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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

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,

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Date: 2026.05.15
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Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

Hawaiʻi 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 Hawaiʻi at Mānoa

Hawaiʻi QUEST Integration Section 1115(a) Demonstration

Approval Period: January 8, 2025 through December 31, 2029

For questions, please contact:

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I. General Background Information

The State of Hawaiʻi, Department of Human Services (DHS), Med-QUEST Division (MQD) is Hawaiʻi'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 Hawaiʻi's most recent request to extend the Section 1115 Demonstration project titled "Hawaiʻi 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 Hawaiʻi ʻOhana Nui Project Expansion (HOPE) Program (Med-QUEST Division, 2017), an effort that furthers MQD's mission to "*empower Hawaiʻi'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 Hawaiʻi'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.[1] **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.**

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[1] 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: Hawaiʻi, Delaware, Montana, and Washington. CM Services encourage individual positive behavior change consistent with substance non-use or medication/treatment adherence. Hawaiʻi 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 Hawaiʻi 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. Hawaiʻi'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 Hawaiʻi'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, Hawaiʻi 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, Hawaiʻi 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 Hawaiʻi or out of state

This approval continues existing authority for Hawaiʻi 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 Hawaiʻi 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 Hawaiʻi. 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 Hawaiʻi'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 Hawaiʻi 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 Hawaiʻi'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 Hawaiʻi'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 Hawaiʻi 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 services, access to and quality of care in community settings after release, resulting in	**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 identified physical

	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.	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 Hawaiʻi 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 Hawaiʻi 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:

- **Hawaiʻi Medicaid (MQD) Administrative Claims and Encounter Data**: QI health plans in Hawaiʻi 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 Hawaiʻi 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 Hawaiʻi 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).” (Hawaiʻi 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 Hawaiʻi Health Analytics Program (HAP)		
Hawaiʻi 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 Hawaiʻi 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.

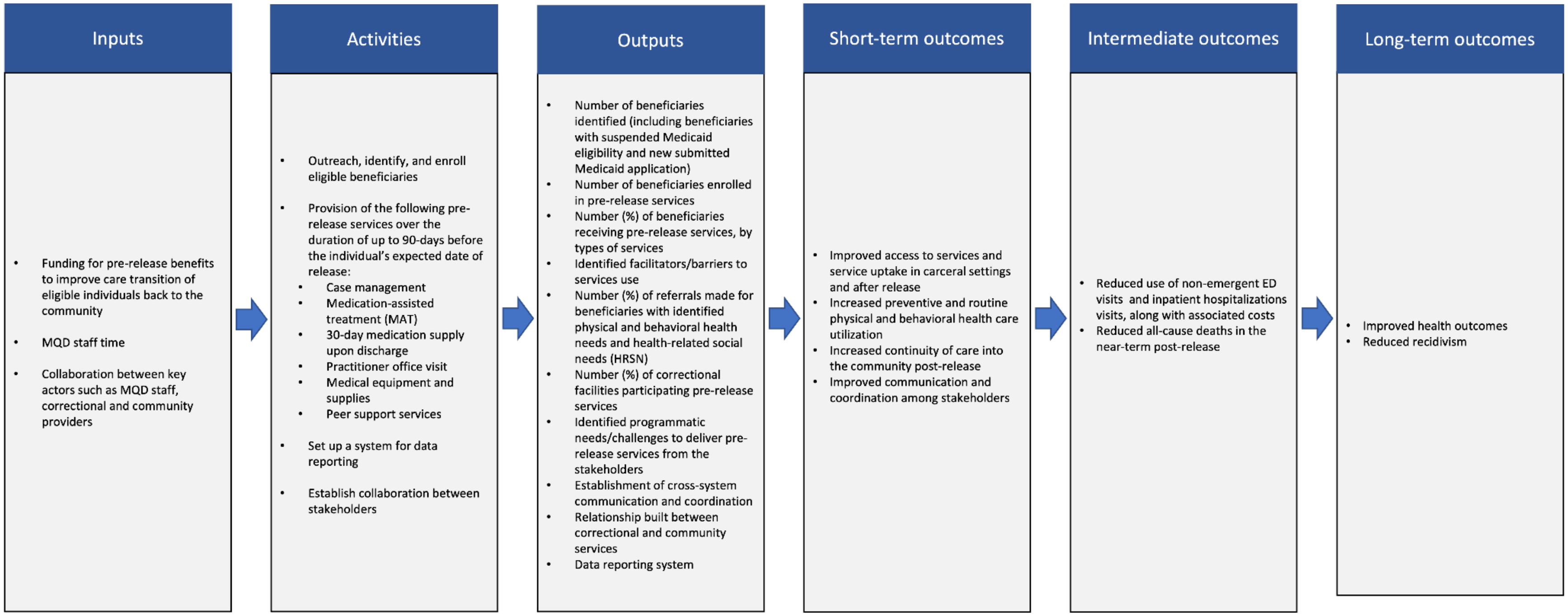
Demonstration Objective 1. Improve Health Outcomes for Medicaid-enrolled Individuals Covered under the Demonstration

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



Inputs

- Funding for pre-release benefits to improve care transition of eligible individuals back to the community
- MQD staff time
- Collaboration between key actors such as MQD staff, correctional and community providers

Activities

- Outreach, identify, and enroll eligible beneficiaries
- Provision of the following pre-release services over the duration of up to 90-days before the individual's expected date of release:
  - Case management
  - Medication-assisted treatment (MAT)
  - 30-day medication supply upon discharge
  - Practitioner office visit
  - Medical equipment and supplies
  - Peer support services
- Set up a system for data reporting
- Establish collaboration between stakeholders

Outputs

- Number of beneficiaries identified (including beneficiaries with suspended Medicaid eligibility and new submitted Medicaid application)
- Number of beneficiaries enrolled in pre-release services
- Number (%) of beneficiaries receiving pre-release services, by types of services
- Identified facilitators/barriers to services use
- Number (%) of referrals made for beneficiaries with identified physical and behavioral health needs and health-related social needs (HRSN)
- Number (%) of correctional facilities participating pre-release services
- Identified programmatic needs/challenges to deliver pre-release services from the stakeholders
- Establishment of cross-system communication and coordination
- Relationship built between correctional and community services
- Data reporting system

Short-term outcomes

- 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
- Improved communication and coordination among stakeholders

Intermediate outcomes

- Reduced use of non-emergent ED visits and inpatient hospitalizations visits, along with associated costs
- Reduced all-cause deaths in the near-term post-release

Long-term outcomes

- Improved health outcomes
- Reduced recidivism

Analytic Approach

Hawaiʻi'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 Hawaiʻi 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 (Oʻahu 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 • Contextual factors (e.g., staff training, screening tools) that trigger mechanisms (e.g., participant disclosure of needs)	• Correctional facility staff • Pre-release services case managers • Eligible beneficiaries Subgroups: Facility type (jail vs. prison vs. youth); geography (Oahu vs. neighbor islands); race/ethnicity; length of days before expected release date	• Interviews with correctional facility staff and case managers • QI Health Plan Re-Entry Reports • KOLEA Eligibility and Enrollment Data	• Descriptive analysis • Thematic analysis of qualitative interviews using framework approach

	• 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	under 30 days, 30 to 59 days, or 60 to 90 days		
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 days, or 60 to 90 days	● 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
Research question 1A.5b Is receiving pre-release services associated with	● ED visit count/rate per 100 releases (30-90 days); hospitalization count/rate, focusing on	Pre-release services beneficiaries released from facilities **Comparison groups**: individuals released from comparable		● DiD ● Subgroup analysis using

reduced non-emergent ED visits and inpatient hospitalization visits and their associated costs among beneficiaries?	preventable/ambulatory-care sensitive conditions; - Cost of care for ED visits - Cost of care for hospitalizations	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		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 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 - State death data	- DiD - Subgroup analysis using Interaction terms in DiD models - If needed ITS

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.

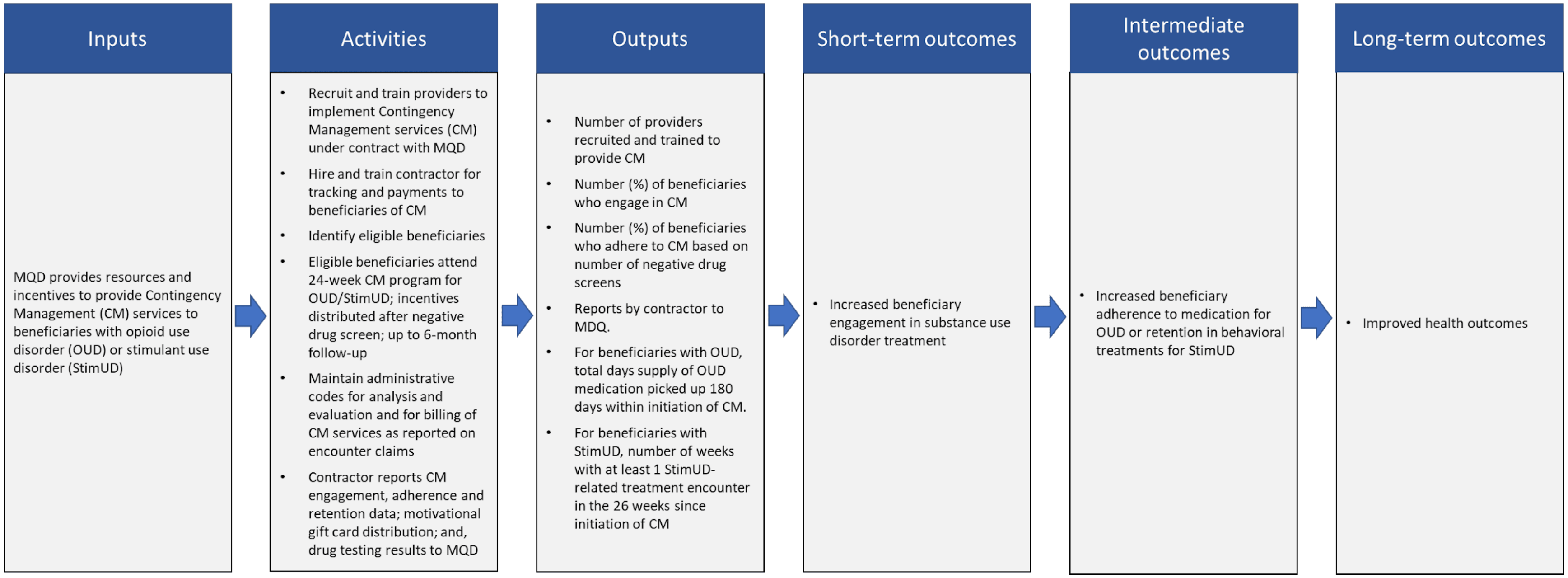
The core intervention involves a 24-week CM program for beneficiaries. The evaluation will be conducted on a sample of beneficiaries who meet the eligibility criteria for CM services and received services, vs. those that met eligibility criteria and did not receive services. The eligibility criteria 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



Inputs	Activities	Outputs	Short-term outcomes	Intermediate outcomes	Long-term outcomes
MQD provides resources and incentives to provide Contingency Management (CM) services to beneficiaries with opioid use disorder (OUD) or stimulant use disorder (StimUD)	• Recruit and train providers to implement Contingency Management services (CM) under contract with MQD • Hire and train contractor for tracking and payments to beneficiaries of CM • Identify eligible beneficiaries • Eligible beneficiaries attend 24-week CM program for OUD/StimUD; incentives distributed after negative drug screen; up to 6-month follow-up • Maintain administrative codes for analysis and evaluation and for billing of CM services as reported on encounter claims • Contractor reports CM engagement, adherence and retention data; motivational gift card distribution; and, drug testing results to MQD	• Number of providers recruited and trained to provide CM • Number (%) of beneficiaries who engage in CM • Number (%) of beneficiaries who adhere to CM based on number of negative drug screens • Reports by contractor to MDQ. • For beneficiaries with OUD, total days supply of OUD medication picked up 180 days within initiation of CM. • For beneficiaries with StimUD, number of weeks with at least 1 StimUD-related treatment encounter in the 26 weeks since initiation of CM	• Increased beneficiary engagement in substance use disorder treatment	• Increased beneficiary adherence to medication for OUD or retention in behavioral treatments for StimUD	• Improved health outcomes

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 period (2025-2029)	• MQD Administrative Claims and Encounter Data • KOLEA Eligibility and Enrollment Data • QI Health Plan HCS reports	• 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 statistical techniques will be applied to

			• QI Health Plan CM reports I	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 of services associated with the CM program?	• The cost of services associated with the CM program will be quantified as the cost of services delivered in encounters that involved treatment of SUD	• 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: the total cost of treatment services related to SUD diagnosis will be calculated.

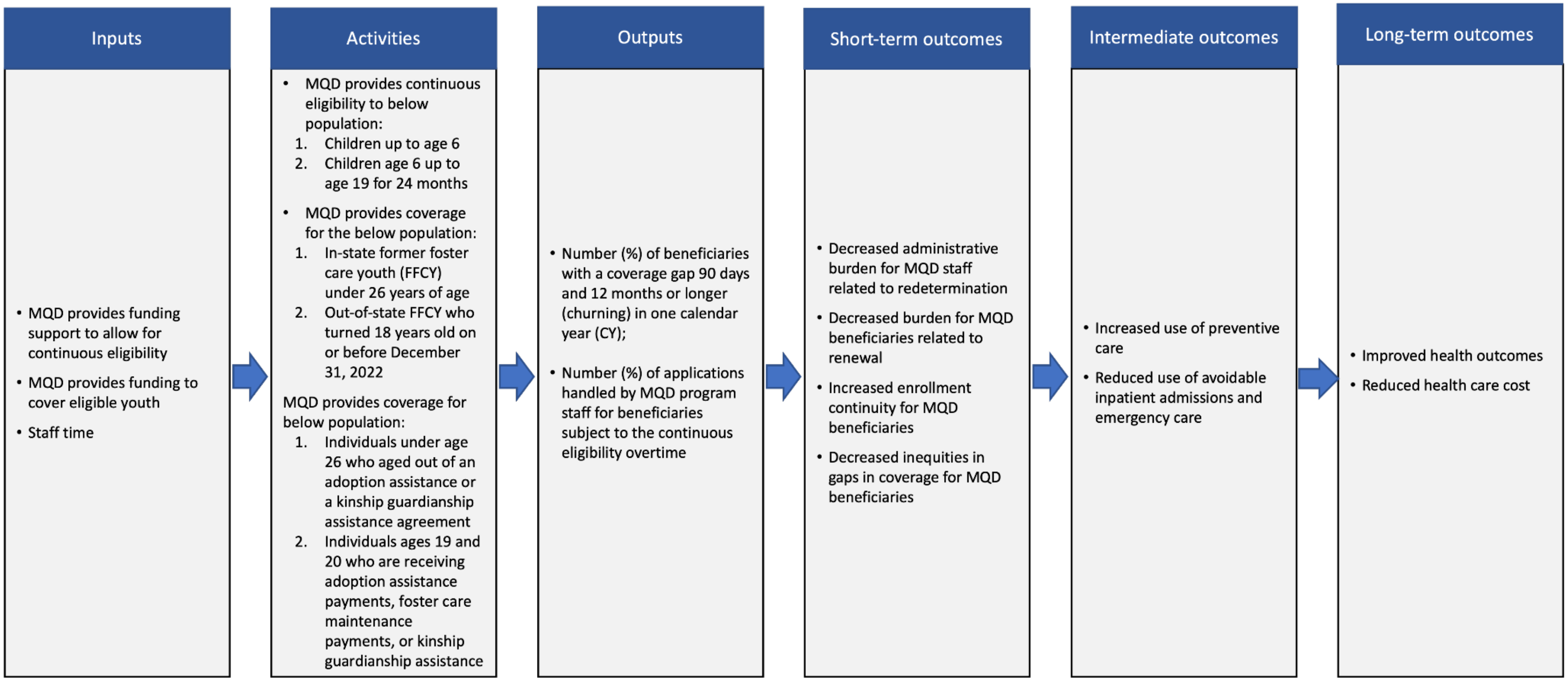
Project 1C: Continuous Eligibility for Medicaid Children and Coverage for Former Foster Care Youth (FFCY) and Youth Aged Out from Adoption System/Kinship Guardianship System

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



Inputs

- MQD provides funding support to allow for continuous eligibility
- MQD provides funding to cover eligible youth
- Staff time

Activities

- MQD provides continuous eligibility to below population:
  1. Children up to age 6
  2. Children age 6 up to age 19 for 24 months
- MQD provides coverage for the below population:
  1. In-state former foster care youth (FFCY) under 26 years of age
  2. Out-of-state FFCY who turned 18 years old on or before December 31, 2022

MQD provides coverage for below population:

1. Individuals under age 26 who aged out of an adoption assistance or a kinship guardianship assistance agreement
2. Individuals ages 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance

Outputs

- Number (%) of beneficiaries with a coverage gap 90 days and 12 months or longer (churning) in one calendar year (CY);
- Number (%) of applications handled by MQD program staff for beneficiaries subject to the continuous eligibility overtime

Short-term outcomes

- Decreased administrative burden for MQD staff related to redetermination
- Decreased burden for MQD beneficiaries related to renewal
- Increased enrollment continuity for MQD beneficiaries
- Decreased inequities in gaps in coverage for MQD beneficiaries

Intermediate outcomes

- Increased use of preventive care
- Reduced use of avoidable inpatient admissions and emergency care

Long-term outcomes

- Improved health outcomes
- Reduced health care cost

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 and enrollment for beneficiaries?	• Description of eligibility determination and redetermination process	MQD program staff and other stakeholders involved in eligibility determination and redetermination	• Semi-structured interviews • Focus groups • State policy documents (e.g., the State Plan Amendments)	Qualitative analysis of documents and interviews/focus 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 Demonstration
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, language), before and after	KOLEA Eligibility and Enrollment Data	• Descriptive statistics • Trend analysis to look at the trends of administrative burden and

		the implementation of continuous eligibility		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

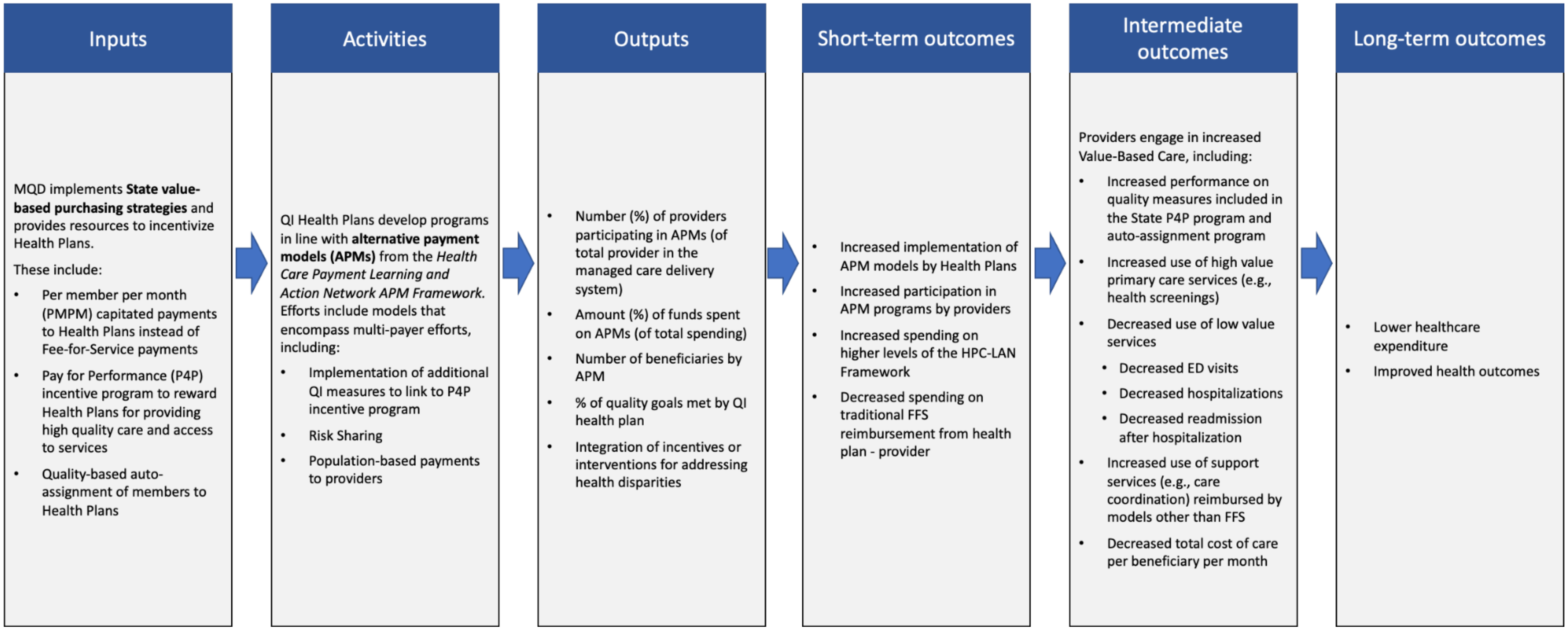
Project 2: Value-Based Purchasing and Alternative Payment Models (APMs)

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



Inputs

MQD implements **State value-based purchasing strategies** and provides resources to incentivize Health Plans.

These include:

- Per member per month (PMPM) capitated payments to Health Plans instead of Fee-for-Service payments
- Pay for Performance (P4P) incentive program to reward Health Plans for providing high quality care and access to services
- Quality-based auto-assignment of members to Health Plans

Activities

QI Health Plans develop programs in line with **alternative payment models (APMs)** from the *Health Care Payment Learning and Action Network APM Framework.* Efforts include models that encompass multi-payer efforts, including:

- Implementation of additional QI measures to link to P4P incentive program
- Risk Sharing
- Population-based payments to providers

Outputs

- Number (%) of providers participating in APMs (of total provider in the managed care delivery system)
- Amount (%) of funds spent on APMs (of total spending)
- Number of beneficiaries by APM
- % of quality goals met by QI health plan
- Integration of incentives or interventions for addressing health disparities

Short-term outcomes

- Increased implementation of APM models by Health Plans
- Increased participation in APM programs by providers
- Increased spending on higher levels of the HPC-LAN Framework
- Decreased spending on traditional FFS reimbursement from health plan - provider

Intermediate outcomes

Providers engage in increased Value-Based Care, including:

- Increased performance on quality measures included in the State P4P program and auto-assignment program
- Increased use of high value primary care services (e.g., health screenings)
- Decreased use of low value services
  - Decreased ED visits
  - Decreased hospitalizations
  - Decreased readmission after hospitalization
- Increased use of support services (e.g., care coordination) reimbursed by models other than FFS
- Decreased total cost of care per beneficiary per month

Long-term outcomes

- Lower healthcare expenditure
- Improved health outcomes

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.[2] 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' 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.

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[2] Interview scheduling for research question 2.1a and 2.1b may be combined to reduce participation burden on participants.

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 addressing health disparities	● 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

			● 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, and expenditure?	● Use of primary care defined in the 2019-2024 1115 demonstration waiver ● ED visits ● Hospitalizations ● Readmission after hospitalization ● Total cost of care per beneficiary per month	● Adult (age18+) Medicaid beneficiaries attributed to HCP-LAN APM level three and four during the Demonstration period (2025-2029). Comparison group ● Adult (age 18+) Medicaid beneficiaries without attribution to APM level 3 and 4.	● QI Health Plan VHC reports ● MQD Administrative Claims and Encounter Data ● KOLEA Eligibility and Enrollment Data ● Milliman Actuarial Risk Score Data	● Regression analysis to identify differences in outcomes between beneficiaries attributed to advanced HCP-LAN APMs (controlling covariates including demographics, risk score)

		Subgroup analyses by beneficiaries' demographics (age, sex, race/ethnicity, region, language)		

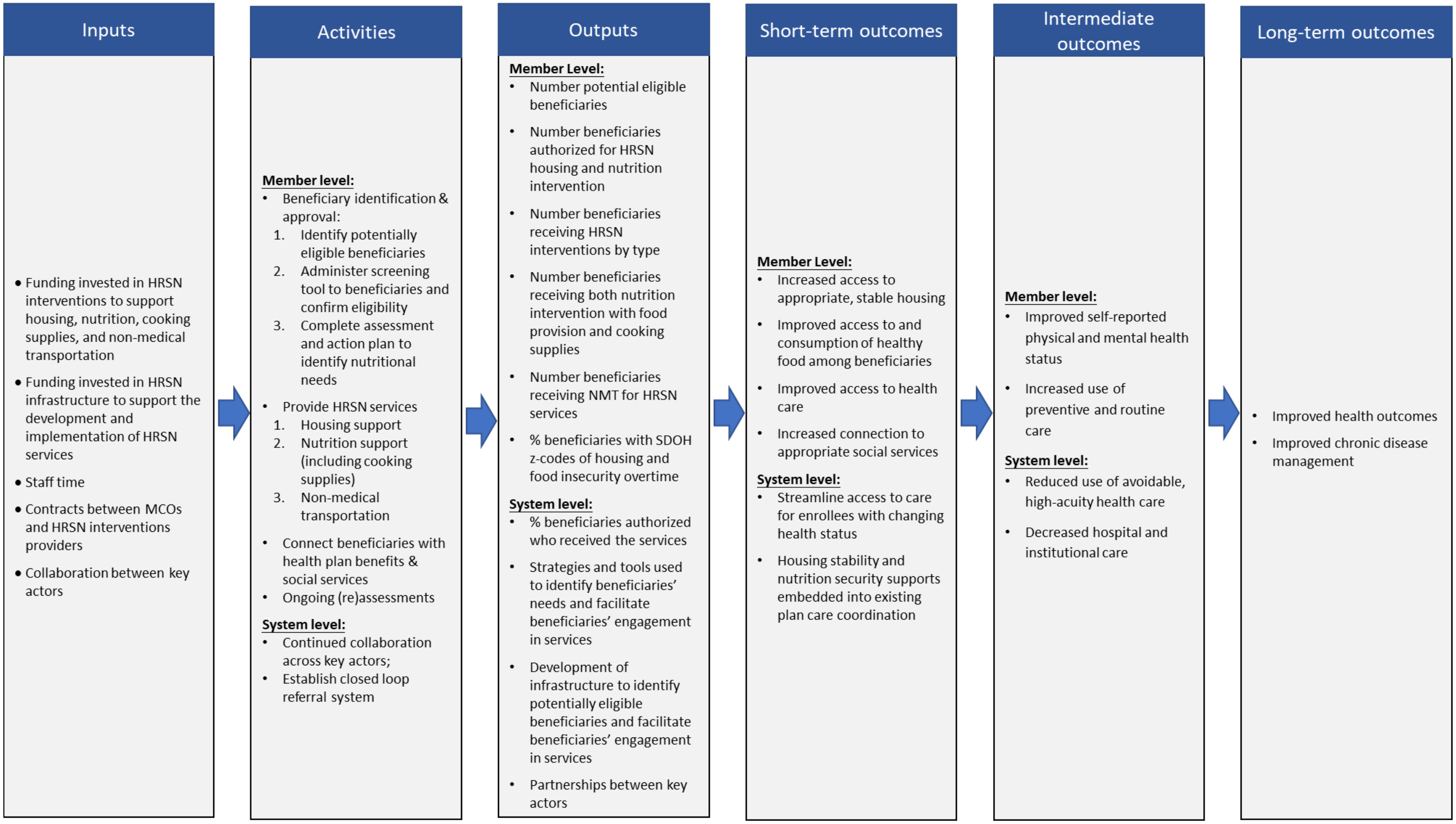
Demonstration Objective 3. Address Social Drivers of Health to Improve Health Outcomes and Lower Healthcare Costs

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



Inputs

- Funding invested in HRSN interventions to support housing, nutrition, cooking supplies, and non-medical transportation
- Funding invested in HRSN infrastructure to support the development and implementation of HRSN services
- Staff time
- Contracts between MCOs and HRSN interventions providers
- Collaboration between key actors

Activities

Member level:

- Beneficiary identification & approval:
  1. Identify potentially eligible beneficiaries
  2. Administer screening tool to beneficiaries and confirm eligibility
  3. Complete assessment and action plan to identify nutritional needs
- Provide HRSN services
  1. Housing support
  2. Nutrition support (including cooking supplies)
  3. Non-medical transportation
- Connect beneficiaries with health plan benefits & social services
- Ongoing (re)assessments

System level:

- Continued collaboration across key actors;
- Establish closed loop referral system

Outputs

Member Level:

- Number potential eligible beneficiaries
- Number beneficiaries authorized for HRSN housing and nutrition intervention
- Number beneficiaries receiving HRSN interventions by type
- Number beneficiaries receiving both nutrition intervention with food provision and cooking supplies
- Number beneficiaries receiving NMT for HRSN services
- % beneficiaries with SDOH z-codes of housing and food insecurity overtime

System level:

- % beneficiaries authorized who received the services
- Strategies and tools used to identify beneficiaries' needs and facilitate beneficiaries' engagement in services
- Development of infrastructure to identify potentially eligible beneficiaries and facilitate beneficiaries' engagement in services
- Partnerships between key actors

Short-term outcomes

Member Level:

- Increased access to appropriate, stable housing
- Improved access to and consumption of healthy food among beneficiaries
- Improved access to health care
- Increased connection to appropriate social services

System level:

- Streamline access to care for enrollees with changing health status
- Housing stability and nutrition security supports embedded into existing plan care coordination

Intermediate outcomes

Member level:

- Improved self-reported physical and mental health status
- Increased use of preventive and routine care

System level:

- Reduced use of avoidable, high-acuity health care
- Decreased hospital and institutional care

Long-term outcomes

- Improved health outcomes
- Improved chronic disease management

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 between entities and how the Demonstration
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 HRSN interventions and what is the cost?	● Description of HRSN infrastructure components as a result of this Demonstration ● Expenditure of HRSN infrastructure components developed as part of this demonstration by HRSN stakeholders including providers,	Comparison of HRSN infrastructure and expenditure by region (e.g., islands, counties)	● Monitoring reports ● Relevant meeting notes ● Longitudinal interviews with key actors	

	community organizations and MQD			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 implementation of HRSN interventions
Research question 3.2b How do HRSN interventions impact the use of housing and nutrition services and the rate of housing	● Number of potential eligible beneficiaries	Beneficiaries meeting the HRSN services eligibility criteria	● MQD Administrative Claims and Encounter Data	● Descriptive statistics ● ITS analysis to compare the

stability and nutrition security among 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 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)	● 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	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,	● Self-reported physical and mental health status ● Use of primary care defined in the 2019-2024 1115 demonstration waiver ● ED visits	Beneficiaries receiving HRSN interventions **Comparison group:** Eligible beneficiaries who are not yet	● MQD Administrative Claims and Encounter Data	● Descriptive statistics ● Regression analysis (controlling covariates

hospital and institutional care, health care spending?	● 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	receiving the HRSN interventions Subgroup analyses by beneficiaries' demographics (age, sex, race/ethnicity, region, language)	● KOLEA Eligibility and Enrollment Data ● QI Health Plan Nutrition Intervention Reports ● QI Health Plan CIS+ Reports ● QI Health Plan HCS Reports	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 ● QI Health Plan Re-entry Reports ● QI Health Plan Contingency Management Reports ● QI Health Plan HCS Reports	• Regression analysis (controlling covariates including demographics and risk score) to examine whether receiving multiple services is linked to better health outcome

VI. Attachments

A. Independent Evaluator

The State of Hawaiʻi has contracted the Social Science Research Institute at the University of Hawaiʻi 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 Hawaiʻi 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 Hawaiʻi 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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