, and beneficiaries receiving HRSN services, the percentage of beneficiaries with SDOH Z-codes of housing and food insecurity over time, and the percentage of beneficiaries who were authorized to receive HRSN services who actually received the services. These outputs are expected to lead to short-term outcomes, particularly increased access to appropriate, stable housing or healthy food, improved access to health care and increased connection to appropriate social services; and intermediate outcomes that represent sustained changes, including improved self-reported physical and mental health status and increased use of preventive and routine care.

Figure V.3 HRSN Interventions



Analytic Approach

Research question 3.1a–Research question 3.1c Who are the key actors collaborating to implement and operationalize the interventions, what are their main roles, and how are they related to each other?

The process of the implementation of HRSN interventions and the development of HRSN infrastructure to address housing and nutrition needs will be analyzed qualitatively. Data will be collected by reviewing monitoring reports and meeting notes, and interviews with key actors. For interviews, we will use purposive sampling and snowball sampling methodology to identify key actors involved in the design and implementation of HRSN services, including MQD staff, QI health plans, nutrition services providers, housing services providers, and health care providers. As team size for different key actors and personnel involvement varies, the quantity of interviews will depend on the implementation details. We estimate 3 interviewees for MQD staff, 10-15 interviewees for five QI health plans, 10-15 interviewees for nutrition and housing services providers respectively, and 15-20 interviewees for healthcare providers. Qualitative data will be analyzed through text analysis and thematic analysis. Visualization of the network of key entities (e.g., map) and basic network analysis are used to capture the roles and collaboration between key actors during the implementation. Data collection will vary based on the implementation time of each program under the HRSN services.

Research question 3.2a How do key actors identify beneficiaries with social risk factors related to housing and nutrition and facilitate their participation in the interventions? What facilitators and barriers to participation do key actors and beneficiaries experience?

Also qualitatively, the evaluation will assess how the HRSN interventions improve the access to HRSN services through document review and in-depth case studies. Other than data collection identified for Research question 3.1a–Research question 3.1c, focus groups with beneficiaries will be conducted to understand the HRSN services implementation from beneficiaries' perspective. We estimate 5 focus groups for each component of HRSN services. Purposive sampling and snowball sampling methodology will be used to identify focus group participants. We will work with stakeholders to recruit participants at health care settings or services provision settings. Data collection will vary based on the implementation time of each program under the HRSN services.

Research question 3.2b How do HRSN interventions impact the use of housing and nutrition services and the rate of housing stability and nutrition security among beneficiaries?

In order to examine whether the HRSN interventions mitigate the severity of housing and nutrition needs, the evaluation will conduct descriptive analysis to describe housing and nutrition needs and HRSN services utilization over time, such as number of potential eligible beneficiaries, number of beneficiaries authorized for HRSN housing and nutrition interventions, number of beneficiaries receiving HRSN services, etc.
Moreover, ITS analysis will be used to investigate whether the Demonstration reduces the percentage of claims affiliated with SDOH Z-codes of housing and food insecurity. Subgroup analyses will be conducted by stratifying beneficiaries' demographics, including age, sex,

race/ethnicity, region, and language. This part of data analysis will use at least five years of pre-implementation data and two years of post-implementation data. Data from MQD Administrative Claims and Encounter Data and KOLEA Eligibility and Enrollment Data will be analyzed.

Research question 3.3 How do interventions impact beneficiaries' physical and mental health status, the use of preventive and routine care, potentially avoidable, high-acuity health care, hospital and institutional care, health care spending?

Lastly, the impact of beneficiary use of HRSN services on outcomes and costs will be assessed through descriptive analysis, regression analysis, and ITS analysis. Descriptive analysis will be applied to describe all the quantitative outcomes over time. Regression analysis will be used to investigate whether receiving HRSN services predicts self-reported health outcomes. ITS analysis will be applied to test whether the Demonstration reduces ED visits, hospitalizations and associated costs, and readmissions after hospitalization. Additionally, DiD analysis will be applied if a reasonable comparison group can be identified. The evaluation team will work closely with the implementation team to identify a wait list comparison group of beneficiaries who meet the eligibility criteria for HRSN services but are not yet receiving the HRSN interventions (due to various implementation delays: e.g., waiting for available service providers). Subgroup analyses will be conducted by stratifying beneficiaries' demographics, including age, sex, race/ethnicity, region, and language. Same as above, we will use at least five years of pre-implementation data and two years of post-implementation data. Data from MQD Administrative Claims and Encounter Data and KOLEA Eligibility and Enrollment Data will be analyzed.

Table V.3 HRSN Interventions

Project 3 HRSN Interventions				
Research Question	**Outcome Measures Used to Address the Research Question**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Hypotheses 3.1 HRSN interventions will promote the development of HRSN infrastructure to support HRSN implementation and increase local investments in housing supports and nutrition services over time.				
Research question 3.1a Who are the key actors collaborating to implement and operationalize the interventions, what are their main roles, and how are they related to each other?	● List of key actors (e.g., MQD implementation team, QI health plan coordinators, nutrition services providers, housing services providers, health care providers) ● Map of role descriptions and connections among key actors	Comparisons of key actors by region (e.g., islands, counties)	● Monitoring reports ● Relevant meeting notes ● Interviews with key actors	● Qualitative analysis of documents, meeting notes and interviews (e.g., text analysis, thematic analysis) to understand the implementation of HRSN interventions ● Visualization of network of key entities (e.g., map) ● Basic network analysis to understand patterns of relationships
Research question 3.1b How does the Demonstration change the way key actors form and maintain partnerships to implement HRSN services?	● Process of forming and maintaining partnerships ● Strength and closeness of relationships ● Description of data sharing between health and social services providers ● Linkages with WIC and SNAP	Comparison of partnerships and data sharing by region (e.g., islands, counties) Comparison of partnerships and data sharing before and after implementation	● Monitoring reports ● Relevant meeting notes ● Longitudinal interviews with key actors	
Research question 3.1c What infrastructure is developed to support the implementation of	● Description of HRSN infrastructure components as a result of this Demonstration	Comparison of HRSN infrastructure and expenditure by	● Monitoring reports	

HRSN interventions and what is the cost?	• Expenditure of HRSN infrastructure components developed as part of this demonstration by HRSN stakeholders including providers, community organizations and MQD	region (e.g., islands, counties)	• Relevant meeting notes • Longitudinal interviews with key actors	between entities and how the Demonstration connect different entities
Hypothesis 3.2 HRSN interventions will improve access to HRSN services and mitigate the identified HRSN among beneficiaries.				
Research question 3.2a How do key actors identify beneficiaries with social risk factors related to housing and nutrition and facilitate their participation in the interventions? What facilitators and barriers to participation do key actors and beneficiaries experience?	• Strategies and tools used to identify potential beneficiaries • Strategies and tools used to facilitate eligible beneficiaries' participation • Description of facilitators and barriers experienced by key actors and beneficiaries	Comparisons of key actors and beneficiaries by region and beneficiaries' demographics	• Monitoring reports • Longitudinal interviews with key actors • Focus group with beneficiaries	• Qualitative analysis of documents (e.g., text analysis, thematic analysis) to understand the process of identifying social risk factors and facilitators and barriers of the implementation of HRSN interventions • In-depth case studies to identify facilitators and barriers of the implementatio

				n of HRSN interventions
Research question 3.2b How do HRSN interventions impact the use of housing and nutrition services and the rate of housing stability and nutrition security among beneficiaries?	• Number of potential eligible beneficiaries • Number of beneficiaries authorized for HRSN housing and nutrition intervention • Number of beneficiaries receiving HRSN interventions by types • Number of beneficiaries receiving both nutrition intervention with food provision and cooking supplies • Number of beneficiaries receiving NMT for HRSN services • Percent of beneficiaries authorized who received the services • Percent of beneficiaries with SDOH Z-codes of housing and food insecurity over time • Self-reported HRSN housing and nutrition need and services provided within or outside of the Demonstration • Self-reported experience of how HRSN interventions address housing and nutrition needs	Beneficiaries meeting the HRSN services eligibility criteria Beneficiaries receiving HRSN interventions **Comparison group**: Eligible beneficiaries who are not yet receiving the HRSN intervention Subgroup analyses by beneficiaries' demographics (age, sex, race/ethnicity, region, language)	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • QI Health Plan Nutrition Intervention Reports • QI Health Plan CIS+ Reports • QI Health Plan HCS Reports • HRSN beneficiary focus group	• Descriptive statistics • ITS analysis to compare the trends of outcome measures before and after the Demonstration • Qualitative analysis (e.g., text analysis, thematic analysis) to understand how the HRSN interventions address the housing and nutrition needs for beneficiaries.

Hypothesis 3.3 HRSN interventions will increase beneficiaries' health status, the use of preventive and routine care, and reduce the use and costs associated with potentially avoidable, high-acuity health care, and the use of hospital and institutional care, leading to reduced health care spending over time.				
Research question 3.3 How do interventions impact beneficiaries' physical and mental health status, the use of preventive and routine care, potentially avoidable, high-acuity health care, hospital and institutional care, health care spending?	• Self-reported physical and mental health status • Use of primary care defined in the 2019-2024 1115 demonstration waiver • ED visits • All-cause hospitalizations • Readmission after hospitalization • Inpatient Prevention Quality Indicators (PQIs) • Total cost of care • Cost of care for ED visits • Cost of care for hospitalizations • Cost of HRSN interventions	Beneficiaries receiving HRSN interventions **Comparison group:** Eligible beneficiaries who are not yet receiving the HRSN interventions Subgroup analyses by beneficiaries' demographics (age, sex, race/ethnicity, region, language)	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • QI Health Plan Nutrition Intervention Reports • QI Health Plan CIS+ Reports • QI Health Plan HCS Reports	• Descriptive statistics • Regression analysis (controlling covariates including demographics, risk score) to investigate whether receiving HRSN services is associated with better self-reported health outcomes • ITS analysis to compare trends of outcome measures before and after the Demonstration • DiD analysis to compare the

				change of outcome measures overtime between beneficiaries receiving the HRSN intervention and who are not yet receiving the HRSN interventions

Cross-Cutting Evaluation

Beyond individual project area evaluations, a crucial part of this assessment is a cross-cutting analysis. While individual projects will assess the costs and outcomes of their initiatives, this overarching assessment will combine findings from all project areas. Included in both the interim and summative reports, its goal is to develop comprehensive insights into how the collective efforts are meeting the Demonstration's three stated objectives.

Table V.4 Cross-Cutting Hypotheses

Cross-Cutting Hypotheses				
Research Question	**Outcome Measures Used to Address the Research Question**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Hypotheses 4.1 Beneficiaries receiving multiple services will have higher use of preventive and routine care, and lower use of potentially avoidable, high-acuity health care, and hospital and institutional care than beneficiaries receiving only one or no				

services.				
Research question 4.1a What are the characteristics of beneficiaries receiving multiple services compared to beneficiaries receiving one service or none.	• Beneficiaries' demographics (age, sex, race/ethnicity, region, language) • Milliman Actuarial Risk Score	Beneficiaries receiving multiple services Comparison group: Beneficiaries receiving one services or none	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • QI Health Plan Nutrition Intervention Reports • QI Health Plan CIS+ Reports • QI Health Plan Re-Entry Reports • QI Health Plan Contingency Management Reports • QI Health Plan HCS Reports • Milliman Actuarial Risk Score Data	• Descriptive statistics to describe key characteristics of beneficiaries receiving multiple services and compare these characteristics with beneficiaries receiving only one service, or none
Research question 4.1b How receiving multiple services impact beneficiaries' use of preventive and routine care, and potentially avoidable, high-acuity health care, and hospital and institutional care.	• Use of primary care defined in the 2019-2024 1115 demonstration waiver • ED visits • All-cause hospitalizations • Readmission after hospitalization • Inpatient Prevention Quality Indicators (PQIs)	Beneficiaries receiving multiple services Comparison group: Beneficiaries receiving one services or none	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • Milliman Actuarial Risk Score Data • QI Health Plan Nutrition Intervention Reports • QI Health Plan CIS+ Reports	• Regression analysis (controlling covariates including demographics and risk score) to examine whether receiving multiple services is linked to better health outcome

			• QI Health Plan Re-entry Reports • QI Health Plan Contingency Management Reports • QI Health Plan HCS Reports	

VI. Attachments

A. Independent Evaluator

The State of Hawai‘i has contracted the Social Science Research Institute at the University of Hawai‘i at Mānoa to conduct evaluation services. The contract outlines the roles and responsibilities of the Social Science Research Institute to evaluate programs and activities for the State of Hawai‘i Department of Human Services, and to serve as the external evaluator of the Section 1115 Demonstration. The Associate Dean for Research and Director of the Social Science Research Institute, Dr. John Barile, is the lead evaluator on the Demonstration. Dr. Barile has over 20 years of experience evaluating health-related programs and is well published in the areas of social service delivery, quality of life, and program impact. Members of the evaluation team are also in tenured faculty positions at the University of Hawai‘i and external to the State Department of Human Services. Their backgrounds are in health policy, health economics, quantitative research methods, and statistical modeling.

B. Evaluation Budget

The five-year evaluation budget totals $4,980,777, which includes direct costs of $3,952,998 and indirect costs of $1,027,779 (26% indirect cost rate). A 3% increase is built in each year for salary and other cost-of-living increases. The year one budget (including indirect costs) is $938,152, year two is $966,297, year three is $995,286, year four is $1,025,144, and year five is $1,055,898. After year one, which will be primarily devoted to planning and designing the evaluation, subsequent years include funds for five research associates and seven graduate assistants. Summer overload (1-3 months) is included for eight faculty evaluators over the five-year period. Funds to support travel to professional Medicaid-related conferences and to purchase software, hardware, and supplies are also included. These expenses are necessary to support all aspects of the evaluation including project administration, development of instruments to support primary data collection efforts, accessing administrative data, data cleaning and analyses, and report generation.

C. Timeline and Major Milestones

The proposed timeline below is shown separately for administrative deliverables and project or research deadlines.

Evaluation Activities	**Date**
Initial access to data/data preparation/cleaning	Quarter 4, 2025
Preparation of instruments for primary data collection	Quarter 2, 2026
Pilot testing of instruments	Quarter 3, 2026
Administration of instruments for primary data collection	Quarter 4, 2026
Preliminary testing of statistical models and analytic approaches	Quarter 4, 2026 – Quarter 2 2027
Interim evaluation report	Quarter 4, 2027
Data analyses, modeling	2028-2029
Report writing (including revisions to drafts)	Quarter 2, 2030 – Quarter 1, 2031
Renewal Submitted	TBD
Summative Report	Quarter 2, 2031

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ATTACHMENT D
Home and Community-Based Services (HCBS) and Long-Term Care Provider Guidelines and Service Definitions

The following are the criteria for the populations eligible for HCBS provided in the QUEST Integration program.

Population	Eligibility Criteria
Individuals who meet an Institutional Level of Care	This is a 1915(c)-like population. Individuals must meet an institutional level of care and are able to choose to receive care at home or in the community. Individuals who meet an Institutional Level of Care are those who meet Nursing Facility Level of Care (NF LOC) criteria. A NF LOC is defined as the determination that a member requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. In addition, Individuals who meet an Institutional Level of Care includes members who are or who are likely to be inpatient at a medical facility receiving a NF LOC.
At-Risk Population	This is a 1915(i)-like population. Individuals do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional level of care. Individuals eligible for at risk services must: • Score at least a 5 on the individualized functional assessment and/or • Be determined to be "at risk" of deteriorating to institutional level of care if long-term services or supports are not provided, as demonstrated by needing hands-on assistance with at least one ADL or IADL due to a health condition. • In addition to meeting one of the criteria above, the individual must be at risk of deteriorating to institutional level of care, due to caregiver support system(s) unable to provide assistance with ADLs and/or IADLs.

The following are the provider guidelines and service definitions for 1915(c)-like and 1915(i)-like HCBS provided in the QUEST Integration program.

Service/Provider Term	Service Definition
Adult Day Care Center	Adult day care is defined as regular supportive care provided to four (4) or more disabled adult participants in accordance with HAR§17-1417. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services. Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training. All healthcare related activities must be performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency. Adult Day Care Centers are licensed by the Department of Human Services and maintained and operated by an individual, organization, or agency. Included in the sub-set of services for the "At Risk" population.
Adult Day Health Center	Adult Day Health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight

Service/Provider Term	Service Definition
	or care in accordance with HAR §11-96 and HAR §11-94-5. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community. Each program must have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services must be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse. In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, meals which do not constitute a full nutritional program, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services. Adult Day Health Centers are licensed by the Department of Health. Included in the sub-set of services for the "At Risk" population.
Assisted Living Facility	Assisted living services include personal care and supportive care services (homemaker, chore, attendant services, and meal preparation) that are furnished to members who reside in an assisted living facility. Assisted living facilities are home-like, non-institutional settings. Payment for room and board is prohibited. Section 30.200 describes Assisted Living Facilities as a facility, as defined in HRS 321-15.1, that is licensed by the Department of Health. This facility must consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility must be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own. Included in the sub-set of services for the "At Risk" population.
Community Care Management Agency (CCMA)	CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. A health plan may, at its option, demonstrate the ability to provide CCMA services by contracting with an entity licensed under HAR subchapters 1 and 2. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of members; ongoing face-to-face monitoring and implementation of the member's care plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. CCMAs shall (1) communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders, (2) work with families regarding service needs of member and serve as an advocate for their members, and (3) be accessible to the member's caregiver twenty-four (24) hours a day, seven (7) days a week. CCMA's are agencies licensed by the DHS or its designee under HAR chapter 17-1454, subchapters 1 and 2, to engage in locating, coordinating and monitoring comprehensive services to residents in community care foster family homes or members in E-ARCHS and assisted living facilities. A health plan may be a community care management agency.
Community Care Foster Family Home (CCFFH)	CCFFH services is personal care and supportive services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted under state law) provided in a certified private home by a principal care provider who lives in the home. The number of adults receiving services in CCFFH is determined by HAR, Title 17, Department of Human Services, SubTitle 9, Chapter 1454-43. CCFFH services are currently furnished to up to three (3) adults who receive these services in conjunction with residing in the home. All providers must provide individuals with their own bedroom. Each individual bedroom shall be limited to two (2)

Service/Provider Term	Service Definition
	residents. Both occupants must consent to the arrangement. The total number of individuals living in the home, who are unrelated to the principal care provider, cannot exceed four (4). In accordance with HAR, Title 17, Department of Human Services, SubTitle 9, Chapter 1454-42, members receiving CCFFH services must be receiving ongoing CCMA services. A CCFFH is a home issued a certificate of approval by the DHS to provide, for a fee, twenty-four (24) hour living accommodations, including personal care and homemaker services. The home must meet all applicable requirements of HAR §17-1454-37 through HAR §17-1454-56.
Counseling and Training	Counseling and training activities include the following: member care training for members, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling. Counseling and training is a service provided to members, families/caregivers, and professional and paraprofessional caregivers on behalf of the member.
Environmental Accessibility Adaptations	Environmental accessibility adaptations are those physical adaptations to the home, required by the individual's care plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services must be provided in accordance with applicable state or local building codes.
Expanded Adult Residential Care Home (E-ARCH) or Residential Care Services	Residential care services are personal care services, homemaker, chore, attendant care and companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principal care provider who lives in the home. Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH), allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of the DHS to live in a Type I home with no more than two (2) of whom may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home. An E-ARCH's is a facility, as defined in HAR §11-100.1.2 and licensed by the Department of Health, that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in an intermediate care facility or skilled nursing facility. There are two types of expanded care ARCHs in accordance with HRS § 321-1562 as described above.
Home Delivered	Home delivered meals are nutritionally sound meals delivered to a location where an individual

Service/Provider Term	Service Definition
Meals	resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization. Included in the sub-set of services for the "At Risk" population
Home Maintenance	Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.
Moving Assistance	Moving assistance is provided in rare instances when it is determined through an assessment by the care coordinator that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; member is evicted from their current living environment; or the member is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.
Non-Medical Transportation	Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and must not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.
Personal Assistance Services (Level I)	Personal assistance services Level I are provided to individuals requiring assistance with instrumental activities of daily living (IADLs) in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I may be self-directed and consist of companion services and homemaker services. Homemaker services include: • Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish; • Care of clothing and linen by washing, drying, ironing, mending; • Marketing and shopping for household supplies and personal essentials (not including cost of supplies); • Light yard work, such as mowing the lawn; • Simple home repairs, such as replacing light bulbs; • Preparing meals; • Running errands, such as paying bills, picking up medication; • Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the service plan, when no other resource is available; • Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer; • Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate; and

Service/Provider Term	Service Definition
	• Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service. Included in the sub-set of services for the "At Risk" population
Personal Assistance Services (Level II)	Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform activities of daily living (ADLs) and health maintenance activities. Personal assistance services Level II must be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. The following activities may be included as a part of personal assistance services Level II: • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing; • Assistance with bowel and bladder care; • Assistance with ambulation and mobility; • Assistance with transfers; • Assistance with medications, which are ordinarily self-administered when ordered by member's physician; • Assistance with routine or maintenance healthcare services by a personal care provider with specific training, satisfactorily documented performance, care coordinator consent and when ordered by member's physician; • Assistance with feeding, nutrition, meal preparation and other dietary activities; • Assistance with exercise, positioning, and range of motion; • Taking and recording vital signs, including blood pressure; • Measuring and recording intake and output, when ordered; • Collecting and testing specimens as directed; • Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, Hawaii Administrative Rules; • Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished; • Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and • Maintaining documentation of observations and services provided. When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the care plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may also be provided. Personal assistance services Level II may be self-directed. Personal Assistance is care provided when a member, member's parent, guardian, family member or legal representative employs and supervises a personal assistant who is certified by the health plan as able to provide the designated services whose decision is based on direct observation of the member and the personal assistant during the actual provision of care. Documentation of this certification will be maintained in the member's individual plan of care. Included in the sub-set of services for the "At Risk" population
Personal	PERS is a twenty-four (24) hour emergency assistance service which enables the member to

Service/Provider Term	Service Definition
Emergency Response Systems	secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The following are allowable types of PERS items: • 24-hour answering/paging; • Beepers; • Med-alert bracelets; • Intercoms; • Life-lines; • Fire/safety devices, such as fire extinguishers and rope ladders; • Monitoring services; • Light fixture adaptations (blinking lights, etc.); • Telephone adaptive devices not available from the telephone company; and • Other electronic devices/services designed for emergency assistance. All types of PERS, described above, must meet applicable standards of manufacture, design, and installation. Repairs to and maintenance of such equipment shall be performed by the manufacturer's authorized dealers whenever possible. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting. Included in the sub-set of services for the "At Risk" population
Private Duty Nursing	Private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses (as defined in HAR § 16-89) within the scope of state law. Included in the sub-set of services for the "At Risk" population
Respite Care	Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; foster home/expanded-care adult residential care home; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the state. Respite care services are authorized by the member's PCP as part of the member's care plan. Respite services may be self-directed.
Specialized Medical Equipment and Supplies	Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, assessment costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. All items must meet applicable standards of

Service/Provider Term	Service Definition
	manufacture, design and installation and may include: • Specialized infant car seats; • Modification of parent-owned motor vehicle to accommodate the child (i.e., wheelchair lifts); • Intercoms for monitoring the child's room; • Shower seat; • Portable humidifiers; • Electric bills specific to electrical life support devices (ventilator, oxygen concentrator); • Medical supplies; • Heavy duty items including, but not limited to, patient lifts or beds that exceed $1,000 per month; • Rental of equipment that exceeds $1,000 per month such as ventilators; and • Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month. Items reimbursed shall be in addition to any medical equipment and supplies furnished under the Medicaid State Plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies shall be recommended by the member's PCP.

ATTACHMENT E
Behavioral Health Services Protocol

OVERVIEW

The Med-QUEST Division (MQD) is responsible for providing behavioral health services to all its beneficiaries. MQD provides standard behavioral health services to all beneficiaries and specialized behavioral health services to beneficiaries with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral disorder (SEBD).

Regardless of the type of behavioral health service a beneficiary receives or where the beneficiary receives his/her behavioral health services, the beneficiary continues to have access to all of the other services for which he/she is eligible, including:

- Primary and acute care services from his/her health plan;
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services if he/she is under the age of 21;
- Home and community based services/long-term supports and services (HCBS/LTSS) services under the section 1115 demonstration waiver; and
- Services under the Developmental Disabilities or Intellectual Disabilities (DD/ID) 1915(c) waiver.

All beneficiaries have access to standard behavioral health services through the contracted managed care health plans. The standard behavioral health services include inpatient psychiatric hospitalization, medications, medication management, psychiatric and psychological evaluation and management, and substance use disorder (SUD) treatment services.

Beneficiaries with SMI, SPMI, or SEBD may be in need of specialized behavioral health services. For children (individuals <21), the SEBD services are provided through the Department of Health (DOH) Child and Adolescent Mental Health Division (CAMHD);

For adults (individuals ≥18), SMI/SPMI services are provided through the DOH Adult Mental Health Division (AMHD) if the beneficiary is legally encumbered and, MQD's behavioral health program Community Care Services (CCS), or the managed care health plans. Regardless of how adults with SMI/SPMI access specialized behavioral health services, all have access to the same services, and MQD ensures no duplication. The available specialized services include:

- For children: multidimensional treatment foster care, family therapy, functional family therapy, parent skills training, intensive home and community based intervention, community-based residential programs, and hospital-based residential programs, and
- For adults: crisis management, crisis and specialized residential treatment, intensive care coordination/case management, psychosocial rehabilitation (including clubhouse), peer specialist, financial management services, supported employment, HRSN services, partial or intensive outpatient hospitalization, and therapeutic living supports.

See Exhibit 1 for an overview of the behavioral health services delivery systems for individuals with SMI, SPMI, or SEBD; and see Exhibit 2 for a detailed description of the services provided by CAMHD, AMHD, CCS, and the managed care health plans.

I. RECEIPT OF BEHAVIORAL HEALTH SERVICES BY CHILDREN (INDIVIDUALS <21 YEARS)

A. Clinical Criteria

Beneficiaries <21 years old with a diagnosis of SEBD are eligible for additional behavioral health services within CAMHD if meeting the following criteria:

- The beneficiary is age three through twenty (3-20) years;
- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least six (6) months or is expected to demonstrate the qualifying diagnosis for the next six (6) months; and
- The beneficiary's Child and Adolescent Functional Assessment Scale (CAFAS) score is > 80.
- Beneficiaries who do not meet the eligibility criteria, but based upon assessment by the CAMHD medical director that additional behavioral health services are medically necessary for the member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

B. Service Delivery

MQD has a Memorandum of Understanding (MOU) with CAMHD to provide services to Medicaid beneficiaries. CAMHD is responsible for providing SEBD services to all individuals age three through twenty (3-20) years who meet eligibility criteria. CAMHD provides services to approximately 900 children. CAMHD had previously functioned as a Pre-paid Inpatient Health Plan (PIHP) but changed to billing these services to MQD through a fee-for-service (FFS) process effective October 1, 2008.

The health plan can make a referral to CAMHD through use the SEBD Referral Form developed by CAMHD. The health plan will continue to provide behavioral health services even after CAMHD admits the individual into their program. In these cases, the health plan will not provide services offered by CAMHD, and CAMHD will not provide services offered by the health plan. The MQD informs the health plans, via the 834-transaction file, when an individual is receiving services through the CAMHD program. When a child is no longer eligible for services through CAMHD, CAMHD will coordinate transition of care with the child's health plan. The health plan will be notified that the individual is no longer receiving services via CAMHD via the 834-transaction file.

Referrals to CAMHD can also occur through the school, parent, child, or the health plan. CAMHD considers all referrals through an assessment process. Even if a child qualifies for SEBD services, parents can choose to have their children's behavioral health services

provided through the child's health plan. However, the health plans are only able to provide the standard and specialized behavioral health services identified in their contract. CAMHD would need to be involved for any specialized behavioral health services. These additional behavioral health services include both intensive case management and targeted case management and are distinct from the services provided through the health plans.

II. RECEIPT OF SPECIALIZED BEHAVIORAL HEALTH SERVICES BY ADULTS (INDIVIDUALS ≥18 YEARS)

A. Clinical Criteria

For the beneficiaries ≥18 years old with a SMI or SPMI are eligible for specialized behavioral health services if they meet the following criteria:

- The beneficiary falls under one of the qualifying diagnoses (see Addendum C);
- The beneficiary demonstrates presence of a qualifying diagnosis for at least twelve (12) months or is expected to demonstrate the qualifying diagnosis for the next twelve (12) months; and
- The beneficiary meets at least one (1) of the criteria below demonstrating instability and/or functional impairment:
    - Clinical records demonstrate that the beneficiary is currently unstable under current treatment or plan of care. (Examples include, but are not limited to:
        - Multiple hospitalizations in the last year and currently unstable; substantial history of crises and currently unstable; consistently noncompliant with medications and follow-up; unengaged with providers; significant and consistent isolation; resource deficit causing instability; significant co-occurring medical illness causing instability; poor coping/independent living/problem solving skills causing instability; at risk for hospitalization); or
        - Beneficiary is under Protective Services or requires intervention by housing or law enforcement officials.
- Beneficiaries who do not meet the requirements listed above, but based upon an assessment by a programmatic medical director or other designated person, that additional behavioral health services are medically necessary member's health and safety, shall be evaluated on a case-by-case basis for provisional eligibility.

B. Service Delivery

AMHD provides coverage of behavioral health services for QI beneficiaries that are legally encumbered. Currently, CCS provides coverage of behavioral health services to approximately 5,000 adult members. If a beneficiary is enrolled in CCS, they receive both their standard and specialized behavioral health services through CCS. MQD awards the CCS contract through a Request for Proposal (RFP) for a capitated payment. Certain new services may be reimbursed through a fee-for-service (FFS) basis until able to be incorporated in the capitated payment.

All referrals are submitted to MQD for eligibility determination. CCS referrals may be submitted to the MQD by the following agencies:

- QI Health Plan
- Hawaii State Hospital (HSH)
- Department of Health: AMHD, CAMHD or Developmental Disabilities Division (DDD)
- Department of Public Safety correctional facilities
- Hawaii Youth Correctional Facilities
- Medicaid individuals self-referring directly to CCS or first contact with CCS through crisis services

The MQD physician or MQD-designated physician reviews the referrals and determines CCS eligibility based on the Clinical Criteria in the RFP. Once the member has been determined to meet the criteria, the member will be enrolled into CCS five (5) working days after the date of approval.

Upon enrollment, the member can choose from the CCS contracted, community-based case management (CBCM) agencies. Once chosen, the agency will assign a case manager to conduct an assessment and develop an Individualized Treatment Plan. If an agency is not chosen, CCS will assign a CBCM agency.

III. COVERED SPECIALIZED BEHAVIORAL HEALTH SERVICES

The standard behavioral health services are State plan services. The covered specialized behavioral health services include those covered under the State plan and those covered under the section 1115 demonstration. These services may be provided through CAMHD or through AMHD, CCS, or health plans. The State plan services are listed below with details available in the State plan. The 1115 demonstration services are described in detail in subparagraph (C) below, and these services are not available through the health plans. The delivery system for these services are futher clarified in exhibit 2. Individuals receiving specialized behavioral health services through the health plans in need of these additional services can receive them either through AMHD or CCS.

A. State Plan Standard Behavioral Health Services (including SUD treatment)

1. Acute Psychiatric Hospitalization
2. Diagnostic/Laboratory Services
3. Electroconvulsive Therapy
4. Evaluation and Management
5. Methadone Treatment
6. Prescription Medications
7. SUD Treatment
8. Transportation

B. State Plan Specialized Behavioral Health Services

1. Intensive Case Management and Community-Based Residential Programs)

2. Biopsychosocial Rehabilitation
3. Crisis Management
4. Crisis Residential Services
5. Hospital-based Residential Programs
6. Intensive Family Intervention
7. Intensive Outpatient Hospital Services
8. Therapeutic Living Supports and Therapeutic Foster Care Supports
   (Addendum D includes the State plan pages for these Community Mental Health Rehabilitative Services)
9. Peer Support and Peer Specialist

C. 1115 Demonstration Specialized Behavioral Health Services

1. Financial management services

a. Services provided by an individual or organization for a beneficiary that cannot manage his or her money. This benefit is only for those without access to the social security representative payee program.
b. The financial manager shall direct the use of the beneficiary's income to pay for the current and foreseeable needs of the beneficiary and properly save any income not needed to meet current needs. The individual or organization must also keep records of expenses. Reports shall be provided quarterly to the beneficiary (if appropriate), and the beneficiary's legal guardian (or other designated responsible individuals).

2. Supported Employment

a. Supported employment includes activities needed to obtain and sustain paid work within the general workforce by beneficiaries and includes assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the beneficiary, transitioning the beneficiary from volunteer work to paid employment, and assisting the beneficiary in maintaining an individual job in the general workforce at or above the state's minimum wage.
b. Supported employment support is conducted in a variety of settings to include self-employment. With regard to self-employment, individual employment support services may include:
   i. Aiding the beneficiary to identify potential business opportunities;
   ii. Assisting in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business;
   iii. Identifying the supports that are necessary in order for the beneficiary to operate the business; and
   iv. Providing ongoing assistance, counseling and guidance once the business has been launched.

3. HRSN

a) HRSN services will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual. HRSN services are described in STC 8.2.

Exhibit 1 to Behavioral Health Protocol

Overview of Behavioral Health Services Delivery

	Basic BH Services	Adults with SMI/SPMI Enrolled in AMHD	Adults with SMI/SPMI Enrolled in CCS	Children with SEBD Enrolled in CAMHD
Acute Psychiatric Hospitalization	HP	HP	CCS	HP
Diagnostic/laboratory Services	HP	HP	CCS	HP
Electroconvulsive Therapy	HP	HP	CCS	HP
Evaluation and Management	HP	HP	CCS	CAMHD/ HP
Methadone Treatment	HP	HP	CCS	HP
Prescription Medications	HP	HP	CCS	HP
SUD Treatment	HP	HP	CCS	HP
Transportation	HP	HP	CCS	HP
Biopsychosocial Rehabilitation	n/a	AMHD	CCS	n/a
Community Based Residential Programs	n/a	AMHD	n/a	CAMHD
Crisis Management	HP	AMHD	CCS	CAMHD
Crisis Residential Services	HP	AMHD	CCS	CAMHD
Hospital-based Residential Services	n/a	n/a	n/a	CAMHD
Intensive Case Management	n/a	AMHD	CCS	CAMHD
Intensive Family Intervention	n/a	n/a	n/a	CAMHD
Intensive Outpatient Hospital Services	n/a	AMHD	CCS	CAMHD
Therapeutic Living Supports and Therapeutic Foster Care Supports	HP	AMHD	CCS	CAMHD
Financial management services	n/a	AMHD	CCS	n/a
Supportive Employment	n/a	AMHD	CCS	n/a
HRSN Services	HP	AMHD	CCS	n/a

Legend:

AMHD	Adult Mental Health Division in the Department of Health
HP	Health Plan
CAMHD	Child and Adolescent Mental Health Division in the Department of Health
CCS	Community Care Services program
SEBD	Support for Emotional and Behavioral Development
SMI	Severe Mental Illness
SPMI	Serious and Persistent Mental Illness

Exhibit 2 to Behavioral Health Protocol

Behavioral Health Services in the QUEST Integration Program

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Payment methodology	**N/A**	**Payment to health plans** Capitation	**Payment to DOH-AMHD** Billed FFS to MQD	**Payment to the Behavioral Health Organization** Capitation/FFS	**Payment to DOH-CAMHD** Billed FFS to MQD
Standard Behavioral Health Services					
Acute psychiatric hospitalization	Hospitals[5] licensed to provide psychiatric services	Twenty-four (24) hour care for acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services as needed o Other medically necessary services o Pharmaceuticals	Provided by health plan	Twenty-four hour acute psychiatric illnesses including: o Room and board o Nursing care o Medical supplies and equipment o Diagnostic services o Physician services o Other practitioner services, as needed o Other medically necessary services o Pharmaceuticals	Provided by health plan

[5] Excludes Institutions of Mental Disease (IMDs) as defined at 42 CFR 435.1010

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		○ Rehabilitation services, as needed		○ Rehabilitation services, as needed	
Diagnostic/ laboratory services	Laboratories	Diagnostic/laboratory services including: ○ Psychological testing ○ Screening for drug and alcohol problems Other medically necessary diagnostic services	Provided by health plan	Diagnostic/laboratory services including: ○ Psychological testing ○ Screening for drug and alcohol Other medically necessary diagnostic services	Provided by health plan
Electroconvulsive Therapy (ECT)	Acute Psychiatric Hospital Outpatient facility	ECT ○ Medically necessary, may do more than one/day Inclusive of anesthesia	Provided by health plan	ECT ○ Medically necessary, may do more than one/day Inclusive of anesthesia	Provided by health plan
Evaluation and Management	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice registered nurse (APRN) with prescriptive authority	Psychiatric or psychological evaluation Individual and group counseling and monitoring	Psychiatric or psychological evaluation for SMI/SPMI Individual and group counseling and monitoring for SMI/SPMI	Psychiatric, psychological or neuropsychological evaluation for SMI/SPMI Individual and group counseling and monitoring for SMI/SPMI	Psychiatric, psychological or neuropsychological evaluation for SEBD Individual and group counseling and monitoring for children requiring SEBD

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	(APRN Rx), clinical social workers, mental health counselors, and marriage family therapists		HP provides individual and group counseling and monitoring for non-SMI/SPMI		HP provides individual and group counseling and monitoring for all other children
Methadone treatment	Methadone clinics	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan	Methadone treatment services which include the provision of methadone or a suitable alternative (e.g. LAAM), as well as outpatient counseling services	Provided by health plan
Prescription Medications	Providers licensed to prescribe (e.g. Psychiatrist and APRN Rx). Medications are dispensed by licensed pharmacies.	Prescribed drugs including medication management and patient counseling	Provided by health plan	Prescribed drugs including medication management and patient counseling	Provided by health plan
SUD	Licensed providers and certified substance abuse counselors*	SUD- Residential o Medically necessary services based on American Society of Addiction	Provided by health plan	SUD- Residential o Medically necessary services based on American Society of Addiction	Provided by health plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	Specialized residential treatment facilities Facilities licensed to perform substance abuse treatment	Medicine (ASAM) SUD – Out-patient o Screening o Treatment and treatment planning o Therapy/counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary o SUD screening		Medicine (ASAM) SUD – Out-patient o Screening o Treatment and treatment planning o Therapy/counseling o Therapeutic support & education o Homebound services o Continuous treatment teams o Other medically necessary o SUD screening.	
HRSN Services*	As described in STC Section 8.	As described in STC Section 8.	NA	As described in STC Section 8.	NA
Transportation	Approved transportation providers to include medical vans, taxi cabs, bus services, and handicap	Transportation o Air o Ground for medically necessary services	Provided by health plan	Transportation o Air o Ground for medically necessary services	Provided by health plan

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	bus services.				
Specialized Behavioral Health Services					
Biopsychosocial Rehabilitative Programs (including Clubhouse services)	AMHD Qualified Mental Health Provider**	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Psychosocial Rehabilitative Programs	Not provided
Community Based Residential Programs[6]	Small homes certified to perform community based residential programs. Each home is staffed with several qualified mental health professionals.	Not provided	Not provided	Not provided	These programs provide twenty-four (24) hour integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, aggression, or deviance, which prevent the youth from taking part in family and/or community life.+
Crisis Management	Qualified Mental Health Provider**	Crisis Management a. 24-hour crisis telephone consultation b. Mobile outreach services	Crisis Management d. 24-hour crisis telephone consultation e. Mobile outreach services	Crisis Management 24/7 Crisis hotline (through 800#) a. Mobile crisis response/ outreach	Crisis Management a. 24/7 Crisis hotline (through 800#)

[6] Meet inpatient psych under 21 requirements under 42 CFR 440.160

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
		c. Crisis intervention/ stabilization services	f. Crisis intervention/ stabilization services	b. Crisis intervention/ stabilization	b. Mobile crisis response/ outreach c. Crisis intervention/ stabilization
Crisis Residential Services	Qualified Mental Health Provider**	Crisis Residential Services	Crisis Residential Services	Crisis Residential Services	Crisis Residential Services
Hospital based residential treatment[7]	Acute psychiatric hospital	Not provided	Not provided	Not provided	Hospital based residential treatment
Intensive Case Management	Qualified Mental Health Provider**	Not Provided	Intensive Case Management/ community-based case management Targeted Case Management	Intensive Case Management/community-based case management o Assessment o Individualized care planning o Outreach o Ongoing monitoring	Intensive Case Management/ community-based care management Targeted Case Management
Intensive family intervention	Qualified licensed behavioral health professional: psychiatrists, psychologists, behavioral health advanced practice	Not provided	Not provided	Not provided	Intensive family intervention

[7] Excludes services in IMD as defined at 42 CFR 435.1010.

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
	registered nurse (APRN) with prescriptive authority (APRN Rx), clinical social workers, mental health counselors, and marriage family therapists				
Intensive Outpatient Hospital Services	Acute psychiatric Hospitals Qualified Mental Health Provider**	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and aftercare o Other medically necessary services	Intensive Outpatient Hospital Services o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and aftercare o Other medically necessary services	Intensive Outpatient Hospital Services: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and aftercare o Other medically necessary services	Intensive Outpatient Hospital Services: o Medication management o Pharmaceuticals o Medical supplies o Diagnostic testing o Therapeutic services including individual, family, and group therapy and aftercare o Other medically necessary services

Benefits	Providers	Health Plans	AMHD	CCS Program	CAMHD
Peer Specialist	Certified peer specialist	Structured activities within a peer support center that promotes socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promotes socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Structured activities within a peer support center that promotes socialization, recovery, wellness, self advocacy, development of natural supports, and maintenance of community skills.	Not provided
Financial management services*	Licensed Organization or Individual	Not provided	Assist beneficiary in managing their financial status.	Assist beneficiary in managing their financial status.	Not provided
Supported Employment*	Qualified Mental Health Provider**	Not provided	Activities to obtain and sustain paid work by beneficiaries.	Activities to obtain and sustain paid work by beneficiaries.	Not provided
Therapeutic Living Supports and Therapeutic Foster Care Supports	Specialized residential treatment facility providing therapeutic living supports and/or therapeutic foster care supports	Therapeutic living supports	Therapeutic living supports	Therapeutic living supports	Therapeutic living and therapeutic foster care supports

Legend:

* Approved waiver services

** Medicaid provider that offers multiple behavioral health services in one organization in order to provide continuity for the participants in the behavioral health program. Qualified providers are licensed or certified as required by Hawaii Revised Statutes.

Exhibit 3 to Behavioral Health Protocol

Eligibility Diagnoses for Specialized Behavioral Health Services

Eligible Diagnoses:

- Demonstrates the presence of a primary DSM (most current edition) Axis I diagnosis for at least six (6) months or is expected to demonstrate the diagnosis for the next six (6) months. See excluded diagnoses in the next section.

Excluded Diagnoses*

- *Intellectual Disability** (317, 318.0, 318.1, 318.2, 319)
- Pervasive Developmental Disorders** (299.0, 299.80, 299.10)
- Learning Disorders (315.0, 315.1, 315.2, 315.9)
- Motor Skills Disorders (315.3)
- Communication Disorders (315.31, 315.32, 315.39, 307.0, 307.9)
- Substance Abuse Disorders
- Mental Disorders Due to a General Medical Condition
- Delirium, Dementia, Amnestic, and other Cognitive Disorders
- Factitious Disorders
- Feeding Disorders of Infancy or Childhood
- Elimination Disorders
- Sexual Dysfunctions
- Sleep Disorders

*If a diagnosis listed above is the **ONLY** DSM (most current edition) diagnosis, the child/youth is ineligible for SEBD services. However, these diagnoses may and often do co-exist with other DSM diagnoses, which would not make the child/youth ineligible for SEBD services.
**Co-occurring diagnoses of Intellectual Disability and Pervasive Developmental Disorders require close collaboration and coordination with State of Hawaii Department of Health (DOH) and State of Hawaii Department of Education (DOE) services. The health plan, with CAMHD, is responsible for coordinating these services. These diagnoses may be subject to a forty-five (45) day limit on hospital-based residential services, after which utilization review and coordination of services with DOE need to occur.

Severe Mental Illness/Serious and Persistent Mental Illness

Eligible Diagnoses:

- Substance Induced Psychosis:
  - Alcohol Induced Psychosis (F10.15x, F10.25x, F10.95)
  - Opioid Induced Psychosis (F11.15x, F11.25x, F11.95x)
  - Cannabis Induced Psychosis (F12.15x, F12.25x, F12.95x)
  - Sedative Induced Psychosis (F13.15x, F13.25x, F13.95x)

    - Cocaine Induced Psychosis (F14.15x, F14.25x, F14.95x)
    - Other Stimulant Induced Psychosis (F15.15x, F15.25x, F15.95x)
    - Hallucinogen Induced Psychosis (F16.15x, F16.25x, F16.95x)
    - Inhalant Induced Psychosis (F18.15x, F18.25x, F18.95x)
    - Other Substance Induced Psychosis (F19.15x, F19.25x, F19.95x)
- PTSD (F43.1x)
- Schizophrenia (F20.x, includes Schizophreniform disorder F20.81)
- Schizoaffective Disorder (F25.x)
- Delusional Disorder (F22)
- Bipolar Disorder (F30.xx, F31.xx)
- Major Depressive Disorder, Severe: (F32.3, F33.2, F33.3)
- Borderline Personality Disorder (F60.3)

ATTACHMENT F
Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services Protocol [Reserved]

HRSN Services. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs), this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) program, as specifically required by STC 8.7. The state may claim FFP for the specified evidence-based HRSN services identified in STC 8.2 (subject to the restrictions described below and the exclusions in STC 8.4). This protocol outlines the covered HRSN services and processes/policies for identifying eligible individuals, determining the services medically appropriate, developing care plans based on assessment of need, conducting closed-loop referrals to services and providers based on assessment of need, and delivering services in a culturally competent manner without duplication/displacement of nutrition and housing programs like SNAP. In addition to the below services, eligible beneficiaries may be provided complementary services authorized outside of the HRSN framework, including nutrition counseling, the provision of cooking supplies, and non-medical transportation to and from HRSN services.

I. Member Eligibility

a. The eligibility criteria listed below encompasses the most expansive eligibility framework for which the state has CMS approval. In recognition of the cap on HRSN expenditures, the state may further narrow eligibility criteria upon implementation to maintain compliance with expenditure caps. If the state chooses to narrow eligibility parameters, it will identify its approach for doing so in STC 8.8, Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services.

b. **Covered Populations.** All Medicaid eligible populations will be eligible to receive HRSN services, provided that they also satisfy the applicable clinical and social risk criteria and the HRSN service is determined to be medically appropriate. To be eligible for Community Integration Services Plus (CIS+), a beneficiary must be 18 years of age or older.

c. **Medical Appropriateness.** To ensure the services are medically appropriate, the state will require that individuals identified as in need of HRSN services meet the following clinical and social risk criteria. To qualify for a HRSN service, a beneficiary must:

i. Have at least one of the clinical risk factors. The HRSN clinical risk

factors for CIS+ are listed in the appendix in Table 1. The HRSN clinical risk factors for Nutrition Supports are listed in the appendix in Table 2;

ii. Have one of the social risk factors listed in Table 3; and

iii. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service.

d. **Publicly Maintained Criteria.** The state will maintain the clinical and social risk criteria detailed above on a public facing MQD webpage and require that QI Health Plans also maintain these criteria on a public facing webpage. The content will be updated if the criteria is changed. Any changes must be approved by CMS prior to posting.

II. HRSN Services

a. **Program Administration.** MQD will leverage QI Health Plans to perform functions related to the administration of HRSN services, including performing service authorization, development of care plans, and other administrative functions. QI Health Plans may also contract with provider agencies and other delegates to perform some of these functions.

b. **Reporting, Monitoring, and Evaluation.** The state, QI Health Plans, and HRSN providers will participate in all required reporting, monitoring, and evaluation activities. As such, the state affirms that it will meet the enhanced monitoring and evaluation requirements stipulated in the STCs, which require the state to monitor and evaluate how the renewals of recurring nutrition services affect care utilization and beneficiary physical and mental health outcomes, as well as the cost of providing such services.

c. **Providing Culturally and Linguistically Appropriate Services.** All HRSN services must be provided in a way that is culturally responsive and ensures meaningful access to language services.

d. **Nonduplication of Services.** No HRSN service will be covered that is found to be duplicative of a state or federally funded service or other HRSN service the beneficiary is already receiving.

e. **Covered HRSN Services.** The state will cover the following HRSN services as defined in the table below. The benefit maximums listed below encompass the most expansive benefit maximums for which the state has CMS approval. Individuals are not entitled to receive benefit maximums. Further, in recognition of the cap on HRSN expenditures, the state may narrow benefit maximums upon implementation to maintain compliance with expenditure caps. If the state chooses to narrow benefits available, it

will identify its approach for doing so in an update to this protocol as described in the STCs.

Service	Description
Community Integration Services Plus (CIS+)	
Housing Navigation Supports	
Pre-Tenancy Supports	Activities may include: 1. Engaging beneficiaries and obtaining consent from them to participate in CIS+ via multiple modalities, including via mail, text, phone, email, street-level engagement, and in person meetings where the beneficiary lives, seeks care or other social services. 2. Connecting individuals to settings or programs where identified basic needs can be immediately met, such as access to shower, laundry, shelter, and food. 3. Working with the beneficiary to provide information necessary for and to conduct a housing needs assessment to: identify the beneficiary's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); and provide assistance in budgeting for housing and living expenses. 4. Providing beneficiaries who may have needs for medical, peer, social, educational, legal, and other related services with information and logistical support. Activities include but are not limited to assisting beneficiaries with connecting to services, helping beneficiaries find and apply for necessary supports to meet their needs, and other referral activities. 5. Developing an individualized care plan based upon the housing needs assessment. Identifying and

	establishing short and long-term measurable goal(s) and establishing how goals will be achieved and how concerns will be addressed. 6. Participating in care plan meetings at enrollment, redetermination and/or revision plan meetings, as needed. 7. Assisting in obtaining identification/ documentation (e.g., Social Security card, birth certificate, prior rental history) needed to apply for and receive benefits and other supports. 8. Coordinating and linking the recipient to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports.
Tenancy Sustaining Services	Activities may include: 1. Service planning support and participating in care plan meetings at enrollment, redetermination, and/or revision plan meetings, as needed. 2. Entitlement assistance including assisting beneficiaries in obtaining, maintaining or renewing documentation, navigating and monitoring application/renewal process, and coordinating with the entitlement agency. 3. Assistance in accessing supports to preserve the most independent living environment such as individual and family counseling, support groups, and natural supports. 4. Providing supports to assist the beneficiary in the development of independent living skills, such as skills coaching, financial counseling, and anger management. 5. Providing supports to assist the beneficiary in communicating with the landlord and/or property

	manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. 6. Coordinating with the beneficiary to review, update and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. 7. Connecting the beneficiary to training and resources that will assist the individual in being a good tenant and complying with the terms of their lease, including ongoing support with activities related to household management. 8. Providing beneficiaries who may have continued or newly identified needs for medical, peer, social, educational, and other related services with information and logistical support. Activities include but are not limited to assisting beneficiaries with connecting to services, helping beneficiaries find and apply for necessary supports to meet their needs, and other referral activities. 9. Assisting the individual by referring the beneficiary to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. This service does not include legal representation or payment for legal representation.
Housing Supports	
One-Time Transition and Moving Costs and Housing Deposits	One-time transition and moving costs necessary to establish a basic household such as: 1. Housing application costs. 2. Deposits needed to secure housing (i.e., security deposits); 3. Non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related

	to unpaid utility bills; 4. Relocation expenses; 5. Pest eradication; 6. Pantry stocking at move in (up to 30 days of food); and 7. Basic household goods and furniture, which may include appliances necessary for food consumption, bedding, furnishings, cribs, bathroom supplies, and cleaning supplies.
Utility Costs	Utility costs are available for up to six months per demonstration period for total prospective/retrospective payments (utility assistance provided as a one-time transition service is included in this limit). This service provides payment for: 1. Recurring utilities. 2. Non-refundable, non-recurring utility set-up costs for utilities or restart costs if the service has been discontinued, and up to six months of arrears related to unpaid utility bills (non-duplicative of one-time transition and moving costs above). This service will cover expenses for the following types of utility payments: • Garbage/Rubbish • Water • Sewage • Recycling • Gas • Electric • Internet • Phone (inclusive of land line phone service and cell phone service)
Short-Term Rental Assistance	Payment for rent and/or short-term, temporary stays for up to six months, including: • Rent payments for apartments, single room occupancy (SRO) units, single-family homes, multi-family homes, accessory dwelling units (ADUs), micro housing units, shared housing arrangements, co-housing communities, middle housing types,

	trailers, manufactured homes; manufactured home lots, motel, or hotel when it is serving as the beneficiary's primary residence; transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming (e.g., kauhales). • Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded as housing settings for this service. Eligible costs for Short-Term Rental Assistance, as applicable, include: • Rent payment (past due or forward rent) or program/facility fees • Storage fees • Renter's insurance if required by the lease • Landlord paid utilities that are part of the rent payment and are not duplicative of other HRSN utility payments Payments must only be provided in connection with dwellings that are meant for human habitation. Room and board-only interventions are limited to a combined 6 months per household per demonstration period. All section 1115 demonstration HRSN housing interventions with room and board are limited to a global HRSN housing cap of a combined 6 months per rolling 12-month period.
Medically Necessary Repairs, Remediation, and Home Accessibility Modifications	Repairs or remediation for issues such as mold or pest infestation if repair or remediation provides a cost-effective method of addressing occupant's health condition, as

	documented by a health care professional, and remediation is not covered under any other program. This service is furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's care plan and the enrollee is unable to meet such expense or when the services cannot be obtained from other sources. Modifications to improve accessibility of housing (e.g., ramps, rails) and safety (e.g., grip bars in bathtubs) are covered when they are necessary to ensure occupant's health, and when the modification(s) are not covered under any other provision such as the Americans with Disabilities Act.
Housing interventions with clinical services with room and board including Pre-Procedure Housing, Recuperative Care, and Short-Term Post-Hospitalization Housing are limited to up to a combined 6 months per rolling year, defined as a continuous 12-month period with the start date beginning when the beneficiary begins receiving the service. All section 1115 demonstration HRSN housing interventions with room and board are limited to a global HRSN housing cap of a combined 6 months per rolling 12-month period. Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded as housing settings for these services.	
Pre-Procedure Housing	Short-term housing prior to a planned procedure or medical treatment. Pre-procedure housing will be provided to those meeting CIS+ eligibility criteria who have a planned medical procedure requiring preparation care (e.g., colonoscopy) or who have a planned medical treatment (e.g., chemotherapy treatment) requiring care prior to or following treatment. Pre-procedure stays are limited to a clinically appropriate amount of time as determined by the clinical provider or as indicated by the procedure or treatment requiring a stay.
Recuperative Care	Up to 90 days of short-term residential care that

	provides for ongoing medical and psychiatric needs. Such care may include monitoring vital signs, conducting assessments, wound care, medication monitoring, coordinating transportation to discharge appointments, connecting individuals to other needed medical or psychiatric services, support in accessing other social services and benefits, monitoring and supporting nutrition and diet, and other support services. The state will allow facilities with appropriate staffing and experience, as determined by the state and/or QI Health plans, to provide recuperative care services, including but not limited to: 1. Interim housing facilities with additional on-site support (e.g., kauhales); 2. Shelter beds with additional on-site support; 3. Converted homes, hotels, or other lodging facilities with additional on-site support; and 4. Recuperative care or medical respite facilities.
Short-Term Post-Hospitalization Housing	Up to six months of short-term housing for individuals who do not have a residence to continue recovery for physical, psychiatric, or substance use conditions following discharge or exit from an institution. Based on the individual's level of care needs, the services provided may include appropriate physical and behavioral healthcare. The state will allow facilities with appropriate staffing and experience, as determined by the state and/or QI Health Plans, to provide short-term post hospitalization housing services,

	including but not limited to: 1. Interim housing facilities with additional on-site support (e.g., kauhales); 2. Shelter beds with additional on-site support; 3. Converted homes, hotels, or other lodging facilities with additional on-site support; and 4. Recuperative care or medical respite facilities.
Nutrition Supports	
Nutrition Instruction	Any combination of instructional and educational strategies designed to motivate and facilitate voluntary adoption of food choices and other food- and nutrition-related behaviors conducive to health and well-being. Nutrition education topics that might be addressed include, but are not limited to: • Food preparation • Reading food labels • Budgeting for meals • Navigating grocery stores and farmer's markets • Gardening • Other topics to support access to healthy foods. Individuals may receive up to 12 sessions per six-month period of eligibility. This service must: • Be provided in accordance with evidence-based nutrition guidelines and other best practices. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.
Medically Tailored Meals[8]	Medically Tailored Meals are tailored to support individuals with health condition(s) for which nutrition supports would

[8] This intervention may be renewed for additional six-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria.

	improve health outcomes. This service includes: 1. The preparation and provision of the prescribed meals consistent with a nutrition plan, up to three meals a day, with each authorization of services for up to six months; and 2. Delivery of the meal. Each meal must contain sufficient food to support approximately one-third of an individual's daily nutritional need as indicated by the Dietary Reference Intakes and Dietary Guidelines. The meal may also include an accompanying fluid/drink and/or a supplementary food item to support meeting a beneficiary's nutrition needs between meals if medically appropriate (for example, to provide access to fluids and/or support taking medication accompanied by food). Meals may consist of fresh or frozen food. If a beneficiary is receiving three medically tailored meals/day, the beneficiary may not concurrently receive meals or pantry stocking or fruit and vegetable prescriptions or protein boxes. The service must: • Be provided in accordance with evidence-based nutrition guidelines and other best practices. • Follow food safety standards. • Consider an individual's personal and cultural dietary preferences. Assessments for Medically Tailored Meals are conducted through nutrition counseling services (covered by the State Plan). This visit provides an initial assessment with an eligible provider to develop a medically appropriate nutrition plan for the HRSN Medically Tailored Meals service. This also covers a reassessment, if needed, to understand whether the service is meeting the beneficiary's needs.

Meals or Pantry Stocking[9]	Meals or pantry stocking services provide healthy meals, groceries, or supplies to grow fruits and vegetables to provide adequate food for an individual for up to three meals per day, seven days per week. Meals and pantry stocking may be provided through any combination of vouchers, spendable cards, and direct provision (e.g., pre-made meal delivery), and may be accessed via delivery, at the provider site, or through other arrangements. These services must be consistent with the beneficiary's care plan and are available for up to three meals a day, with each authorization of services for up to six months. Pantry stocking should not duplicate pantry stocking covered as part of one-time moving costs under CIS+. Examples of allowable foods for pantry stocking include: • Fruits, vegetables, and legumes; • Meat, poultry, and fish; • Dairy products; • Breads and cereals; • Snack foods and non-alcoholic beverages; and • Seeds and plants, which produce food for the household to eat. This service may: • Take into account a beneficiary's household size when provided to the household of a child or a pregnant individual (plus twelve months postpartum); • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases. This service must: • Be provided in accordance with evidence-based nutrition guidelines and other best practices.

[9] This intervention may be renewed for additional six-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria.

	• Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.
Fruit and Vegetable Prescription or Protein Boxes[10]	Fruit and vegetable prescriptions and protein boxes provide fruits, vegetables, supplies to grow fruits and vegetables, and proteins through any combination of vouchers, spendable cards, and direct provision (e.g., subsidized food boxes, garden-based deliveries, etc.). Fruits and vegetables available for purchase through this service may be fresh, frozen, or canned. These prescriptions and boxes may be delivered, accessed at the organization site, or offered through other arrangements. This service is not intended to cover all costs of all meals, but rather to support a beneficiary in increasing their consumption of healthy foods. Further, this benefit may be used to supplement and augment the nutritional value of any other benefit that fully meets an individual's nutrition needs. Each authorization of this service will be for up to six months. This service may: • Take into account a beneficiary's household size when provided to the household of a child or a pregnant individual (plus twelve months postpartum); • Be administered through, for example, a voucher or prepaid card to be used only at a food retailer for allowable purchases; and This service must: • Be provided in accordance with evidence-based nutrition guidelines and other best practices. • Follow food safety standards. • Be person-centered, consider dietary preferences, and be culturally appropriate.

[10] This intervention may be renewed for additional six-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria.

III. Provider Qualifications

a. Service providers will be required to meet the following minimum qualification requirements:

i. Demonstrate the capacity and experience to provide HRSN services as described below:

1. CIS+ providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.
2. Nutrition Supports providers must have knowledge of principles, methods, and procedures of the nutrition services covered under the waiver, or comparable services meant to support an individual in obtaining food security and meeting their nutritional needs. Nutrition service providers must follow best practice guidelines and industry standards for food safety.
3. **HRSN Provider Experience and Expertise**: All HRSN services providers are expected to meet certain qualifications that ensure they are capable of providing high-quality and culturally appropriate services to qualifying beneficiaries. In addition to the qualifications noted below, all HRSN service providers will be expected to comply with all applicable Medicaid provider requirements. HRSN service provider qualifications may include, for example:
    a. Maintain sufficient hours of operation and staffing to serve the needs of HRSN participants.
    b. Demonstrate their capabilities and/or experience with providing at least one HRSN service. HRSN Providers may demonstrate these capabilities and/or experience through, for example:
        1 One or more years of demonstrated experience to provide the specified HRSN service(s). In addition to direct service provision, demonstrated experience may also include community outreach, completing assessments, assisting individuals with applying for benefits, obtaining necessary documentation, and other relevant experience as determined by the QI Health Plans.
        2 Maintaining all necessary licenses, registrations,

and certifications as required by applicable federal and state laws, and the QI Health Plans. All HRSN Providers should have relevant training for the HRSN services they are providing, which may include specific training and education on common housing and nutrition-related capabilities such as harm reduction, fair housing laws, food safety standards, and the Health Insurance Portability and Accountability Act (HIPAA).

3. Other methods deemed appropriate by the QI Health Plan.
4. Demonstrate that it has qualified service delivery and administrative staff, as determined at the QI Health Plan's discretion.

c. The ability to comply with applicable federal and state laws.
d. The capacity to provide culturally and linguistically appropriate service delivery by:
    1. Demonstrating a willingness and ability to draw on community-based values, traditions, and customs to devise strategies to better meet culturally diverse beneficiary needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.
    2. Providing services to people of all cultures, races, ethnic backgrounds, and religions, including those with limited English proficiency and/or disabilities, and regardless of gender, sexual orientation, or gender identity, in a manner that recognizes, affirms, and respects the worth of the individual beneficiary and protects and preserves the dignity of each.

b. QI Health Plans will be required to ensure that HRSN service providers meet and maintain compliance with these minimum qualification requirements.

IV. Member Identification and Assessment of Service Need.

a. **Member Identification.** MQD and QI Health Plans will use multiple pathways for beneficiaries to be identified as having one or more HRSN social or clinical risk factors, and potentially having one or more HRSN service needs. Pathways for beneficiary identification includes:
    i. QI Health Plans proactively identifying beneficiaries with HRSN through targeted outreach, reviews of available data (including encounter and claims data), and other methods;
    ii. Accepting beneficiaries' self-referrals; and
    iii. Coordinating with and accepting referrals from entities that identify beneficiaries with HRSN needs. For example, housing service agencies or housing providers, healthcare providers, and other CBOs that engage with Medicaid beneficiaries (e.g. food banks) are examples of entities that may refer individuals for HRSN services.

b. **HRSN Referrals.**

    i. The state will develop an HRSN Referral Form that contains necessary information about individuals identified with a service need for an approval decision. Given the multiple points of entry into HRSN services, completion of the HRSN Referral Form is not mandatory; rather, the form is provided as a tool to enable standardized data collection from community-based referral sources. Information collected, as known by and available to the referring entity, in the HRSN Referral Form includes:
        1. Referring party information;
        2. Beneficiary information;
        3. Identification of possible HRSN service needs;
        4. Beneficiary HRSN eligibility information (e.g., clinical and social risk factors); and
        5. Documentation substantiating beneficiary risk factors.
    ii. HRSN Referral Forms shall be sent to the beneficiary's QI Health Plans or to MQD Health Care Services Branch (HCSB) if the QI Health Plan is unknown. MQD will forward any HRSN Referral Forms received to the beneficiary's current QI Health Plan.
    iii. HRSN Referral Forms should be completed as feasible; however, referring parties will be encouraged to submit the referral form with any available information and documentation regardless of

completeness. QI Health Plans will be responsible for obtaining any additional information required to determine eligibility and authorize appropriate services.

V. Eligibility Determination.

a. Once a beneficiary is identified by QI Health Plans through internal sources, self-referrals, or referrals by external entities, QI Health Plans are responsible for obtaining and verifying any additional information/documentation required to confirm eligibility.

b. For beneficiaries identified through internal sources, QI Health Plans will have 30 days from identification to determine eligibility and engage the individual. For beneficiaries identified through self or external referrals, QI Health Plans will have no more than 30 days from the receipt of the referral to determine eligibility and engage the individual.

c. Where required for specific HRSN services, as determined by MQD, the QI Health Plan (or their delegates) will contact the beneficiary and obtain consent to participate in the HRSN program(s) or service(s). As a part of this process, the QI Health Plans will explain the services, provide an opportunity for the beneficiary to ask questions, and provide other adequate information to support the beneficiary in making an informed choice. Beneficiaries may engage any advocates of their choosing (e.g., a parent, guardian, or caregiver) to participate in this consent process on their behalf.

d. QI Health Plans must incorporate a protocol for HRSN eligibility determination appeals into their overall member and provider grievance and appeals processes.

VI. Services Approval and Care Plans.

a. QI Health Plans (or their delegates) will authorize HRSN services as expeditiously as possible by:

i. Performing assessments to determine eligibility and appropriateness for specific HRSN services where an assessment is required, such as Medically Tailored Meals.

ii. Authorizing HRSN services based on the following criteria:

1. Confirmation that the beneficiary is enrolled in Medicaid;
2. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;

3. Assessment of the individual's clinical and social needs (described above in Section I.c) that justify the medical appropriateness of the service; and,
4. Determination of the medically appropriate service duration, not to exceed the service duration limits specified in the definitions of Covered HRSN Services (Section II.e) or create duplication of existing benefits received through other programs, such as SNAP.

iii. QI Health Plans must incorporate a protocol for HRSN service appeals into their overall member and provider grievance and appeals processes.

b. The QI Health Plans will coordinate and monitor the receipt of HRSN services. Beneficiaries can opt out of coordination and monitoring activities. The QI Health Plans will:

i. Develop a care plan with the beneficiary, with review at least every 12 months;
ii. Conduct closed loop referrals to HRSN provider(s) for the approved services, and support beneficiary choice of provider, ensuring beneficiary needs are met by the provider, including through regular communication with the individual and HRSN provider delivering the service, and finding alternative providers if needed;
iii. Identify the HRSN services the beneficiary has been authorized for;
iv. Identify other services the beneficiary is receiving or may be eligible to receive under Medicaid or other programs;
v. Coordinate with other social support services and care management the beneficiary is already receiving or becomes eligible for while receiving the HRSN service;
vi. Conduct a reassessment for services prior to the conclusion of the service; and
vii. At a minimum, conduct a six-month check-in to understand if HRSN services are meeting the beneficiary's needs, if additional/new services are needed, or if HRSN services are duplicating other services they are receiving.

c. The QI Health Plan and the beneficiary will create the care plan for the individual to obtain the HRSN service(s) as approved by the QI Health Plan. The care plan will be in writing and developed with and agreed upon by the beneficiary. Care plans will be updated to reflect follow-ups, transitions, and reassessment of needs at least annually.

i. The care plan will include:

1. The recommended HRSN service(s);
2. The service duration;
3. The determination that the recommended service(s), unit(s) of service, and service duration is medically appropriate based on clinical and social risk factors; and
4. The goals of the service(s).
5. Beneficiaries may engage any advocates of their choosing (e.g., a parent, guardian, or caregiver) to participate in the assessment, care planning, or receipt of HRSN on their behalf.

VII. Conflict of Interest.

a. To protect against conflict of interest and ensure compliance with HCBS conflict of interest standards, the state will require that the QI Health Plan perform the service authorization function and develop the care plan and prohibit the subcontracting of such functions where that would result in a single entity conducting the assessment, service planning, and service provision, except as provided in subsection (b) below, or otherwise approved by MQD.

b. Assessment, service planning, and service provision for select services may be provided by QI Health Plans subject to protocols established by the state to ensure that assessment, service planning, and service provision are performed in a manner that guards against conflicts of interest.

VIII. Payment.

a. After providing HRSN services to beneficiaries who satisfy HRSN eligibility requirements, HRSN service providers will submit an invoice and any additional required documentation to the beneficiary's QI Health Plan.

b. QI Health Plans will reimburse HRSN service providers according to a fee schedule for HRSN services to be developed by the state.

Appendix

Clinical Risk Factors

Table 1. Clinical Risk Factors for CIS+	
Clinical Risk Factor	**Clinical Risk Factor Description**
Complex Behavioral Health Need	1. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or 2. Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1 indicating the need for intensive outpatient treatment for a substance use disorder (SUD).
Complex Physical Health Need	Beneficiary assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).
Recuperative Care or Short-Term Post-Hospitalization Housing Need	An individual must meet one of the three following criteria: 1. Are at risk of ED/hospitalization or institutional care due to a clinical condition; 2. In the ED or hospitalized; or 3. In institutional care And, an individual must have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of recuperative care or short-term post-hospitalization housing.
Pre-Procedure Housing Need	Have a planned medical procedure requiring preparation care (e.g., colonoscopy) or have a planned medical treatment (e.g., chemotherapy treatment) requiring care prior to or following treatment as determined by a qualified health professional.

Table 2. Clinical Risk Factors for Nutrition Supports	
Clinical Risk Factor	**Clinical Risk Factor Description**
Complex Behavioral Health Need	An individual with a persistent, disabling, progressive, or life-threatening mental health condition or substance use disorder that requires treatment and/or supports, and would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals.
Developmental Disability Need	An individual with an Intellectual Disability or Developmental Disability, or both, as defined in HRS § 333F-1, that would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals.
Complex Physical Health Need	An individual with an acute or chronic physical health condition(s) that would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals. Chronic conditions that would benefit from nutrition supports include eating disorders, severe food allergies, gastrointestinal disorders, complex non-healing wounds, malnourishment disorders, seizure disorders, COPD, Chronic Kidney Disease, hypertension, diabetes, cardiovascular disorders, stroke, high-risk perinatal conditions, cancer, HIV, morbid obesity (BMI 40+), pre-diabetes, and metabolic syndrome. Nutrition supports for acute physical health conditions will be limited to the time period of healing.
Needs Assistance with ADLs/IADLs or Eligible for LTSS	Individuals who meet an institutional level of care requirement and individuals who are assessed to be at risk of deteriorating to the institutional level of care (i.e., the "at risk" population) who do not reside in a Medicaid-paid setting that would benefit from nutrition supports in order to facilitate treatment, achieve

	and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals.
Health Conditions Related to Trauma	An individual who is experiencing a health condition, including but not limited to behavioral health and developmental syndromes, stemming from child abuse, domestic violence, neglect, or other types of trauma.
Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services	An individual with repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months); with repeated hospitalizations (defined as two or more hospitalizations in the past six months or five or more hospitalizations within the past 12 months); or who has received services from the Hawai‘i State Department of Health's Adult Mental Health Division, Child and Adolescent Mental Health Division, Developmental Disabilities Division, Alcohol and Drug Abuse Division, or Hawai‘i State Hospital within the past 12 months; that would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals.
Pregnant/Postpartum	1. **Medically Complicated Pregnancy:** An individual who is currently pregnant or up to 12 months postpartum for a medically complicated pregnancy. 2. **Pregnancy without Complicating Factors:** An individual who is currently pregnant or up to 2 months postpartum for a pregnancy without complicating factors.

Table 3: Social Risk Factors

Social Risk Factor	Risk Factor Description
Housing Related Need	An individual who is at least 18 years of age and homeless or at risk of homelessness as defined by HUD and codified in 24 CFR 91.5 with the following modifications: 1. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless under the HUD definition to twenty-one (21) days; 2. Individuals and families are considered at risk of homelessness if they have been notified that they will lose their current housing or living situation in writing or with verbal notification; and 3. Individuals and families are considered at risk of homelessness without additional income-based eligibility determinations (removes requirement that individuals or families have an annual income below 30 percent of Median Family Income).
Clinically Appropriate Home Modification/Remediation Service Need	An individual who is at least 18 years of age and: 1. Requires a clinically appropriate home modification/remediation service; 2. Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition; or 3. Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained.
Nutrition Related Need	An individual meeting the USDA definition[11] of low or very low food security.

[11] "Definitions of Food Security." *USDA Economic Research Service*, 2022. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/

Table 4. Service Matrix Summary

Service Category	Service	All eligible Medicaid enrollees
Housing/Home Environment interventions without room and board	Pre-tenancy Services	**X**
	Tenancy Sustaining services	**X**
	One-time transition and moving costs *other than* rent	**X**
	Utility assistance	**X**
	Medically Necessary Home Remediations	**X**
	Home/environmental accessibility modifications	**X**
Housing interventions *with* Room and Board (Episodic Interventions)	Short-term pre-procedure housing	**X**
	Short-term Recuperative care	**X**
	Short-term post-hospitalization housing	**X**
Housing interventions with Room and Board (Rent Only Interventions)	First month's rent, as a transitional service	**X**
	Short-term rental assistance	**X**
Nutrition interventions without food	Nutrition instruction	**X**
Nutrition interventions with food	Home Delivered meals/pantry stocking	**X**
	Medically Tailored Meals	**X**
	Nutrition prescriptions	**X**

Table 5. Summary of CIS+ Services, Eligible Populations, and Social and Clinical Risk Criteria

	Service	Population	Social Risk Factor	Clinical Criteria for the pop
Housing/Home Environment interventions without room and board	Pre-tenancy Services	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Tenancy Sustaining services	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	One-time transition and moving costs *other than* rent	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex

	Service	Population	Social Risk Factor	Clinical Criteria for the pop
				Behavioral Health Need 2. Complex Physical Health Need
	Utility assistance	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Medically Necessary Home Remediations	All eligible Medicaid enrollees	**Clinically appropriate home modification/remediation service need**	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Home/environmental accessibility modifications	All eligible Medicaid enrollees	**Clinically appropriate home**	One of the following health

	Service	Population	Social Risk Factor	Clinical Criteria for the pop
			modification/remediation service need	needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need

	Service	Population	Social Risk Factor	Clinical Criteria for the Population
Housing interventions with Room and Board (Episodic Interventions)	Short-term pre-procedure housing	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	Pre-Procedure Housing Need
	Short-term Recuperative care	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	Recuperative Care or Short-term Post-Hospitalization Housing Need
	Short-term post-hospitalization housing	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	Recuperative Care or Short-term Post-Hospitalization Housing Need
Housing interventions with Room and Board (Rent Only Interventions)	First month's rent, as a transitional service	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Short-term rental assistance	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need

Table 6. Summary of Nutrition Supports Services, Eligible Populations, and Social and Clinical Risk Criteria

	Service	Population	Social Risk Factor	Clinical Criteria for the Population
Nutrition interventions without food	Nutrition instruction	All eligible Medicaid enrollees	**Nutrition Related Need:** An individual meeting the USDA definition of low or very low food security	1. Complex Behavioral Health Need 2. Developmental Disability Need 3. Complex Physical Health Need 4. Needs Assistance with ADLs/IADLs or Eligible for LTSS 5. - Health Conditions related to trauma Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services 6. Pregnant/Postpartum
Nutrition interventions with food	Home Delivered meals/pantry stocking	All eligible Medicaid enrollees	**Nutrition Related Need:** An individual meeting the USDA definition of low or very low food security	1. Complex Behavioral Health Need 2. Developmental Disability Need 3. Complex Physical Health Need 4. Needs Assistance with ADLs/IADLs or Eligible for LTSS 5. Health Conditions related to trauma Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services 6. Pregnant/Postpartum
Nutrition interventions with food	Medically Tailored Meals	All eligible Medicaid enrollees	**Nutrition Related Need:** An individual meeting the USDA definition of low or very low food security	1. Complex Behavioral Health Need 2. Developmental Disability Need 3. Complex Physical Health Need 4. Needs Assistance with ADLs/IADLs or Eligible for LTSS 5. Health Conditions related to trauma Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services

	Service	Population	Social Risk Factor	Clinical Criteria for the Population
				6. Pregnant/Postpartum
	Nutrition prescriptions	All eligible Medicaid enrollees	**Nutrition Related Need:** An individual meeting the USDA definition of low or very low food security	1. Complex Behavioral Health Need 2. Developmental Disability Need 3. Complex Physical Health Need 4. Needs Assistance with ADLs/IADLs or Eligible for LTSS 5. Health Conditions related to trauma Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services 6. Pregnant/Postpartum

ATTACHMENT G
HRSN Implementation Plan [Reserved]

ATTACHMENT H
HRSN Infrastructure Protocol

HRSN Infrastructure. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs), this protocol provides additional detail on the requirements on infrastructure investments for the Health-Related Social Needs (HRSN) program, as specifically required by STC 8.9. The state's HRSN program allows qualifying Medicaid beneficiaries to receive evidence-based clinically-appropriate services. Over the course of the demonstration the state is authorized to spend up to $76.89M on infrastructure investments necessary to support the development and implementation of HRSN services. This protocol outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts and implementation timeline.

HRSN Infrastructure

II. Implementation Timeline and Approach.

a. **Timeline for Disbursement of Infrastructure Funding**
   i. The state intends to begin awarding infrastructure funds to eligible entities no sooner than **March 1, 2025**. The state will utilize a phased approach to disbursing infrastructure funds to ensure providers beginning their participation at different times have sufficient infrastructure and capacity.
   ii. Eligible entities can apply for capacity building funding on an ongoing basis.

b. **Approach to Infrastructure Funding Applications and Disbursements**

   i. The state will conduct the HRSN infrastructure application and funding disbursement activities through a combination of entities:
      1. The state intends to perform many of the activities through contracts with QI Health Plans to perform the functions listed in Section I.b.ii.
      2. The state reserves the right to assume any of the below activities directly or through a contracted vendor based on experience operationalizing the HRSN Infrastructure program.
      3. The state will review and determine awards for all HRSN Infrastructure funding applications submitted by QI Health Plans. QI Health Plans will not review or determine awards for HRSN Infrastructure funding applications submitted by QI Health Plans.
   ii. The state intends to work with QI Health Plans to conduct the following activities:
      1. Develop a joint infrastructure funding application and budget template.
      2. Conduct coordinated outreach and education to eligible entities regarding

infrastructure funding opportunities.

3. Jointly review applications against minimum entity eligibility criteria.
4. Review funding request budget templates to ensure compliance with requirements.
5. Award infrastructure funding to eligible entities.
6. Disburse funding from one or more QI Health Plans to awarded entities using a streamlined process.
7. Monitor infrastructure funding uses amongst eligible entities to prevent fraud, waste, and abuse.
8. Develop reporting templates for awardees to report on funding uses.
9. Review and analyze reports from awardees on funding uses.
10. Report on the funding utilization to the state.

iii. QI Health Plans will develop a state-approved streamlined process to evaluate and approve applications and funding requests from eligible entities. The process will encompass several activities, including, for example:

1. The state will set specific HRSN application windows in which entities can apply for and receive HRSN infrastructure funding.
2. The state will collaborate with QI Health Plans, at a minimum, to develop a process for evaluating and approving HRSN infrastructure funding requests. The state, alongside QI Health Plans, will leverage a centralized, streamlined process for submitting and evaluating HRSN infrastructure funding requests to minimize administrative burden on Community Based Organizations (CBOs) and other entities applying for funds, and to ensure non-duplication of efforts across QI Health Plans.
3. QI Health Plans will leverage standardized criteria to support evaluation of HRSN funding applications and requests across the following categories:
    a. The entity has submitted a complete application and budget request.
    b. The entity has requested HRSN funding within one of the allowable use categories listed in Section III, below.
    c. The entity has provided a strong justification for the need for HRSN infrastructure funding.
    d. Applicant has demonstrated ability to provide or support the provision of one or more HRSN services.

c. **Monitoring and Oversight**

i. QI Health Plans will monitor the utilization of infrastructure funds and provide

routine reporting to the state to ensure that any HRSN infrastructure fund disbursements are consistent with these STCs. The state will ensure that any HRSN infrastructure funding is subject to program integrity standards, including:

1. **Participating in audit processes.** The state may conduct spot audits to ensure that infrastructure funds are being spent on permissible uses and are being documented and reported on appropriately.
2. **Taking action to address non-compliance.** Action will be taken to address any identified non-compliance with HRSN infrastructure funding parameters. If the funding recipient has failed to demonstrate appropriate performance, the state may impose corrective actions (e.g., caps on funding, discontinuation of funding and/or recoupment of funding). The state will provide notice to any funding recipient prior to initiating corrective action.
3. **Ensuring non-duplication of funds.** Funding recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state will monitor for funding irregularities and potential duplication of funds.
4. **Monitoring for fraud, waste and abuse.** The state will monitor all HRSN infrastructure disbursements for instances of fraud, waste, and abuse. The state will direct QI Health Plans to suspend and/or terminate infrastructure funding in cases of confirmed fraud, waste, and/or abuse. The state reserves the right to recoup funding as necessary.

III. Eligible Entities. The following entities may be eligible to apply for and receive HRSN infrastructure funding:

a. QI Health Plans
b. Providers of HRSN services, including, but not limited to:
    i. Community-based organizations (CBOs)
    ii. Social service agencies
    iii. Housing agencies and providers
    iv. Food and nutrition service providers
    v. Case management providers
    vi. Child welfare providers
    vii. City, county, and local governmental agencies
    viii. Native Hawaiian Health System providers
    ix. Healthcare providers such as community health centers (e.g. Federally Qualified Health Centers and Rural Health Centers) and hospitals
    x. Outreach and engagement providers

c. Entities that support infrastructure and processes critical for HRSN service delivery, such as HRSN contracting, network development, billing and invoicing, and other functional activities.

In addition, entities must meet the following minimum eligibility criteria in order to be considered eligible for the HRSN infrastructure funding. Minimum eligibility criteria may include:

a. The entity is capable of providing or supporting the provision of one or more HRSN services to Medicaid beneficiaries within the state.
b. The entity intends to contract to serve as an HRSN provider for at least one HRSN service.
c. The entity has attested to being financially stable, as defined by the state.

IV. Intended Purpose and Proposed Uses of HRSN Infrastructure Funding. The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains.

a. Technology
b. Development of business or operational practices
c. Workforce development and network provider capacity
d. Outreach, education, and stakeholder convening

The state intends to provide infrastructure funding to eligible entities for activities within the domains listed above and specified below:

b. Technology. Qualifying entities can leverage HRSN infrastructure funding to support a range of technology needs, including those that support closed-loop referral platforms and other community information exchange priorities.

i. Procuring IT infrastructure/data platforms/systems needed to enable:
    1. Authorization of HRSN services
    2. Documentation of eligibility for HRSN services and track enrollment
    3. Closed loop referral to HRSN services
    4. Record assessments and plans of care
    5. HRSN service delivery
    6. HRSN service billing and invoicing
    7. HRSN program oversight, monitoring and reporting, including for activities beyond HRSN infrastructure (e.g., reporting on HRSN services delivered, monitoring to ensure beneficiaries receive the services for which they were authorized, activities to prevent fraud, waste and abuse across the HRSN program)
    8. Determine eligibility for other federal, state and local programs including Supplemental Nutrition Assistance Program (SNAP) and/or Women, Infants, and Children (WIC)

9. Data sharing between entities to support HRSN implementation, monitoring, evaluation, and ongoing operational activities including transitions of care.

ii. Modifying existing systems (e.g., community/health information exchange) to support HRSN.

iii. Development of an HRSN eligibility/services screening tool.

iv. Integration of data platforms/systems/tools.

v. Onboarding to new, modified, or existing systems.

vi. Training for use of new, modified, or existing systems.

c. Development of Business or Operational Practices.

i. Development of policies/procedures/workflows/standard operating procedures (SOPs) related to operationalizing a variety of business and operational practices supporting HRSN implementation related to:
   1. HRSN referral and service delivery workflows
   2. Billing/invoicing
   3. Data sharing/reporting
   4. Program oversight/monitoring
   5. Evaluation
   6. Privacy and confidentiality

ii. Training/technical assistance on HRSN program and roles/responsibilities.

iii. Administrative items necessary to perform HRSN duties and/or expand HRSN service delivery capacity. (e.g., initial month of lease payments for new or an extension of existing office spaces needed to support HRSN operations).

iv. Cost of furnishings, supplies, and equipment that support the delivery of HRSN services (e.g., computers, desks, chairs, etc.).

v. Procurement of administrative supports to assist implementation of HRSN.

d. Workforce Development.

i. Cost of recruiting, hiring, and training new staff to provide HRSN.

ii. Salary and fringe for staff that will have a direct role in overseeing, designing, implementing and/or executing HRSN responsibilities.

iii. Necessary certifications, training, technical assistance and/or education for staff participating in the HRSN program (e.g., on culturally responsive care).

iv. Privacy/confidentiality training/technical assistance (TA) related to HRSN service delivery.

v. Production costs for training materials and/or experts as it pertains to the HRSN program.

e. Outreach, Education and Stakeholder Convening.

i. Production of materials necessary for marketing, outreach, training and/or education related to HRSN.
ii. Translation of materials.
iii. Planning for and facilitation of community-based outreach events to support awareness of HRSN services.
iv. Planning for and facilitation of learning collaboratives or stakeholder convenings for HRSN.
v. Community engagement activities necessary to support HRSN program implementation and launch (e.g., roundtable to solicit feedback on guidance documents).
vi. Administrative or overhead costs associated with outreach, education or convening directly tied to HRSN.

V. Projected Expenditure Amounts. The state estimates the following infrastructure expenditure amounts by allowable use category over the course of the demonstration. The state used the annual infrastructure spending amounts articulated in the state's STCs, and an analysis of anticipated need across the state to develop the estimates below. The state anticipates that the percentage of spend permissible use categories (as illustrated in the table below) will stay relatively constant across the Demonstration Years.

Allowable Use Category	% of Spend	Estimated Amount
Technology	25%	$19.2M
Development of Operational or Business Practices	30%	$23.1M
Workforce Development	20%	$15.4M
Outreach, Education and Stakeholder Convening	25%	$19.2 M
Total	**100%**	**$76.89M**

ATTACHMENT I
Approved DSHP List

The DSHP-eligible expenditures in this list exclude prohibited costs, in accordance with STC 12.2

Program	Description	DSHP-Eligible Expenditures
Newborn Metabolic Screening Program	The Hawaii Department of Health Newborn Metabolic Screening Program provides genetic medical tests to identify 33 disorders using tandem mass spectrometry. The goal of this screening is to provide early detection and treatment options to promote growth and development of the child. This screening is required for every baby born in Hawaii, unless the parents have religious objections and sign a refusal form. These services are financed by state funds and program fees and not matched with federal funding or used to meet federal maintenance of effort requirements.	$1,985,936 (annual) $9,929,680 (5-year Demo)
In-Home and Community-Based Services	The Hawaii Department of Health's Executive Office on Aging provides in-home and community-based services to assist older adults in remaining independent and active. Services provided include adult day care, attendant care, case management, congregate meals, home delivered meals, homemaker, nutrition education, personal care, and transportation. There are also services available to family caregivers including training, and respite. The expenditures listed here to provide these services are financed by state funds and are not matched with federal funding or used to meet federal maintenance of effort (MOE) requirements.	$13,515,422 (annual) $67,577,110 (5-year Demo)
Community Health Centers	The Hawaii Department of Health supports fourteen federally qualified health centers (FQHCs) to provide medical (perinatal, pediatric, adult primary care) & support services to un- and under-insured individuals that are at or below 250% of the federal poverty level. Optional services include behavioral health care, dental treatment, & pharmaceutical services. This fund also supports FQHCs Hana Health and Waianae Coast	$4,283,309 (annual) $21,416,545 (5-year Demo)

Program	Description	DSHP-Eligible Expenditures
	Comprehensive Health Center to provide 24-hour urgent care and emergency room services, respectively. This special fund is financed by the State, via taxes on cigarettes, and is not matched with federal funding or used to meet federal maintenance of effort requirements.	
Communicable Disease and Nursing Services	The Hawaii Department of Health supports the provision of services, including public health nursing, tuberculosis clearance, hepatitis treatment, HIV and STI prevention, and other services. Public health nursing services include facilitating healthy lifestyles and disease prevention across the lifespan of target populations, providing care in response to disasters and public health emergencies, preventing and treating the spread of communicable diseases such as Hansen's disease and vaccine preventable diseases, and offering health consultation to public and private schools, preschools, and childcare facilities. These services are financed by State general funds and not matched with federal funding or used to meet federal maintenance of effort requirements.	$8,389,311 (annual) $41,946,555 (5-year Demo)
Family and Children's Health Services	The Hawaii Department of Health supports the provision of services to families, including those with disabilities ranging from autism spectrum disorder to cerebral palsy. The population served is low income uninsured and underinsured non Medicaid members. These services include maternal and child health services, early childhood disability diagnoses and interventions, and behavioral health services, among others. Provider types range from major hospital systems and federally qualified health centers to community-based specialty providers. These services are financed by State general funds and not matched with federal funding or used to meet federal maintenance of effort requirements.	$13,805,265 (annual) $69,026,325 (5-year Demo)

Program	Description	DSHP-Eligible Expenditures
Tobacco Quitline and Cessation Grantees Program	The Hawaii Department of Health contracts with the Hawaii Community Foundation to administer the Hawaii Tobacco Prevention and Control Trust Fund which implements comprehensive tobacco prevention and control program consistent with CDC best practices. Cessation interventions include the (Hawaii Tobacco Quitline and My Life, My Quit) and a grant program to 16 community-based cessation programs that assist adults in priority populations (persons with mental health and/or substance abuse challenges, LGBTQ+ communities, and low socio-economic status populations) to end tobacco use Free services provided by the Tobacco Quitline include nicotine replacement therapies and programs specifically serving the following populations: pre-pregnancy, pregnant and postpartum, individuals with behavioral health conditions, and youth/young adults. These programs are supported by the Hawaii Tobacco Prevention and Control Trust Fund and not matched with federal funding or used to meet maintenance of effort requirements.	$2,555,436 (annual) $12,777,180 (5-year Demo)
Total Allowable DSHP-Eligible Expenditures		$222,673,395
Total Allowable DSHP-Eligible Expenditures with Adjustment		$215,770,520
Total DSHP Cap. The state must not claim more than the capped amount of DSHP.		$128,100,000

ATTACHMENT J
DSHP Claiming Protocol [Reserved]

ATTACHMENT K
Contingency Management Protocol [Reserved]

ATTACHMENT L
Reentry Demonstration Initiative Services

Covered Service	Definition
Case Management	In-reach case management, including: • comprehensive initial assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services; • development (and periodic revision) of a specific transition care plan based on the information collected through the assessment(s); • making referrals and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed supportive and stabilizing services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; • monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary; • developing medication management plans, and other coordination and management supports; and • providing culturally and linguistically appropriate care and education to individuals, families, caretakers, and other circles of support. Case management will be delivered by QI health plans or contracted care management providers, including peers with lived experience.
Medication for Addiction Treatment Services	Medication Assisted Treatment (inclusive of necessary MAT counseling and therapy) for all types of substance use disorders, as clinically appropriate, including coverage for all FDA approved medications for use during the pre-release period.

30-day Supply of Prescription Medications	A minimum of 30-day supply of prescription medications (consistent with the State Plan coverage), including prescribed over-the-counter drugs (as clinically appropriate) and MAT prescriptions (or support to ensure a beneficiary can access appropriate MAT that must be provided in-person, such as methadone), for use post-release in the community.
Practitioner Office Visit	Physical and behavioral health clinical consultation services, including screenings, diagnostic services, referrals, and orders, provided by carceral or in-reach community-based providers.
Diagnostic services	Laboratory and radiology services, consistent with state plan coverage.
Medical Equipment and Supplies	Durable Medical Equipment (DME) for use post-release into the community, consistent with State Plan coverage.
Peer Support Services	Peer support services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. Peer support providers are self-identified consumers who are in recovery from mental illness, physical illness and/or substance use disorders, other lived experiences such as justice-involved or child welfare system. Peer support providers must be certified by the State Department of Health, Adult Mental Health Division (AMHD) as part of their Hawaii Certified Peer Specialist (HCPS) program or a peer support program established by another State agency that meets existing and established national peer support criteria and be supervised by a mental health professional. Peer Support Services must be coordinated within a comprehensive, individualized plan of care. Peer support services may include educational skill building groups, activities and coaching to support participation in treatment and transitions, and structured non-clinical activities to promote recovery, wellness, self-advocacy, and other activities to support recovery within the community.

ATTACHMENT M
Reentry Demonstration Initiative Implementation Plan [Reserved]

ATTACHMENT N
Reentry Demonstration Initiative Reinvestment Plan [Reserved]

ATTACHMENT O
Monitoring Protocol [Reserved]

ATTACHMENT P
Provider Rate Increase Attestation Table

Hawaii HRSN and DSHP Related Provider Payment Increase Assessment – Attestation Table		
The reported data and attestations pertain to HRSN and DSHP related provider payment increase requirements for the demonstration period of performance DY 32 through DY 36.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service Ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	**100%**	**100%**
	We believe the approach is consistent with STC 13.5(a) *We note also that Hawai`i is effectively 100% Managed Care.*	*We believe the approach is consistent with STC 13.5(a).*
Obstetric Care Services	**100%**	**100%**
	We believe the approach is consistent with STC 13.5(a). *We note also that Hawai`i is effectively 100% Managed Care.*	*We believe the approach is consistent with STC 13.5(a).*

Behavioral Health Care Services	**100%**	**100%**
	We believe the approach is consistent with STC 13.5(a). *We note also that Hawai`i is effectively 100% Managed Care.*	*We believe the approach is consistent with STC 13.5(a).*

In accordance with STCs 13.1 through 13.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in each of the three categories with a ratio below 80 percent in both fee-for-service and managed care delivery systems as applicable to the state's Medicaid or demonstration service delivery model. Such provider payment increases for each service will be effective beginning on January 1, 2027 and will not be lower than the highest rate for that service code in DY 32 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least December 31, 2029.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 13.4 will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b. below]

X a. The effective date of the rate increases is the first day of DY 34 (January 1, 2027) and will be at least sustained, if not higher, through DY 36 (December 31, 2029).

☐ b. Hawaii has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of DY 34 (January 1, 2027). Hawaii will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 36 (December 31, 2029).
Hawaii *does* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care. For any such payments, as necessary to comply with the HRSN and DSHP STCs, I agree to submit by no later than [*see statement at the end of this document*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*see statement at the end of this document*]. Hawaii does include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care. For any such payments, as necessary to comply with the HRSN and DSHP STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 13.10 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than [*see statement at the end of this document*].
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 13.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Hawaii further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 13.
I, *Eric Nouchi, Med-QUEST Division Finance Officer,* attest that the above information is complete and accurate. [*Provide signature*  *] [Provide date* April 7, 2025 *]* *[Eric Nouchi]*

Provider Rate Increase Attestation Narrative

The State updated fee schedule methodologies to be consistent with 100% of the Medicare Fee Schedule in effect for the prior calendar year effective January 1, 2024. This was incorporated into the State Plan and managed care plans were directed to follow the state plan with regard to payment for physicians, behavioral health providers, and other health care professionals outlined in the memo below.

Our understanding of the 13.5(a) approach is that it is a broad comparison to Medicare such that all services in that cohort should compute to the same percentage of Medicare as a ratio to the Medicaid fee schedule, where 13.5(b) may have more variation in the ratio for each service but the aggregate meets the threshold.

Further supporting this attestation:

- State Plan Memo 23-08 implementing professional fee schedule changes.

  https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/spa-memos/SPA%20MEMO%2023-08%20and%20Attachments.pdf

- Memo instructing managed care plans to reimburse professional and behavioral health providers at 100% of the prevailing Hawai`i Medicare fee schedule.

  https://medquest.hawaii.gov/content/dam/formsanddocuments/provider-memos/qi-memos/qi-memos-2023/QI-2341,%20CCS-2314,%20FFS-23-24%20Professional%20Fee%20Schedule%20Update%20to%20100_%20Medicare%20(part%201)%20-%20signed.pdf

ATTACHMENT Q
HRSN Services Matrix

Service Category	Service	All eligible Medicaid enrollees
Housing/Home Environment interventions without room and board	Pre-tenancy Services	**X**
	Tenancy and sustaining services	**X**
	One-time transition and moving costs *other than* rent	**X**
	Utility assistance	**X**
	Medically Necessary Home Remediations	**X**
	Home/environmental accessibility modifications	**X**
Housing interventions *with* Room and Board (Episodic Interventions)	Short-term pre-procedure housing	**X**
	Short-term Recuperative care	**X**
	Short-term post-hospitalization housing	**X**
Housing interventions with Room and Board (Rent Only Interventions)	First month's rent, as a transitional service	**X**
	Short-term rental assistance	**X**
Nutrition interventions without food	Nutrition instruction	**X**
Nutrition interventions with food	Home Delivered meals/Pantry Stocking	**X**
	Medically Tailored Meals	**X**
	Nutrition prescriptions	**X**

	Service	Population	Social Risk Factor	Clinical Criteria for the Population
Housing/Home Environment interventions without room and board	Pre-tenancy Services	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Tenancy Sustaining services	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	One-time transition and moving costs *other than* rent	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Utility assistance	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Medically Necessary Home Remediations	All eligible Medicaid enrollees	**Clinically appropriate home modification/remediation service need**	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Home/environmental accessibility modifications	All eligible Medicaid enrollees	**Clinically appropriate home modification/remediation service need**	One of the following health needs-based criteria: 1.Complex Behavioral Health

				Need 2. Complex Physical Health Need
Housing interventions *<u>with</u>* Room and Board (Episodic Interventions)	Short-term pre-procedure housing	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	Pre-Procedure Housing Need
	Short-term Recuperative care	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	Recuperative Care or Short-term Post-Hospitalization Housing Need
	Short-term post-hospitalization housing	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	Recuperative Care or Short-term Post-Hospitalization Housing Need
Housing interventions with Room and Board (Rent Only Interventions)	First month's rent, as a transitional service	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need
	Short-term rental assistance	All eligible Medicaid enrollees	**Housing Related Need:** Individuals at-risk of homelessness or experiencing homelessness	One of the following health needs-based criteria: 1.Complex Behavioral Health Need 2. Complex Physical Health Need

	Service	Population	Social Risk Factor	Clinical Criteria for the Population
Nutrition interventions without food	Nutrition instruction	All eligible Medicaid enrollees	**Nutrition Related Need:** An individual meeting the USDA definition of low or very low food security	- Complex Behavioral Health Need - Developmental Disability Need - Complex Physical Health Need - Needs Assistance with ADLs/IADLs or Eligible for LTSS - Health Conditions related to trauma - Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services - Pregnant/Postpartum
Nutrition interventions with food	Home Delivered meals/Pantry Stocking	All eligible Medicaid enrollees	**Nutrition Related Need:** An individual meeting the USDA definition of low or very low food security	- Complex Behavioral Health Need - Developmental Disability Need - Complex Physical Health Need - Needs Assistance with ADLs/IADLs or Eligible for LTSS - Health Conditions related to trauma - Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services - Pregnant/Postpartum

	Medically Tailored Meals	All eligible Medicaid enrollees	**Nutrition Related Need:** An individual meeting the USDA definition of low or very low food security	- Complex Behavioral Health Need - Developmental Disability Need - Complex Physical Health Need - Needs Assistance with ADLs/IADLs or Eligible for LTSS - Health Conditions related to trauma - Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services - Pregnant/Postpartum
	Nutrition prescriptions	All eligible Medicaid enrollees	**Nutrition Related Need:** An individual meeting the USDA definition of low or very low food security	- Complex Behavioral Health Need - Developmental Disability Need - Complex Physical Health Need - Needs Assistance with ADLs/IADLs or Eligible for LTSS - Health Conditions related to trauma - Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services - Pregnant/Postpartum

Clinical Risk Factor	Clinical Criteria Detail
Complex Behavioral Health Need	CIS+ Criteria: 1. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or 2. Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1 indicating the need for intensive outpatient treatment for a substance use disorder (SUD). Nutrition Supports Criteria: An individual with a persistent, disabling, progressive, or life-threatening mental health condition or substance use disorder that requires treatment and/or supports, and would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning(including the ability to live independently without support), or maintain health goals.
Developmental Disability Need	An individual with an Intellectual Disability or Developmental Disability, or both, as defined in HRS § 333F-1, that would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals.

Complex Physical Health Need	CIS+ Criteria: Beneficiary assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support). Nutrition Supports Criteria: An individual with an acute or chronic physical health condition(s) that would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals. Chronic conditions that would benefit from nutrition supports include eating disorders, severe food allergies, gastrointestinal disorders, complex non-healing wounds, malnourishment disorders, seizure disorders, COPD, Chronic Kidney Disease, hypertension, diabetes, cardiovascular disorders, stroke, high-risk perinatal conditions, cancer, HIV, morbid obesity (BMI 40+), pre-diabetes, and metabolic syndrome. Nutrition supports for acute physical health conditions will be limited to the time period of healing.
Needs Assistance with ADLs/IADLs or Eligible for LTSS	Individuals who meet an institutional level of care requirement and individuals who are assessed to be at risk of deteriorating to the institutional level of care (i.e., the "at risk" population) who do not reside in a Medicaid-paid setting that would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals.
Health Conditions related to trauma	An individual who is experiencing a health condition, including but not limited to behavioral health and developmental syndromes, stemming from child abuse, domestic violence, neglect, or other types of trauma
Repeated Emergency Department Use, Repeated Hospitalizations, and Elevated Mental Health Services	An individual with repeated use of emergency department care (defined as two or more visits in the past six months or five or more visits within the past 12 months); with repeated hospitalizations (defined as two or more hospitalizations in the past six months or five or more hospitalizations within the past 12 months); or who has received services from the Hawaii State Department of Health's Adult Mental Health Division, Child and Adolescent Mental Health Division, Developmental Disabilities Division, Alcohol and Drug Abuse Division, or Hawaii State Hospital within the past 12 months; that would benefit from nutrition supports in order to facilitate treatment, achieve and/or maintain care goals, achieve improvements, achieve stabilization, prevent exacerbation or deterioration of functioning (including the ability to live independently without support), or maintain health goals.

Pregnant/Postpartum	1. Medically Complicated Pregnancy: An individual who is currently pregnant or up to 12 months postpartum for a medically complicated pregnancy. 2. Pregnancy without Complicating Factors: An individual who is currently pregnant or up to 2 months postpartum for a pregnancy without complicating factors.
Recuperative Care or Short-term Post-Hospitalization Housing Need	An individual must meet one of the three following criteria: 1. Are at risk of ED/hospitalization or institutional care due to a clinical condition; 2. In the ED or hospitalized; or 3. In institutional care And, an individual must have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of recuperative care or short-term post-hospitalization housing.
Pre-Procedure Housing Need	Have a planned medical procedure requiring preparation care (i.e., colonoscopy) or have a planned medical treatment (i.e., chemotherapy treatment) requiring care prior to or following treatment.

Social Risk Factor	Social Criteria Detail
Housing Related Needs	An individual who is at least 18 years of age and homeless or at risk of homelessness as defined by HUD and codified in 24 CFR 91.5 with the following modifications: 1. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless under the HUD definition to twenty-one (21) days, 2. Individuals and families are considered at risk of homelessness if they have been notified that they will lose their current housing or living situation in writing or with verbal notification, and 3. Individuals and families are considered at risk of homelessness without additional income-based eligibility determinations (removes requirement that individuals or families have an annual income below 30 percent of Median Family Income)
Nutrition Related Needs	An individual meeting the USDA definition[1] of low or very low food security.

Clinically Appropriate Home Modification/ Remediation Service Need	An individual who: 1. Requires a clinically appropriate home modification/remediation service. 2. Lives in housing that is physically inaccessible or unsafe due to a member's disability or medical condition. 3. Is living in housing that is negatively impacting their health, due to factors including but not limited to pests, mold, elements of the home are in disrepair, the member has exposure to pathogens/hazards, and/or the property is inadequately maintained.

1. "Definitions of Food Security." USDA Economic Research Service, 2022. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/