DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

January 8, 2025

Judy Mohr Peterson, Ph.D.
Med-QUEST Division Administrator
State of Hawaii, Department of Human Services
601 Kanokila Blvd, Room 518
Kapolei, HI 96709-0190

Dear Dr. Mohr Peterson:

The Centers for Medicare & Medicaid Services (CMS) is approving Hawaii's request to extend its section 1115 demonstration entitled, "Hawaii QUEST Integration" (Project Number 11-W-00001/9), in accordance with section 1115(a) of the Social Security Act. With this approval, the demonstration extension will be effective January 8, 2025 through December 31, 2029, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS has determined that Hawaii's QUEST Integration demonstration is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality medical assistance and improving health outcomes for beneficiaries. Approval of this request will extend most of the authorities from the 2019 extension of the demonstration and the recent continuous eligibility amendment, and it will include new initiatives related to promoting services addressing health-related social needs (HRSN), designated state health programs (DSHP), contingency management (CM), additional flexibilities in how home and community-based services (HCBS) are delivered, and non-medical transportation (NMT).. In addition, approval of this demonstration extension will provide expenditure authority for limited coverage for certain services furnished to certain incarcerated individuals for up to 90 days immediately prior to the individual's expected date of release. With this extension, Hawaii is introducing new initiatives and investments to assist the state in improving health coverage, access, and consistent provision of high-quality services for Medicaid beneficiaries, while additionally making important gains in advancing health equity among its beneficiary populations.

CMS's approval is subject to the limitations specified in the attached waiver and expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent that those requirements have been specifically listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration Extension

Approval of Hawaii's QUEST Integration demonstration extension includes the following new initiatives: (1) HRSN; (2) Reentry; (3) DSHP; (4) CM; (5) HCBS Flexibilities; (6) assisted living facility benefits for populations at risk of institutionalization; (7) NMT; (8) cooking supplies; (9) coverage for out-of-state former foster care youth and (10) amendment of existing authorities. The overall goals of this demonstration include:

- 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.

1) Health-Related Social Needs (HRSN)

HRSN Services

CMS is authorizing the state to offer coverage of certain services that address HRSN for qualifying beneficiaries, as evidence indicates that these benefits are critical drivers of an individual's access to health services that keep them well.[1,2] Under this demonstration, the state will receive authority to cover the following HRSN housing interventions: housing supports without room and board (i.e., pre-tenancy navigation services, one-time transition and moving costs other than rent, and tenancy and sustaining services), utility assistance, home remediations that are medically necessary, home/environmental accessibility modifications, episodic housing interventions with clinical services with room and board (i.e., short-term pre-procedure housing, short-term recuperative care, and short-term post-transition housing), and room and board-only supports (i.e., first month's rent as a transitional service and short-term rental assistance). In addition, the state will receive authority to cover the following HRSN nutrition interventions: nutrition instruction, home delivered meals or pantry stocking, medically tailored meals, and nutrition prescriptions.

Coverage of targeted HRSN services and supports is likely to assist in promoting the objectives of Medicaid because it is expected to help beneficiaries stay connected to coverage and access to needed health care. The housing and nutritional support services authorized under the demonstration are expected to stabilize the housing and nutritional situations of eligible

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[1] As discussed in a letter to State Health Officials issued on January 7, 2021, https://www.medicaid.gov/federalpolicy-guidance/downloads/sho21001.pdf, addressing Social Determinants of Health can more effectively improve population health, reduce disability, and lower overall health care costs in the Medicaid program. While "social determinants of health" is a broad term that relates to the health of all people, HRSN relates more specifically to an individual's adverse conditions reflecting needs that are unmet and contribute to poor health. See also https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/full/

[2] Bachrach, D., Pfister, H., Wallis, K., Lipson, M. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. The Commonwealth Fund; 2014; https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2014_may_1749_bachrach_addressing_patients_social_needs_v2.pdf.

beneficiaries and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid- and demonstration-covered services to which they are entitled.

Coverage of targeted, clinically appropriate HRSN services will also provide a regular source of care to meet individuals' comprehensive health needs. This is likely to improve health outcomes directly, as well as improve the use of other clinical services. By providing the short-term services needed to stabilize housing, this demonstration will test whether the individual's health outcomes will improve in addition to their utilization of appropriate care.

Moreover, the Medicaid statute, including both sections 1905 and 1915 of the Social Security Act (the Act), already includes mechanisms that reflect the critical role of upstream services (i.e., those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities).

Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides home and community-based services (HCBS) to individuals meeting state-established needs-based criteria that are less stringent than criteria required for institutional placement. These services are also intended to avert a need for nursing facility care.

Available evidence[3] suggests there may be populations in addition to those eligible under 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) HCBS services described above, as well as additional upstream HRSN services. Additional research is needed to better understand the effects of providing both of these types of services to a broader group of people. To that end, this demonstration will test whether expanding eligibility for these services to additional populations or providing additional HRSN services can improve the health outcomes of certain Medicaid beneficiaries. The demonstration will also test whether extending eligibility for a broader range of Medicaid beneficiaries or providing additional services will help to maintain coverage by preventing health-related incidents that could lead to enrollment churn.[4]

Moreover, access to these services for individuals with poorer health outcomes may help to reduce health disparities. Expanding who can receive both HCBS and HRSN services is expected to help a broader range of Medicaid beneficiaries not only receive, and benefit from, the medical assistance to which they are entitled, but also, these services are expected to further reduce health disparities often rooted in socioeconomic factors.[5] Thus, broadening the availability of certain HCBS and HRSN services is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional medical services.

All section 1115 demonstration HRSN nutrition interventions with provision of food (full board; that is, three meals a day or any other complete nutritional regimen) are limited to a duration of 6

[3] September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions
[4] April 12, 2021. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf
[5] April 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort.
https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

months, renewable while the beneficiary continues to meet qualifying criteria. Under this demonstration, Hawaii will receive authority for several HRSN housing assistance services classified as episodic interventions with clinical services with room and board and services classified as room and board-only support (also known as rent-only interventions). Separate duration caps apply to each category of housing assistance (that is, episodic interventions with clinical services with room and board, and room and board-only support). Episodic interventions may be covered up to a combined 6 months per beneficiary, per rolling year. Separately, room and board-only support may be covered up to a combined 6 months per household, per demonstration period. For each of these 6-month caps, coverage will be permitted in one or more spans or episodes as long as the total duration remains under the cap for the rolling year or demonstration period. CMS will also apply a total combined cap of 6 months of all types of HRSN housing interventions with room and board, per beneficiary, in any 12-month period. However, if a beneficiary is considered to have received room and board-only support because that intervention was covered for another member of the beneficiary's household, the beneficiary still may receive up to 6 months of coverage for episodic interventions in the same 12-month period.

As specified further in the STCs, HRSN services authorized in this demonstration must be clinically appropriate for the beneficiary. Beneficiaries qualified to receive HRSN services are those eligible for and enrolled in Medicaid with a documented medical need for the services. Attachment Q, which CMS is approving concurrently with this demonstration approval, reflects a comprehensive list of clinical criteria and social risk factors that the state will incorporate into the post-approval protocol that will define beneficiary qualifications for HRSN services.

CMS also expects the state to maintain existing state funding and efforts for HRSN services, without this demonstration authority supplanting existing efforts, and to have in place partnerships with other state and local entities to coordinate possible pathways to permanency for services to be provided without demonstration authorities.

With this approval, CMS is also concurrently approving the state's HRSN Services and Infrastructure Protocols, which will permit the state to immediately draw federal financial participation (FFP) for applicable expenditures.

HRSN Infrastructure

CMS is authorizing expenditure authority for the state to claim FFP for certain infrastructure expenditures to support the development and implementation of HRSN services, as specified further in the STCs.

Provider Rate Increase Condition

CMS is committed to improving access to quality care for all Medicaid beneficiaries and is engaged in an "all of Medicaid" approach to improve coverage, access to, and quality of care, as well as to improve health outcomes for all beneficiaries consistent with Medicaid's statutory objectives. Further, we expect that such policies will also have the effect of mitigating health

disparities. Research shows that increasing Medicaid payments to providers improves beneficiaries' access to health care services and the quality of care received.

As a condition of approval and ongoing provision of FFP for the DSHP and HRSN expenditures over this demonstration period of performance, DY 32 through DY 36, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and/or require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates. That rate increase must be at least two percentage points in the ratio of Medicaid to Medicare provider rates for each of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services for any delivery system operated by the state is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for any delivery system operated by the state, the state must increase provider payment rates in accordance with these STCs.

Hawaii has statutorily established that its Medicaid obstetric, behavioral health, and primary care service rates[6] all be established at 100 percent of Medicare rates, effective January 1, 2024. As a result, the state has demonstrated that it meets the initial requirement, but it must continue to maintain a payment ratio of at least 80 percent for the duration of the demonstration period. This requirement will be satisfied, provided Hawaii continues to maintain Medicaid payment rates for these services at 100 percent of equivalent Medicare rates.

2) *Pre-Release Services under the Reentry Demonstration Initiative*

Expenditure authority is being provided to Hawaii to provide limited coverage for a targeted set of services furnished to certain incarcerated individuals for 90 days immediately prior to the individual's expected date of release. The state's proposed approach closely aligns with CMS' "Reentry Demonstration Opportunity" as described in the State Medicaid Director Letter (SMDL) released on April 17, 2023.

Eligible Individuals

Hawaii will cover a set of pre-release benefits for certain individuals who are inmates residing in jails, prisons, and youth correctional facilities (herein after referred to as "correctional facilities"). To qualify for services covered under this demonstration approval, individuals residing in a correctional facility have been determined eligible for Medicaid pursuant to an application filed before or during incarceration and have an expected release date within 90 days.

Medicaid Eligibility and Enrollment

CMS is requiring, as a condition of approval of this demonstration extension, that Hawaii make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities listed above and outlined in the STCs.

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[6] State Plan Amendment (SPA) HI-23-0008.

For a Medicaid covered individual entering a correctional facility, Hawaii will not terminate Medicaid coverage but will suspend the individual's coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, Hawaii will ensure the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to improve care transitions of such eligible individuals back to the community, including by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of both physical and behavioral health needs and health-related social needs (HRSN). It is designed to address these overarching demonstration goals, while aiming to ensure that participating correctional facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing Hawaii to provide coverage for the following services to be detailed in an attachment to the demonstration's STCs:

- Case management to assess and address physical and behavioral health needs and health-related social needs;
- Medication assisted treatment (MAT) for all types of substance use disorders (SUDs) as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;
- A 30-day supply of all prescription medications provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;
- Practitioner office visit (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other);
- Diagnostic services, including laboratory and radiology services;
- Medical equipment and supplies; and
- Peer support services.

CMS recognizes that many individuals exiting correctional facilities may not have received sufficient health care to address all of their physical or behavioral health care needs while incarcerated. This demonstration initiative will provide individuals leaving correctional facilities the opportunity to receive short-term Medicaid pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, while providing the state the opportunity to test whether these pre-release services improve uptake and continuity of MAT and other SUD and behavioral health treatment, as appropriate for the individual, to reduce decompensation, suicide-related death, overdose, and overdose-related death. In addition, Hawaii has state specific goals for the reentry demonstration initiative including advancing the state's health equity priorities for racial and ethnic groups overrepresented in the justice-involved population (e.g., Native Hawaiians and Pacific Islanders),

identifying unaddressed medical and HRSNs prior to release and improving insights into healthcare delivery for justice-involved individuals, and reducing rates of recidivism among the justice-involved population. Therefore, CMS is approving a demonstration benefit package in Hawaii that is designed to improve identification of physical and behavioral health needs and HRSNs to facilitate connections to providers with the capacity to meet those needs in the community during the period immediately before an individual's expected release from a correctional facility. Once an individual is released, the coverage for which the individual is otherwise eligible must be provided consistent with all requirements applicable to such coverage.

Eligible Juveniles and This Reentry Demonstration Initiative

Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends the Social Security Act (the Act) and describes a mandatory population (eligible juveniles and targeted low-income children) and set of pre-release and post-release services, while section 5122 of the CAA, 2023 amends the Act and gives a state the option to receive federal financial participation for the full range of coverable services for eligible juveniles and targeted low-income children while pending disposition of charges. Every state is required to submit Medicaid and CHIP State Plan Amendments (SPAs) attesting to meeting the requirements in Section 5121 beginning January 1, 2025.[7]

To the extent there is overlap between the services required to be covered under sections 1902(a)(84)(D) of the Act and coverage under this demonstration, we understand that it would be administratively burdensome for states to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and this demonstration, we are approving a waiver of the otherwise mandatory state plan coverage requirements to permit the state instead to cover at least the same services for the same beneficiaries under this demonstration. This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring, and evaluation of the state's reentry coverage under the demonstration. The state will provide coverage under the reentry demonstration to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under section 5121 of the CAA, 2023 will remain unchanged. Coverage of the population and benefits identified in sections 1902(a)(84)(D) of the Act, as applicable, will automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in those provisions.

Implementation and Reinvestment Plans

As described in the demonstration STCs, Hawaii will be required to submit to CMS a Reentry Initiative Implementation Plan (Implementation Plan) and Reinvestment Plan documenting how the state will operationalize coverage and provision of pre-release services and how existing

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[7] SHO# 24-004, RE: Provision of Medicaid and CHIP Services to Incarcerated Youth. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf

funding for correctional facility health services will continue to support access to necessary care and achievement of positive health outcomes for the justice-involved population.

The Implementation Plan must be submitted to CMS consistent with the STCs and must describe the milestones and associated actions being addressed under this demonstration extension and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities and describe the state's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for both program policy implementation and investments in transitional nonservice elements, as applicable. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the reentry demonstration initiative. The operational plan requirement in section 1902(a)(84)(D) of the Act is satisfied by the state's Implementation Plan. The state is still required to provide coverage and otherwise meet state plan requirements with respect to any population or service specified in section 1902(a)(84)(D) of the Act that is not covered under this demonstration.

The reentry demonstration initiative is not intended to shift current correctional facility health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act; P.L. 155-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of title XIX, which includes the inmate payment exclusion, in recognition that the correctional authority bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve correctional authorities in Hawaii of their Constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a tribal, state, or local correctional authority to the Medicaid program.

Hawaii agrees to reinvest the total amount of new federal matching funds for the reentry demonstration initiative received under this demonstration extension into activities or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement, Hawaii will develop and submit a Reinvestment Plan to CMS outlining how the federal matching funds under the demonstration will be reinvested. The Reinvestment Plan should align with the goals of the state's reentry demonstration initiative. It should detail the state's plans to increase access to or improve the quality of health care services for those who have recently been released, and those who may be at higher risk of future criminal justice system involvement, particularly due to untreated behavioral health conditions. The Reinvestment Plan should describe the activities or initiatives selected by Hawaii for investment and a timeline for implementation. Any investment in carceral health care must add to and/or improve the quality of health care services and

resources for individuals who are incarcerated and those who are soon to be released from carceral settings, and not supplant existing state or local spending on such services and resources. The reinvestment plan may include the services provided to eligible juveniles under 1902(nn)(2) of the Act, who are covered under this demonstration.

3) Designated State Health Programs (DSHP)

In December 2017, CMS issued SMDL #17-005, titled "Phase-out of Expenditure Authority for Designated State Health Programs in Section 1115 Demonstrations," in which CMS announced it no longer would accept state proposals for new or extended section 1115 demonstrations that rely on federal matching funds for DSHP. The 2017 SMDL explained that CMS has approved section 1115 demonstrations that provided federal funding for DSHP that had previously been funded only with state funds, because (absent the section 1115 authority) state expenditures on these programs did not qualify for federal matching funds. These approvals of section 1115 demonstrations enabled the state to use the "freed up" state dollars that it otherwise would have been spent on the DSHP on demonstration expenditures. CMS has rescinded this previous guidance, effective December 23, 2022,[8] and is implementing an updated approach to DSHP as discussed below and as reflected in other recent section 1115 demonstration approvals.[9]

Recently, states have proposed demonstrations that seek federal matching funds for a state-funded DSHP so that they can "free up" state funding for Medicaid-covered initiatives. CMS is approving section 1115 demonstrations that provide federal funding for DSHPs under defined criteria within the STCs that limit both the size and scope of DSHP and apply additional parameters and guardrails. Specifically, CMS is approving federal expenditure authority for DSHP, only if the state uses the "freed up" state funding on a new demonstration initiative that CMS has determined is likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services. CMS expects that any new DSHP-funded demonstration initiative will add to the state's Medicaid program, not supplant existing services or programs.

CMS's revised approach to DSHP demonstrates CMS's continuing commitment to the federal-state financial partnership as a hallmark of Medicaid. CMS approves the Hawaii QUEST Integration extension as it is consistent with CMS's revised approach to approving expenditure authority for DSHP under section 1115 demonstrations. As described in the STCs, the state will be required to contribute state funds other than those freed up by the federal investment in DSHP for expenditures under the DSHP-funded demonstration initiative. DSHP authority will be time-limited, and the state will be required to submit a sustainability plan. The sustainability plan must describe the scope of DSHP-funded initiatives the state wants to maintain, and the state's strategy to secure resources to maintain these initiatives beyond the current demonstration approval period.

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[8] https://www.hhs.gov/guidance/document/phase-out-expenditure-authority-designated-state-health-programs-section-1115

[9] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-09282022-ca.pdf, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf, and https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-appvl-01092024.pdf.

As described in the STCs, Hawaii is contributing non-DSHP funds (e.g., general revenue) as the non-federal share of the DSHP-funded initiatives on an annual basis. With this demonstration extension, CMS is authorizing up to $128,100,000 in DSHP expenditure authority to support DSHP-funded demonstration initiatives, which include HRSN services. Any new DSHP-funded initiative requires approval from CMS via an amendment to the demonstration that meets the applicable transparency requirements, as required in STC 3.7.

As with CMS's other recent approvals of expenditure authority for DSHP, the state can claim federal matching funds up to the amount of the approved DSHP cap only if budget neutrality "savings" are available for that purpose. The state will be permitted to use the "freed-up state funds" that result from payment of the federal matching funds for its DSHP only on initiatives that improve access to covered services. As a result, CMS has determined that its approval of expenditure authority for the state's DSHP is likely to result in an increase in overall service coverage of low-income individuals in the state, improve health outcomes for Medicaid beneficiaries and other low-income populations in the state, and increase efficiency and quality of care. This will also help to ensure that approving these federal expenditures will not have a significant negative impact on Medicaid fiscal integrity.

The state must contribute $11,302,941 in original, non-freed up DSHP funds, over the course of the remaining demonstration period ending on December 31, 2029, towards its DSHP-funded initiatives. Additional requirements for DSHP are set forth in the STCs, including allowable and prohibited DSHP expenditures. The state may claim federal matching funds for DSHP upon CMS approval of the specific DSHP in Attachment I. CMS has generally not approved DSHP requests for expenditures that are already eligible for federal matching funds or other sources of federal funding, that are generally part of normal operating costs that would be included in provider payment rates, or that are not likely to promote the objectives of Medicaid (e.g., bricks and mortar, animal shelters and vaccines, and revolving capital funds). CMS will limit its approval of specific DSHP state programs that: (1) are population- or public health-focused; (2) are aligned with the objectives of the Medicaid program with no likelihood that the DSHP will frustrate or impede the primary objective of Medicaid, which is to provide coverage of services for low-income and vulnerable populations; and (3) serve a community largely made up of low-income individuals.

4) Contingency Management (CM) Services for Certain Beneficiaries with a Stimulant Use Disorder and/or Opioid Use Disorder

Contingency management is an evidence-based tool used for the treatment of stimulant use disorder and opioid use disorder, consisting of a series of incentives for meeting treatment goals. This approval will allow for coverage of contingency management services for Medicaid beneficiaries who are: (1) age 18 or older diagnosed with a stimulant use disorder and/or opioid use disorder; and (2) assessed and determined to have a stimulant use disorder and/or opioid use disorder as a diagnosis for which the contingency management benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based intervention. Beneficiaries aged 18 and older with a stimulant and/or opioid use disorder will be eligible for a twenty-four-week program.

The state will implement the contingency management benefit through approved behavioral health providers. Contingency management will be offered along with other therapeutic interventions, as appropriate, and the coverage of contingency management is not conditioned on an eligible beneficiary's engagement in other psychosocial services. This service will be provided as part of a twenty-four-week program in which a participating beneficiary can receive incentive payments, per an established schedule, for testing negative for identified stimulants or demonstrating treatment adherence for opioid use disorder.

5) HCBS Flexibilities

During the COVID-19 Public Health Emergency (PHE), the traditional provider workforce was diminished leading to inadequate capacity to provide medically necessary services such as supporting activities of daily living. On June 18, 2024, CMS approved a temporary extension of all the currently approved Attachment K HCBS flexibilities, compliant with the maintenance of effort provisions of Section 9817 of the American Rescue Plan Act of 2021 (P.L. 117-2). Approval of the extension transitions the short-term authority for the Attachment K flexibilities to the existing section 1115(a)(2) HCBS authorities. Specifically, the extension provides Hawaii with long-term authority under this demonstration project to allow level of care evaluations, functional assessments, and person-centered service planning to take place telephonically or virtually rather than in person. The extension also permits Hawaii to deliver certain HCBS services remotely, including adult day care, adult day health, and counseling and training activities. The extension also provides long-term authority for family caregivers (i.e., relatives/legal guardians) of participants or their legally responsible individuals, to be paid for providing personal care services. Finally, the extension also provides long-term authority for electronic signatures for person-centered service plans when meetings are held virtually.

6) Assisted Living Facility Services for Populations At Risk of Institutionalization

With this extension, CMS is approving the state's request to approve assisted living facility services as a new benefit for the "at risk" demonstration population to help delay or avoid nursing facility placement. Individuals who meet an institutional level of care are already eligible for assisted living facility services in Hawaii. This benefit is meant to help avoid more costly and intensive care for individuals who are on the cusp, but do not yet meet, an institutional level of care. These individuals are determined to be "at risk" of deteriorating to institutional level of care if long-term services or supports are not provided, as demonstrated by screening above a specific threshold on a functional assessment and/or needing hands-on assistance with at least one activity of daily living (ADL) or instrumental activity of daily living (IADL) due to a health condition. In addition, the individual must lack caregiver support to provide assistance with the ADLs or IADLs.

7) Non-Medical Transportation to HRSN Benefits

As part of this extension, the state can provide non-medical transportation (NMT) to Medicaid beneficiaries to and from HRSN services authorized under this demonstration.

8) Cooking Supplies

CMS is also providing expenditure authority for cooking supplies (e.g., pots and pans, utensils, or a refrigerator) that are necessary for meal preparation and nutritional welfare of a beneficiary when not available through other programs. This service is outside of the HRSN framework and requires separate authority from HRSN. In addition, the expenditures are considered with waiver only for the purpose of budget neutrality, as described below in the budget neutrality section.

9) Coverage for Out-of-state Former Foster Care Youth (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.

With this approval, Hawaii 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 (FFCC) 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, Hawaii 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.

10) Extension and Amendment of Existing Authorities

Hawaii will continue to operate its mandatory managed care delivery system through the demonstration. CMS does not provide any waiver or expenditure authorities for the state for managed care through this demonstration except to mandate enrollment of beneficiaries into managed care; the state is in full compliance with applicable managed care regulations and statute.

The state will continue its HCBS component that provides services similar to those authorized under sections 1915(c) and 1915(i) of the Act to individuals who need HCBS, either as an alternative to institutionalization or otherwise based on medical need. The existing services will continue under the demonstration and be obligated to adhere to HCBS guidelines, policies, and reporting procedures as described in the statute. With this extension, CMS is also removing previous STC language that required Hawaii to transition demonstration services to section 1915(c) and 1915(i) authorities. This language had been included to reflect previous CMS policy that required the transition of demonstration-authorized HCBS that was previously in other authorities back into those authorities. This is no longer CMS policy.

Hawaii’s existing coverage of HCBS-like housing supports through the Community Integration Services (CIS) program and the Community Transition Services (CTS) pilot program are both being subsumed into HRSN as part of this extension request. All of the existing benefits that had been previously delivered to beneficiaries will be continued and/or expanded as part of this extension.

This approval continues existing authority for Hawaii 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 Hawaii 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. CMS is also approving an extension of existing authority to provide Medicaid coverage to individuals ages 19 and 20 who are receiving adoption assistance payments, foster care maintenance payments, or kinship guardianship assistance.
With this approval Hawaii is removing a not-applicable expenditure authority of section 1902(a)(14) for cost sharing, as the state no longer charges any cost sharing to medically needy enrollees.

CMS is continuing the expenditure authority to provide continuous eligibility to children that was recently approved as an amendment to the demonstration on November 14, 2024. The expenditure authority allows the state to provide continuous eligibility to children up to age 6, from birth through the end of the month in which their sixth birthday falls, and children ages 6 up to age 19 for 24 months.

CMS has removed the Quality Review of Eligibility expenditure authority that authorized expenditures for Medicaid services that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings. The Center for Program Integrity (CPI) confirmed it was no longer applicable. The state is in compliance with section 1903(u) of the Act.

Budget Neutrality

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration. The demonstration extension is projected to be budget neutral to the federal government, meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and reporting requirements as outlined in the STCs.

Rebasing Without Waiver Baseline

Under this extension, for existing Medicaid Expenditure Groups (MEGs) that were implemented, CMS calculated the "without waiver" (WOW) baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period) by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline (except MEGs with aggregate cost limits) have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Main Budget Neutrality Test

For states that provide Medicaid coverage for "new adults" described in section 1902(a)(10)(A)(i)(VIII) of the Act under the state plan, but that also have demonstration authority affecting the group under section 1115(a)(1) of the Act, CMS has previously counted demonstration expenditures for this group as hypothetical expenditures, due to the high degree of cost variability from one year to the next, which, due to that volatility, produced highly anomalous trend rates. CMS and states have since gained sufficient experience covering this population for that cost variability to no longer be an issue. Therefore, under this approval, expenditures for "new adults" covered under the state plan to which waivers under section 1115(a)(1) apply are not considered to be hypothetical. Instead, these costs are included in the main budget neutrality test's WOW baseline, and thus, the state can earn "savings" from this population. While CMS evaluates each demonstration proposal on a case-by-case basis, including how it aligns with the objectives of Medicaid, CMS anticipates that it will consistently apply this updated approach to budget neutrality to all similarly situated states going forward. In contrast, in states that provide Medicaid coverage for "new adults" described in section 1902(a)(10)(A)(i)(VIII) of the Act under section 1115(a)(2)(A) expenditure authority and that have not included this group in the Medicaid state plan, CMS anticipates that it will continue to count demonstration expenditures for this group as hypothetical expenditures because the group could have been covered under the Medicaid state plan

Hypothetical Budget Neutrality Treatment

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to

pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS. The "Supplemental HRSN Aggregate Ceiling," or SHAC, for HRSN expenditures is different, as discussed below.

For each of these MEGs, discussed below in this section, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs MEG in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative include coverage of services that states can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be "hypothetical" because the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral setting, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in an institution for mental diseases primarily to receive treatment for SUD, or SMI or SED, under the SUD and SMI/SED section 1115 demonstration opportunities. Any population identified in section 1902(a)(84)(D) of the Act and covered instead under this demonstration will be included in the reentry MEG.

HRSN Budget Neutrality

CMS is treating HRSN expenditures authorized under this approval as "hypothetical" for the purposes of the budget neutrality calculation. Some of these expenditures could be covered under other title XIX authority, and treating those expenditures as hypothetical is consistent with how CMS has historically treated similar expenditures. Other HRSN expenditures could not otherwise be covered under title XIX authority, such as expenditures on section 1915 services for beneficiaries who are not otherwise eligible for them under section 1915, but there are insufficient or inconsistent data to calculate a WOW baseline for at least some of these expenditures. Treating those expenditures as hypothetical is also consistent with how CMS has historically treated similar expenditures. Additionally, treating demonstration HRSN expenditures as hypothetical will give the state the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs, based on robust academic-level research, but predicting these downstream effects on overall Medicaid program costs is extremely difficult. To ensure that treating HRSN expenditures as hypothetical does not have a significant negative fiscal impact on Medicaid, CMS is applying a budget neutrality ceiling to HRSN services expenditures and an additional sub-ceiling to HRSN infrastructure expenditures and is referring to these expenditures collectively as the "Supplemental HRSN Aggregate Ceiling (SHAC)" expenditures in the STCs.

The SHAC differs from the usual limit CMS places on hypothetical expenditures (the "supplemental test" discussed above) in several respects. The expenditures subject to the SHAC are narrowly defined to reflect only expenditures associated with services that research indicates are likely to have certain positive downstream effects. The upper limit on the SHAC is based on a range of estimates of the likely cost of these expenditures over a 5-year period, and is set at a mid-point in that range, but in no case can it exceed 3 percent of the state's total computable Medicaid spending. The sub-ceiling for infrastructure costs cannot exceed 15 percent of total HRSN expenditure authority. And, if the state exceeds these limits, it will not be permitted to offset the additional costs with savings from the rest of the demonstration. However, unspent HRSN infrastructure authority can be applied to HRSN services in the same demonstration year.

With Waiver Only Budget Neutrality

The state's coverage of contingency management, DSHP, and cooking supplies outside of initial community transitions are costs not otherwise matchable that require budget neutrality savings to offset the expenditures.

Mid-Course Correction

CMS has also updated its approach to mid-course corrections to budget neutrality calculations in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Out-of-State FFCY

CMS has deemed coverage of out-of-state FFCY to be budget neutral because the expenditure authority to cover this demonstration population is needed for only a temporary period, through 2030, when all FFCY will be covered via the Medicaid state plan FFCC population. Further, through monitoring budget neutrality, CMS determined that the actual experience of states' covering out-of-state FFCY resulted in limited total expenditures and low enrollment within the demonstrations. CMS generally believes that this FFCY demonstration coverage poses minimal financial risk to the federal government since FFCY demonstration spending is miniscule across states. This decision will increase the administrative ease of maintaining FFCY demonstration coverage in Hawaii.

The state will be required to report total expenditures and member months in its demonstration monitoring reports. The state must still report quarterly claims and report expenditures on the CMS 64.9 WAIVER form. Failure to report FFCY expenditures and member months will result in reinstatement of the budget neutrality requirement.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted its Interim Evaluation Report for the prior demonstration approval period with the extension application. Despite challenges due to the COVID-19 PHE, the state's Interim Evaluation Report showed evidence of some progress made toward the demonstration's goals. One focus of the demonstration was to increase primary care use and preventive services. Primary care spending decreased during the demonstration period; however, primary care visits that did occur were associated with positive outcomes, like better diabetes control and follow-up after ED for behavioral health hospitalizations. Findings for the integrated, team-based care coordination for complex conditions were evaluated by one health plan, which indicated that spending on the initiative was offset by positive impacts on ED utilization and expenditures. The HCBS project yielded promising results in that beneficiaries remaining in home settings displayed stable level of care scores over the demonstration period, while members in nursing homes or Community Care Foster Family Homes showed relative deterioration. Other components under the demonstration—Value-based Reimbursement at Health Plan and Provider Levels and Community Integration Services—could not yet be evaluated regarding health outcomes. The state's Summative Evaluation Report is expected to provide a fuller understanding of the demonstration's effectiveness leveraging additional years of data that may enable separating out the confounding effects of the COVID-19 PHE from those of the demonstration itself.

With this extension of the Hawaii QUEST Demonstration, the state is required to conduct systematic monitoring and robust evaluation of the demonstration extension in accordance with the STCs. The state must develop a Monitoring Protocol to incorporate how it will monitor the extension components, including relevant metrics data as well as narrative details describing progress with implementing the extension. In addition, the state is also required to conduct an independent Mid-Point Assessment of the Reentry Demonstration Initiative, as provided in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies.

The state is required to incorporate the extension into its evaluation activities to support a comprehensive assessment of whether the initiatives approved under the demonstration are effective in producing the desired outcomes for the individuals and the state's overall Medicaid program. The state's monitoring and evaluation efforts must facilitate understanding the extent to which the extension might support reducing existing disparities in access to and quality of care and health outcomes.

Eligible juveniles eligible under 1902(nn)(2) of the Act are included under this 1115 Reentry Demonstration Initiative and must be included in applicable monitoring and evaluation activities.

Consideration of Public Comments

The federal public comment period was open from February 5, 2024, through March 6, 2024, and CMS received 11 comments related to the demonstration. Commenters universally supported the items that were requested by the state in its extension application but offered suggestions to the state and CMS. CMS considered each comment but did not make changes to the demonstration extension as a result of any comments.

One commenter recommended the state amend its application to specifically provide HRSN nutritional interventions to pregnant/postpartum people.

One commenter recommended the state consider the unique needs of pregnant/postpartum people and those with behavioral health or reproductive health needs as it implements the reentry program. Another commenter encouraged the state to consider the unique needs of pregnant/postpartum people and children as part of the design and implementation of its proposed CM benefit.

Another commenter requested that the state pursue authority for continuous eligibility provided to adult populations, and also suggested that the state thoughtfully develop payment methodologies for the new services and populations stemming from this demonstration extension.

Another commenter requested that the state consider an additional accreditation for its nursing facilities as part of its efforts to improve outcomes for beneficiaries receiving long term services and supports and HCBS.

Another commenter asked that CMS and Hawaii consider health information technology (HIT) interoperability and beneficiary-focused data protections while implementing the state's HRSN request.

Other Information

CMS' approval of this demonstration extension is conditioned upon compliance with the enclosed amended set of waiver and expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. Your project officer, Jamie John, is available to answer any questions concerning this demonstration extension, and her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Jamie.John@cms.hhs.gov

If you have questions regarding this approval, please contact Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786 - 9686.

Sincerely,

Chiquita Brooks-LaSure

Enclosure

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